# Community Benefits Report

## Fiscal Year 2019

Beth Israel Lahey Health
Beverly Hospital

Beth Israel Lahey Health
Addison Gilbert Hospital

## Section I: Mission Statement

***Summary and Mission***

Northeast Hospital Corporation (NHC), also known as Beverly and Addison Gilbert Hospitals (BH/AGH), consists of multiple entities organized to service the needs of those in its communities. NHC, under a single license, operates Beverly Hospital, Addison Gilbert Hospital, and BayRidge Hospital, as well as an outpatient facility, Lahey Outpatient Center Danvers. All are members of Beth Israel Lahey Health (BILH). BILH was established with an appreciation for the importance of caring for patients and communities in new and better ways. BILH brings together an exceptional array of clinical organizations spanning the full continuum of health care delivery — academic and teaching hospitals, community hospitals, ambulatory and urgent care centers, behavioral health programs, and home care — in a shared mission to expand access to great care and advance the science and practice of medicine through groundbreaking research and education.

At the heart of BILH is the belief that everyone deserves high-quality, affordable health care, close to home. This belief is what drives us to work with community partners across the region to promote health, expand access, and deliver the best care in the communities BILH serves. BILH's Community Benefits staff is committed to working collaboratively with BILH's communities to address the leading health issues and create a healthy future for individuals, families, and communities.

***Beverly and Addison Gilbert Hospitals Community Benefits Mission Statement:*** The Community Benefits Program at Northeast Hospital Corporation (NHC), also known as BH/AGH (BH/AGH), is a program established to partner with community leaders and organizations to assess and meet the health care needs of the community. NHC incorporates the community health concepts of wellness, adaptation, self-care, and health promotion. Strategies used in community benefits health activities include prevention, early detection, early intervention, long-term management, and collaborative efforts with the affiliate organizations that make up the BILH system. Health issues addressed encompass safety, chronic disease, infectious disease, substance abuse and behavioral health, maternal and child health, and elder health. The corporate mission statement is grounded in the concepts of quality, caring, and community.

The following annual report provides specific details on how NHC is honoring its commitment and includes information on the hospitals' Community Benefit Service Area (CBSA), community health priorities, target population, and community partners, as well as detailed descriptions of its Community Benefits programs and their impacts. More broadly, our mission is fulfilled by:

- **Involving BH/AGH staff,** leadership, and dozens of community partners in the community health assessment process as well as in the development, implementation, and oversight of the IS.
- **Engaging and learning from residents** throughout the service area, in all aspects of the community benefits process, including assessment, planning, implementation, and evaluation. In this regard, special attention is given to engaging diverse perspectives from those who are not patients of BH/AGH and those who are often left out of these assessments, planning, and program implementation processes.
- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to identify unmet health-related needs and to characterize those in the community who are most vulnerable and face disparities in access and outcomes.
- **Implementing community health programs and services** in the hospitals' CBSA geared toward improving current and future health status of individuals, families, and communities by removing barriers to care, addressing social determinants of health, strengthening the health care system, and working to decrease the burdens of the leading health issues.
- **Promoting health equity** by addressing social and institutional inequities, racism, and bigotry, as well as ensuring that all patients are welcomed and received with respect and cultural responsiveness.
- **Facilitating collaboration and partnership** within and across sectors (e.g., public health, health care, social service, business, academic, and community health) to advocate for, support, and implement effective health policies, community programs, and services.

***Target Population***

BH/AGH CBSA comprises nine cities and towns including Gloucester, Rockport, Manchester-by-the-Sea, Essex, Ipswich, Middleton, Danvers, Beverly, and Lynn. Given that NHC operates multiple buildings under a single state license and services different geographic areas and populations, the communities that are part of the CBSA are an aggregate of those areas and populations. The FY16 CHNA, on which this report is based, shows that although all geographic, demographic, and socioeconomic segments of the population face challenges that can hinder the ability to access care or maintain good health, the populations listed below were identified as facing the greatest health disparities and being the most at risk:

- Individuals and Families of Low Resource
- Older Adults
- Youth and Adolescents
- Other Vulnerable Populations

***Basis for Selection***

In FY16, NHC, as a member of Lahey Health at that time, conducted its triennial CHNA in conjunction with all the hospitals in the Lahey Health System. The purpose of the CHNA was to inform and guide the hospital's selection of and commitment to programs and initiatives that address the health needs of the communities it serves. The CHNA was conducted in partnership with John Snow Inc., a public health research organization. Taken into consideration was the CHNA, public health data, community partners, NHC areas of expertise, and the Community Benefits Advisory Committee (CBAC).

***Key Accomplishments for FY19***

While NHC's most recent CHNA was completed in FY19, the accomplishments and programs included in this report are based upon priorities identified in the FY16 CHNA and aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) and the Massachusetts Department of Public Health (DPH):

**DPH:**

- Built Environment
- Social Environment
- Housing
- Violence
- Education
- Employment

**EOHHS:**

- Substance Use Disorders
- Housing/Homelessness
- Mental Health
- Chronic Disease

**FY16 CHNA:**

- Behavioral Health (Mental Health and Substance Use)
- Elder Health
- Wellness, Prevention, and Chronic Disease Management
- Maternal & Child Health

Northeast Hospital Corporation prides itself on its relationships with community partners, working to improve the health of those in need.

- BH/AGH and our community partners, The Open Door in Gloucester and Beverly Bootstraps in Beverly, continue the Emergency Food Bag Program for both communities and mobile markets in the summer.

- BH/AGH helped over 400 seniors take part in the classes provided in partnership with the North Shore YMCA, including Osteo Exercise, Enhance Fitness, and Aqua Aerobics

- BH/AGH hosted a total of 16 Senior Dine and Learn sessions (Senior Suppers), which ran at both Addison Gilbert Hospital and Beverly Hospital, reaching over 880 seniors.

- BH/AGH provided $100,000 in grant funding to local community organizations whose programs address our community priorities.

- BH/AGH partnered with Gloucester High School and coordinated a school-based Health Fair & Resource Information Day, providing health screenings and information to over 700 attendees.

- BH/AGH participated in health fairs and several screening activities throughout the communities of Gloucester, Rockport, Essex, Manchester-by-the-Sea, Beverly, and Danvers.

- BH/AGH provided 47 free weekly blood pressure clinics, screening over 700 people.
- BH/AGH sponsored a free dermatology cancer screening at Beverly Hospital that screened over 40 people.
- BH/AGH continues to provide our medication disposal box at Beverly Hospital, providing a safe and convenient way for the community to dispose of unused medications.

***Plans for Next Reporting Year***

In FY19, NHC conducted a comprehensive and inclusive CHNA that included qualitative and quantitative data collection, robust community engagement activities, and an inclusive prioritization process. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY19. In response to the FY19 CHNA, BH/AGH will focus its FY20-FY22 IS on the following priority areas that collectively address the broad range of health and social issues facing residents with the greatest health disparities living in our CBSA:

**1) Social Determinants of Health and Access to Care –** the social determinants of health (e.g., economic stability, transportation, access to care, housing, and food insecurity) impact many segments of the population. A key finding from the CHNA was the continued impact that the social determinants of health have on residents of the BH/AGH service area, especially those who are low to moderate income, are frail or homebound, have mental health or substance use issues, or lack a close support system. In addition, despite the fact that the communities that make up BH/AGH CBSA are generally insured and employed, findings from the CHNA indicated concern that families face financial stress because they have high out-of-pocket costs for health care services and are not eligible for public benefits, or, if eligible, they are not enrolling because of the stigma of accepting public assistance and/or because they face language and cultural barriers to accessing services.

**2) Chronic/Complex Conditions and Risk Factors –** The CHNA findings revealed a need to address risk factors associated with chronic and complex health conditions including physical inactivity and poor nutrition/lifestyle, particularly for older adults, lower levels of education/health literacy, and/or access issues. Addressing the leading risk factors is at the root of many chronic disease prevention and management strategies.

**3) Mental Health and Substance Use Disorders –** Mental health issues (e.g., depression, anxiety/stress, access to treatment, stigma) underlie many health and social concerns. The CHNA concluded that depression, anxiety/stress, social isolation, and youth e-cigarette/vaping use were particular concerns. Social isolation in older adults and access to mental health services were also identified as priority concerns. In addition, substance dependency continues to impact individuals, families, and communities. The opioid epidemic continues to be an area of focus. Beyond opioids, key informants were also concerned with alcohol misuse, changing community norms in light of the legalization of recreational marijuana use, and use of e-cigarettes/vaping among adolescents. These priority areas are aligned with the statewide health priorities identified by the EOHHS and those identified by the Massachusetts DPH to guide the Community-based Health Initiative (CHI) investments funded by the Determination of Need (DoN) process, which underscore the importance of investing in the social determinants of health:

**EOHHS Priority Needs:**

- Substance Use Disorders
- Housing/Homelessness
- Mental Health
- Chronic Disease *(Cancer, Heart Disease, Diabetes)*

**DPH Priority Needs:**

- Built Environment
- Social Environment
- Housing
- Violence
- Education
- Employment

The FY19 CHNA provided new guidance and invaluable insight on quantitative trends and community perceptions that are being used to inform and refine BH/AGH's efforts. In completing the FY19 CHNA and FY20-FY22 IS, BH/AGH, along with its other health, public health, social service, and community partners, is committed to improving the health status and well-being of all residents living throughout its CBSA. Based on the assessment's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that BH/AGH's FY20-FY22 IS should prioritize certain demographic, socioeconomic, and geographic population segments that have complex needs, face barriers to care, and have other adverse social determinants of health. These factors put these segments at greater risk, limit their access to needed services, and can often lead to disparities in health outcomes. More specifically, the FY19 CHNA identified the importance of supporting initiatives that targeted low-income populations, youth, older adults, and racially/ethnically diverse, limited English-proficient, and LGBTQ populations.

BH/AGH will continue to partner with dozens of community-based organizations and service providers including public agencies, social service providers, community health organizations, academic organizations, and businesses to execute its FY20-FY22 IS.

***Self-Assessment Form***

Working with its Community Benefits Leadership team and its Community Benefits Advisory Committee, BH/AGH completed a self-assessment form. Additionally, the BH/AGH Community Benefits team distributed the Community Representative Feedback Form to many CBAC and community stakeholders who participated in BH/AGH 2019 CHNA.

## Section II: Community Benefits Process

***NHC Community Benefits Advisory Committee (CBAC) Members***

Nancy Palmer – Chairwoman, Northeast Hospital Corporation Board of Trustees
Phil Cormier – CEO, Addison Gilbert and Beverly Hospitals
Charles Favazzo – Trustee, Northeast Hospital Corporation
Robert Irwin – Trustee, Northeast Hospital Corporation
Mark Gendreau, MD – Chief Medical Officer, Addison Gilbert and Beverly Hospitals
Peter Short, MD – Associate Chief Medical Officer, Addison Gilbert and Beverly Hospitals
David DiChiara, MD – Associate Chief Medical Officer, Addison Gilbert and Beverly Hospitals
Kimberly Perryman – Chief Nursing Officer, Addison Gilbert and Beverly Hospitals
Cynthia Donaldson – Vice President, Addison Gilbert Hospital and Lahey Outpatient Center Danvers
Lisa Neveling – Vice President, Business Development, Lahey Health
Christine Healey – Director, Community Relations, Lahey Health
Grace Numerosi – Regional Manager, Community Relations
Chessye Moseley – Resident
Christopher Lovasco – President and CEO, North Shore YMCA
Julie LaFontaine – Executive Director, The Open Door Food Pantry
Scott Trenti – Executive Director, SeniorCare

The membership of the BH/AGH CBAC aspires to be representative of the constituencies and priority populations of BH/AGH programmatic endeavors, including those from diverse racial and ethnic backgrounds, age, gender,

sexual orientation, and gender identity, as well as those from corporate and nonprofit community organizations. Senior management is actively engaged in the development and implementation of the Community Benefits plan, ensuring that hospital policies and resources are allocated to support planned activities.

It is not only the board and senior leadership that are held accountable in fulfilling the Community Benefits mission. Consistent with NHC core values is the recognition that the most successful community benefits programs are those that are implemented organization-wide and integrated into the very fabric of NHC culture, policies, and procedures. It is not a stand-alone effort that is the responsibility of one staff or department, but rather an orientation and value manifested throughout NHC structure, reflected in how it provides care at BH/AGH and in affiliated practices in urban neighborhoods and rural areas.

NHC is a member of BILH. While NHC oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Strategy Officer. This structure ensures that Community Benefits efforts, prioritization, planning, and strategy align and/or are integrated with local and system strategic and regulatory priorities.

The BH/AGH Community Benefits Program is spearheaded by Grace Giambanco Numerosi, Regional Manager, Community Benefits/Community Relations. The Regional Manager of Community Benefits/Community Relations has direct access and is accountable to the BH/AGH President and the BILH Vice President of Community Benefits and Community Relations, the latter of whom reports directly to the BILH Chief Strategy Officer. It is the responsibility of these senior managers to ensure that Community Benefits is addressed by the entire organization and the needs of the underserved populations are considered every day in discussions on resource allocation, policies, and program development. This is the structure and methodology employed to ensure that Community Benefits is not the purview of one office alone and to maximize the extent to which efforts across the organization are fulfilling the mission and goals of community benefits.

***CBAC Meetings***

The CBAC met three times in FY19 to oversee and provide guidance on the Community Benefits programs and services outlined in the FY17-FY19 IS, and to provide feedback and direction on the FY19 CHNA process and development of NHC's corresponding IS.
Meeting Dates: May 14, June 11, and August 2, 2019

***Community Partners***

BH/AGH recognizes its role as a community hospital in a larger health system and knows that to be successful it needs to collaborate with its community partners and those it serves. BH/AGH CHNA and the associated IS were completed in close collaboration with hospital staff, its health and social service partners, and the community at large. BH/AGH Community Benefits Program exemplifies the spirit of collaboration that is a vital part of NHC's mission. Although BH/AGH serves and collaborates with all segments of the population, in recognition of its long-standing ties to the communities and the health disparities that exist for these communities, BH/AGH focuses its Community Benefits efforts on improving the health status of the low-income, underserved populations living in its CBSA. BH/AGH currently supports dozens of educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA by collaborating with many of the area's leading health care, public health, and social service organizations. BH/AGH relies on its community partners to implement its Community Benefits initiatives and has leveraged their expertise and the vital connections they have with residents and other community-based organizations.

The following is a list of the community partners with which BH/AGH joins in assessing community need as well as planning, implementing, and overseeing its Community Benefits IS.

- Action Inc.
- Backyard Growers
- Beverly Bootstraps
- American Cancer Society

- Cape Ann Mass in Motion
- Danvers YMCA
- Danvers Rotary
- North Shore YMCA
- City of Gloucester
- City of Beverly
- DanversCares
- Pathways
- Wellspring House
- The Open Door
- The Grace Center
- CHNA 13/14
- North Shore Elder Services
- Gloucester School Dept.
- SeniorCare, Inc.
- Town of Rockport
- Town of Essex
- Town of Manchester by the Sea
- Town of Danvers
- Town of Ipswich
- Town of Middleton

## Section III: Community Health Needs Assessment

***Date and Current Status of Last Community Health Needs Assessment***

The FY19 CHNA and associated FY20-FY22 IS were developed over a 10-month period from October 2018 to August 2019. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and Federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill NHC's need to conduct a CHNA, engage the community, identify priority health issues, inventory community assets, assess impacts, and develop an IS. However, these activities are driven primarily by NHC's dedication to its mission, its covenant to the underserved, and its commitment to community health improvement. Although BH/AGH most recent CHNA was completed in FY19, the community benefits programming in this annual report was informed by the FY16 CHNA and aligns with the FY17-FY19 IS.

***Approach and Methods***

The assessment began in December 2018 and was conducted in three phases, allowing for the collection of an extensive amount of quantitative and qualitative data:
Phase 1 – Preliminary assessment and engagement
Phase 2 – Targeted engagement
Phase 3 – Strategic planning and reporting
Hundreds of individuals from across BH/AGH CBSA were engaged in the assessment and planning process, including health and social services providers, public health officials, elected officials, public school nurses and administrators, first responders, leaders of faith-based organizations, BILH senior leadership, staff, board members, and community residents.

**Quantitative Data Sources:** The quantitative assessment included an extensive analysis of demographic and socioeconomic data, health status, utilization rates, and behavioral risk survey data. Data from a broad range of sources was collected and analyzed to characterize communities in BH/AGH CBSA, measure health status, and inform a comprehensive understanding of the health-related issues. Sources included:
• U.S. Census Bureau, American Community Survey 5-Year Estimates (2013-2017)
• Massachusetts Department of Elementary and Secondary Education: School and District Profiles

- FBI Uniform Crime Reports (2017)
- Massachusetts Department of Public Health, Registry of Vital Records and Statistics (2015)
- Massachusetts Department of Public Health, Bureau of Substance Abuse Services (2017)
- Massachusetts Department of Public Health, Annual Reports on Births (2016)
- Massachusetts Department of Public Health, Opioid Related EMS Incidents (2018)
- Massachusetts Bureau of Infectious Disease and Laboratory Sciences (2017)
- Massachusetts Center for Health Information Analysis (CHIA) Hospital Profiles (FY13-FY17)
- Massachusetts CHIA Hospital Discharges (2017)
- Massachusetts Healthy Aging Collaborative, Community Profiles (2018)
- Middlesex League Youth Risk Behavior Survey (2019)
- Changing Faces of Greater Boston, Boston Foundation (2019)

**Qualitative Data Sources:** To obtain targeted data and understand the current issues facing the community, the following was carried out:
- Internal Stakeholder Interviews (board members, senior leaders, and service line leaders) – 14 completed
- External Stakeholder Interviews – 41 completed
- Random Household Community Survey – 1,000+ completed in the BH/AGH service area
- Community Listening Sessions – Three sessions completed
- Focus Groups – Three sessions completed with high school students and individuals who are currently or formerly homeless/housing unstable
- Random Household Surveys – 1,000+ completed in the BH/AGH service area

These individuals were invited to provide input through key informant interviews, focus groups, community listening sessions, and a widely distributed Community Health Survey. While it was not possible for this assessment to involve all community stakeholders, BH/AGH made every effort to be as inclusive as possible and to provide a broad range of opportunities for participation over the course of several months. BH/AGH Community Benefits Program is predicated on the notion of partnership and dialogue with its many communities. BH/AGH's understanding of these communities' needs is derived from discussions with and observations by health care and health-related workers in the neighborhoods as well as more formal assessments through available public health data, focus groups, surveys, etc. This data was then augmented by demographic and health status information gleaned from a variety of sources including the Massachusetts DPH and the Boston Public Health Commission, federal resources such as the Institute of Medicine and the Centers for Disease Control and Prevention, and review of literature relevant to a particular community's needs. The articulation of each specific community's needs (in collaboration with community partners) is used to inform BH/AGH's decision-making about priorities for community benefits efforts. BH/AGH works in concert with community residents and leaders to design specific actions to be undertaken each year. Each component of the plan is thus developed and eventually woven into the annual goals and agenda for the BH/AGH' Community Benefits IS, which is adopted by the Board of Trustees.

***Summary of Key Health-Related Findings from the FY19 CHNA***

Below is a high-level summary of health-related findings that were identified after a comprehensive review of all the quantitative and qualitative information that was collected as part of the CHNA. A detailed and in-depth discussion of key findings is included in the full CHNA report.

- **Social Determinants of Health –** The social determinants of health (e.g., transportation, economic stability, access to care, housing, and food insecurity) affect all segments of the population. A key theme from the assessment's key informant interviews, focus groups, listening sessions, and Community Health Survey was the continued impact the social determinants of health have on residents of the BH/AGH service area, especially on those who are low to moderate income, are frail or homebound, have mental health or substance use issues, or lack a close support system.
- **Access to Care –** Certain populations are more vulnerable to health care disparities and barriers to care. Despite the fact that Massachusetts has one of highest rates of health insurance enrollment, and that the communities that make up BH/AGH service area have strong, robust safety net systems, there are still substantial numbers of low-income, Medicaid-covered, uninsured, and otherwise vulnerable individuals who

face health disparities and are not engaged in essential medical and behavioral services. Efforts need to be made to expand access, reduce barriers to care, and improve the quality of primary care medical, medical specialty, and behavioral health services.

- **Mental Health –** Mental health issues (e.g., depression, anxiety/stress, access to treatment, stigma) underlie many health and social concerns. Nearly every key informant interview, focus group, and listening session included discussions of the impact of mental health issues. A review of the quantitative and qualitative information indicated that depression, anxiety/stress, and social isolation were the leading concerns. There were particular concerns about the impact of depression, anxiety, and e-cigarette/vaping on youth and of social isolation among older adults.
- **Substance Use Disorder –** Substance dependency continues to affect individuals, families, and communities. The opioid epidemic continues to be an area of focus. Beyond opioids, key informants were also concerned with alcohol misuse, changing community norms in light of the legalization of recreational marijuana use, and e-cigarette/vaping among adolescents.
- **Chronic/Complex Conditions and Risk Factors –** Chronic diseases (e.g., cardiovascular disease, cancer, diabetes, asthma) require more education, screening/early intervention, and management — and a focus on risk factors. Although there was a major emphasis on behavioral health issues, many key informants, focus group participants, and listening session participants identified a need to address the many risk factors associated with chronic and complex health conditions. Physical inactivity and poor nutrition/lifestyle were discussed by many, with some of these issues being associated with age (mobility issues among older adults), education/health literacy (lack of understanding about healthy eating), and socioeconomic status (inability to pay for fresh foods, gyms, and health centers). Addressing the leading risk factors is at the root of many chronic disease prevention and management strategies.

## Section IV: Community Benefits Programs

## WELLNESS, PREVENTION AND CHRONIC DISEASE MANAGEMENT

***School-Based Health Center at Gloucester High School (GHS)***

**Brief Description:** BH/AGH believes that everyone deserves high-quality, affordable health care, and strives to promote health, expand access, and deliver the best care in the communities it serves. BH/AGH dedicates resources to support and strengthen the capacity of the primary care offices to help community members connect with and access timely, safe, quality patient care. Access to a consistent source of primary care is particularly important, since it greatly affects the individual's ability to receive regular preventive, routine, and urgent care and to manage chronic diseases. While Massachusetts has one of the highest health insurance coverage rates in the U.S., there are still pockets of individuals without coverage, including young people, immigrants and refugees, and those who are unemployed. In Gloucester, 3% of the city's population has no insurance and 40.2% received public insurance (e.g., MassHealth, Medicare).

The mission of the School-Based Health Center (SBHC) is to provide high-quality, comprehensive health care to students in order to support optimal health and academic outcomes. The health clinic is a branch of Addison Gilbert Hospital and is supported in part by the Massachusetts DPH. The mission of the SBHC aligns closely with the priorities identified by Addison Gilbert in its most recent Community Health Assessment. Our recent CHNA of youth health needs and youth focus groups showed that youth were most concerned about chronic stress/anxiety, depression, and suicidality. The SBHC joins with existing school services to provide comprehensive in-school health care that is easily accessible to students. The approach is to take care of the students' health and well-being while supporting attendance and achievement of academic success. The SBHC is a safe place where students are encouraged through a strength-based approach and motivational interviewing to discuss important personal topics such as stress, exercise, healthy eating, alcohol and drug use, friendship, sexual health, and any personal health issues they have questions about. For example, the SBHC improves access to behavioral health and substance abuse services by offering these services on-site, and integrates those services into primary medical care. The SBHC also identifies students with chronic conditions and help them improve self-management of these conditions. Whether an individual has health

insurance — and the extent to which it helps pay for needed acute services and access to a full continuum of high-quality, timely, and accessible preventive and disease management or follow-up services — is a critical determinant of overall health and well-being.
The SBHC is staffed by a Nurse Practitioner, a Licensed Independent Clinical Social Worker, and a Certified Community Health Worker. The SBHC provides an integrated model of care in its approach. Services offered include management of chronic illnesses such as asthma and diabetes, urgent care visits, immunizations, routine and sports physicals, health education, and confidential services, including reproductive health care and behavioral health services. As evidenced by its staffing structure, behavioral health care is a significant focus of the clinic, with individual therapy and group counseling services provided for issues such as depression, anxiety, stress management, and substance use.

**Target Population:**
- Regions Served: Gloucester
- Gender: All
- Age Group: Teenagers
- Race/Ethnicity: All
- Language: English
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Direct Clinical Services
**Additional Program Descriptors:** Community Education, Health Screening
**DoN Health Priorities:** Social Environment, Education
**EOHHS Focus Issues**: Chronic Disease
**Health Issues:** Access to Health Care, Mental Health, Substance Use, Physical Activity, Nutrition, Reproductive and Maternal Health, Alcohol Use, Stress Management

**Goal:** The goal is to provide high-quality comprehensive health care to students in order to support optimal health and academic outcomes.
**Goal Status:** The SBHC joins with existing school services to provide comprehensive in-school health care that is easily accessible to students. The approach is to take care of the students' health and well-being while supporting attendance and achievement of academic success. The clinic had 1,225 nurse practitioner visits, 910 social worker visits, and 4,468 total assessments. Staff organized 21 outreach activities including social skills work groups and reproductive health classes. They also facilitate and mentor the GHS-SBHC Youth Advisory Council (YAC). YAC is a peer-to-peer leadership group open to all GHS students committed to working to promote inclusivity and teen health. The SBHC staff also supports the Gay-Straight Alliance/Sexuality and Gender Acceptance group, and the annual Health Resource Information Fair.
**Type of Goal:** Operational Goal
**Time Frame Year:** 3
**Time Frame Duration:** 3
**Community Partners:** Massachusetts DPH, Gloucester High School, Gloucester Board of Health, Wellspring House, The Open Door, Cape Ann Pediatrics, and Massachusetts School Based Health Alliance.

***Beverly Bootstraps Mobile Market***
**Brief Description:** The Beverly Bootstraps Mobile Market offers fresh produce to residents of the Beverly Housing Authority. Each week from June through October, residents were able to access produce at no cost while also learning basic nutrition and recipes from clinical nutrition managers at BH/AGH. In addition to providing free and nutritious fruits and vegetables to those who might otherwise not be able to afford them, this program brings about a wonderful sense of community that has developed at the markets — not only in the conversations that happen between people while waiting in line, but also with neighbors quite literally helping neighbors.

This program helps promote better health and nutrition by providing participants with fresh fruits and vegetables. Seasonal Mobile Market participants could choose free, fresh produce and had access to nutrition education, SNAP information, food samples, and youth activities. The Mobile Market provides Senior Center participants with fresh nutrient-dense produce for free as well as healthy canned goods for basic meals. Senior participants could choose fresh

produce and non-perishables at each visit. A Case Manager is on-site at all Mobile Markets so clients could establish a relationship and learn about other services available to them.

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: All
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Total Population or Community-Wide Intervention
**Additional Program Descriptors:** Prevention
**DoN Health Priorities:** Social Environment
**EOHHS Focus Issues:** Chronic Disease with a Focus on Cancer, Heart Disease, and Diabetes
**Health Issues:** Access to Healthy Foods, Nutrition, Cardiac Disease, Diabetes

**Goal:** To provide a free fresh traveling farmers market to our Beverly Housing clients and seniors during the summer and fall of 2019.

**Goal Status:**

- Served 225 individuals from 179 households at our Senior Mobile Market. We distributed 6,298 pounds of produce. We served clients from 43 new households at our Senior Mobile Market
- Served 644 individuals from 452 households at our Seasonal Mobile Markets, June through October. We distributed 43,944 pounds of food. We brought 77 new clients to Beverly Bootstraps from this Mobile Market.
- Witnessed a 20% increase in pounds of produce distributed at our Mobile Markets.

**Type of Goal:** Operational Goal
**Time Frame Year:** 3
**Time Frame Duration:** 3
**Community Partners:** Beverly Bootstraps, Beverly Housing Authority, Fairweather Housing, Beverly Veterans Home, and Beverly Council on Aging.

***The Open Door — Registered Dietician for Food Is Medicine***

**Brief Description:** The Registered Dietician (RD) for the Food Is Medicine (Rx) program supports the organizational goals and mission of The Open Door to alleviate the impact of hunger in our communities. They use practical strategies to connect people to good food, to advocate on behalf of those in need, and to engage others in the work of building food security. There are many challenges people with food insecurity face when living with a chronic illness, including not understanding that food is a vital component to wellness and lack of access to nutritious foods. The RD for Rx program was designed to address these issues. The Open Door's Registered Dietitian works to ensure that low-income, food-insecure people struggling with or at risk of chronic illness will have access to free nutrition services.

Services Included: Maridee's (Good Food Box) Community Nutrition Workshops, Nutrition Counseling, the hosting of nutrition interns, management of Maridee's Good Food Box to manage better health and diet of low-income people, and the planning of the Medically Tailored Grocery Program.

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: All
- Race/Ethnicity: All

- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Total Population or Community-Wide Intervention
**Additional Program Descriptors:** Prevention
**DoN Health Priorities:** Social Environment
**EOHHS Focus Issues:** Chronic Disease with a Focus on Cancer, Heart Disease, and Diabetes
**Health Issues:** Nutrition, Access to Healthy Food, Income and Poverty, Cardiac Disease, Diabetes, Hypertension, Overweight and Obesity

**Goal 1:** To connect low-income people to good food. The RD for Rx program is aligned with The Open Door's mission to alleviate the impact of hunger in our community. We use practical strategies to connect people to good food, advocate on behalf of those in need, and engage others in the work of building food security.

- To provide free nutrition counseling and therapy to food-insecure low-income people with or at risk for chronic illness.
- To provide free Maridee's Community Nutrition Workshops throughout the community.
- To manage Maridee's Good Food Boxes, targeted nutrition boxes to better manage health/diet.
- To manage all nutrition education throughout The Open Door programs and services.
- To manage all nutrition interns, including RD and public health practicums.
- To help plan and implement The Open Door pilot program, Medically Tailored Groceries.
- To provide 40 nutritional counseling sessions per year for 10-40 people (depending upon extent of need and intervention).
- To provide 17 nutrition workshops for up to 10 people each per year.
- To host at least four nutrition interns annually.

**Goal Status 1: All goals were exceeded in all categories.**

- Provided: 73 workshops (30 workshops at senior centers/family suppers plus 43 additional pop-up nutrition workshops (goal was 16 workshops).
- Provided: 52 counseling sessions for 16 nutrition counseling clients (goal was 40 counseling sessions for 10 clients).
- Hosted eight nutrition interns (goal was four interns).
- Planned and implemented a session of DISH — a new afterschool nutrition program for middle school girls.
- Provided and distributed 364 Good Food Boxes to clients with compromised health.

**Type of Goal:** Operational Goal
**Time Frame Year:** 1
**Time Frame Duration:** 3

**Goal 2:** Increase knowledge about healthy food.

***Nutrition Counseling/Therapy***

- At least 50% of clients will agree they learned something new during counseling.
- At least 50% of clients will agree they make healthier choices since beginning counseling.
- At least 50% of clients will agree they are better equipped to manage their chronic health.
- At least 50% of clients will agree they know how to read a nutrition label.
- At least 50% of clients will agree they know how to shop for healthy food.

***Maridee's Nutrition Workshops***

- At least 50% will agree they learned something new at the workshop.
- At least 50% will agree they will make healthier choices because of the workshop.
- At least 50% will agree to come to another workshop.
- At least 50% will agree to refer a friend to a workshop.

**Goal Status 2: Qualitative Results:** Exceeded qualitative goals in each category (goal was 50%):

**Maridee's Nutrition Workshop Surveys responded yes:**

| | |
|---|---|
| Did you learn something NEW at this workshop? | 92% |
| Will you make healthier choices because of this workshop? | 94% |
| Would you come to another workshop? | 96% |
| Would you refer a friend to a workshop? | 91% |

**One-on-One Nutrition Counseling Surveys:**

| | |
|---|---|
| Did you learn something NEW during your Nutrition Counseling? | 91% |
| Have you been making healthier choices since beginning Nutrition Counseling? | 91% |
| Are you better equipped to manage your chronic health condition/s? | 100% |
| Are you able to read a nutrition label? | 91% |
| Do you know how to shop for healthy food? | 100% |

**Type of Goal:** Outcome Goal
**Time Frame Year:** 1
**Time Frame Duration:** 3
**Community Partners:** The Open Door, Greater Boston Food Bank, Backyard Growers, Three Sisters, Food Project, Trustees of Reservations, Gloucester Public Scho

***Emergency Department Prescription Food Bag Program***

**Brief Description:** BH/AGH strives to ensure all emergency department (ED) patients have access to the food they need to become and stay healthy after their visit. We know that many of our community members — like individuals across the country — struggle with food insecurity, which means they lack adequate food or access to high-quality foods. Hunger and food insecurity should be addressed and treated like any other health issue. When a patient presents in the ED and screens positive for food insecurity, a member of the nursing team re-engages the patient to validate the positive response. Prior to discharge, a member of the ED team gives a preassembled emergency food bag to the patient and also provides him or her with a brief narrative
of the plan of care, highlighting a $50 gift card incentive that will be given to that person after a meeting at either Beverly Bootstraps or The Open Door.

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: All
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Total Population or Community-Wide Intervention
**Additional Program Descriptors:** Not Applicable
**DoN Health Priorities:** Social Environment
**EOHHS Focus Issues:** Chronic Disease with a focus on Cancer, Heart Disease, and Diabetes
**Health Issues:** Nutrition, Access to Healthy Food

**Goal:** The overall goal is to educate people on the associated health risks of food insecurity while connecting them to community agencies that can provide invaluable resources.

**Goal Status:** BH/AGH distributed over 150 Prescription Food Bags (20 of which were for diabetics); 25 people received gift cards from The Open Door. Once people went to use the Food Pantry, they became regular clients, and they made appointments with their client advocates for SNAP application assistance and recertification and other available services.
**Type of Goal:** Operational Goal
**Time Frame Year:** 3
**Time Frame Duration:** 3
**Community Partners:** Beverly Bootstraps, The Open Door Food Pantry

***Walk-in Blood Pressure Screening Program***
**Description:** Addison Gilbert Hospital offers a free weekly walk-in blood pressure clinic every Monday (minus holidays) from 1 to 3 p.m. in the Babson Wing of Addison Gilbert Hospital. Nursing staff see patients, take blood pressures, review results and medications, and provide counseling if necessary. Nurses also ask patients if they would like their results to be shared with their primary care physician or nurse practitioner for follow-up care. They continue with teachings that encourage a balanced diet, exercise, and healthy lifestyle, proper taking of medications, and ongoing medical care.

**Target Population:**
- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: All
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Community-Clinical Linkages
**Additional Program Descriptors:** Health Screening, Prevention
**DoN Health Priorities:** Not Applicable
**EOHHS Focus Issues:** Chronic Disease with a focus on Cancer, Heart Disease, and Diabetes
**Health Issues:** Hypertension, Nutrition, Physical Activity, Access to Health Care
**Goal:** To educate patients and offer information on additional resources to control their blood pressure.
**Goal Status:** The guidelines for the clinic are from the Joint National Committee on the Prevention, Evaluation and Treatment of High Blood Pressure. Both the Mediterranean and DASH Diets are recommended.
- Number of client visits: 719
- Number of new clients: 31
- Female clients: 65%
- Male clients: 35%
- Average number of clients seen weekly: 16
- Active clients: 92
- Age range of clients: 60-80
- Number of clients advised to seek physician care: 19
- Number of client visits per year:
    - 1 to 9 visits: 75% of clients
    - 10 to 30: 20%
    - 31to 40: 5%

**Type of Goal:** Operational Goal
**Time Frame Year:** 3
**Time Frame Duration:** 3
**Community Partners:** Not Applicable

***Home Blood Draw Program***

**Brief Description:** The BH/AGH Home Blood Draw Program was developed to enhance access to phlebotomy services for homebound patients who have difficulty getting to a laboratory/drawing station. Homebound patients are defined as individuals with a condition due to surgery, illness, or injury that precludes them from accessing medical care outside their home.

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: All
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Access/Coverage Supports
**Additional Program Descriptors:** Not Applicable
**DoN Health Priorities:** Not Applicable
**EOHHS Focus Issues:** Chronic Disease
**Health Issues:** Access to Health Care
**Goal:** To increase access to phlebotomy services for homebound patients who have difficulty getting to a laboratory/drawing station due to illness or injury.
**Goal Status:** In FY20, BH/AGH Lab Services provided free in-home blood draws for over 9,900 homebound patients. In addition to appreciating the convenience of the home blood draw, patients have reported reduced feelings of isolation because the visit with the phlebotomist provides them with a social opportunity.
**Type of Goal:** Operational Goal
**Time Frame Year:** 3
**Time Frame Duration:** 3
**Community Partners:** Not Applicable

***Healthy State: Web-Based Health News***

**Brief Description:** More people are turning to web-based resources for health information. By providing expert health information, personal stories, and connections to resources, Healthy
State provides health information to educate and influence people to change their unhealthy behaviors and encourage interventions capable of improving health status. Healthy State is a health news website that highlights the expertise of our practitioners across Lahey Health. We collaborate with practitioners (doctors, advanced practitioners, staff, etc.) on stories across various service lines to share information relevant to our audience. Story topics range from health and wellness to patients and colleagues to community programs. The site, https://www.myhealthystate.org, offers free, easy-to-read articles for the community. The site strategically addresses health issues that are most pressing to the community, including:

- Cancer awareness, including the benefits of cancer screenings and information on breast, skin, colon, cervical, prostate, and lung cancers.
- Sports and exercise safety, healthful eating, high blood pressure, and heart health.
- Seasonal wellness tips, including educating residents about the difference between the cold and flu and how to avoid heat stroke in extreme heat.
- Emerging health concerns, such as new forms of smoking and understanding vaping/e-cigarette health risks. Articles also address the increase in the suicide rate and how to speak to a child about suicide.

**Target Population:**

- Regions Served: Massachusetts, Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: All

- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Total Population or Community-Wide Initiative
**Additional Program Descriptor:** Community Education
**DoN Health Priorities:** Not Applicable
**EOHHS Focus Issues:** Chronic Disease with a focus on Cancer, Heart Disease, and Diabetes; Substance Use Disorders; Mental Illness and Mental Health
**Health Issues:** Breast Cancer, Cervical Cancer, Colorectal Cancer, Lung Cancer, Prostate Cancer, Skin Cancer, Hypertension, Mental Health, Physical Activity, Sports Injuries, Nutrition, Smoking/Tobacco Use

**Goal:** Healthy State seeks to influence personal health choices, to inform people about ways to enhance health or to avoid specific health risks by:

- Increasing knowledge and awareness of a health issue.
- Influencing behaviors and attitudes toward a health issue.
- Dispelling misconceptions about health.

**Goal Status:**
In FY19:

- 106,720 page views were recorded.
- More than 6,098 views were return users.
- The average duration for each session was 38 seconds, with 1.26 pages viewed per session.

**Type of Goal:** Operational Goal
**Time Frame Year:** 2
**Time Frame Duration:** 3
**Community Partners:** Not Applicable

***Patient Financial Counseling***

**Brief Description/Objective:** The extent to which a person has health insurance that covers or offsets the cost of medical services, coupled with access to a full continuum of high-quality, timely, accessible health care services, has been shown to be critical to overall health and well-being. Access to a routine source of primary care is particularly important because it greatly impacts a person's ability to receive preventive, routine, and urgent care as well as chronic disease management services.

Despite the overall success of the commonwealth's health reform efforts, information captured for this assessment shows that while the vast majority of the area's residents have access to care, significant segments of the population, particularly low-income and racial/ethnic minority populations, face significant barriers to care. These groups struggle to access services due to lack of insurance, cost, lack of transportation, cultural/linguistic barriers, and a shortage of providers willing to serve Medicaid-insured or uninsured patients.

To address these gaps, NHC employs six MassHealth-certified Application Counselors who can screen patients and assist them in applying for state aid. They also estimate for patients their financial responsibility (copay, deductible, coinsurance, self-pay). Financial Counselors spend their time helping patients with issues related to financial assistance and estimates and helping patients understand their insurance benefits.

NHC had over 12,256 patient visits in FY19. These included patients with existing Medicaid, patients who presented as self-pay and completed an application with a Financial Navigator, and patients who qualified for upgraded MassHealth coverage.

**Target Population:**

- Regions Served: Massachusetts, Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: All

- Race/Ethnicity: All
- Language: English
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Access/Coverage Supports
**Additional Program Descriptors:** Not Applicable
**DoN Health Priorities:** Not Applicable
**EOHHS Focus Issues:** Not Applicable
**Health Issues:** Access to Health Care; Income and Poverty, Uninsured/underinsured
**Goals:** Meet with patients who are uninsured to assess their eligibility for and align them with state financial assistance and hospital-based financial assistance programs.
**Goals Status:** Financial Counselors met with patients (both inpatient and outpatient) and completed 5,641 MassHealth applications.
The age ranges of patients and the percentage of patients within each age range were:

- 0-17 years (21%)
- 18-35 years (30%)
- 36-53 years (26%)
- 54-71 years (21%)
- 71-107 years (2%)

Based on the data reviewed, the employment status obtained at time of service was:

- 9,600 employed full time or part time
- 10,500 unemployed
- 1,800 self-employed
- 1,500 retired
- 2,300 disabled
- 1,400 full-time or part-time students
- 5,800 children

**Type of Goal:** Operational Goal
**Time Frame Year:** 3
**Time Frame Duration:** 3
**Community Partners:** Not Applicable

***Interpreter Services***
**Brief Description/Objective:** An extensive body of research illustrates the health disparities and differences in health care access and utilization that exist for diverse individuals/cohorts and foreign-born populations. According to the Centers for Disease Control and Prevention, non-Hispanic blacks have higher rates of premature death, infant mortality, and preventable hospitalization than do non-Hispanic whites. Hispanics have the highest uninsured rates of any racial or ethnic group in the United States. Asians are at a higher risk for developing diabetes than are those of European ancestry, despite a lower average body mass index. These disparities show the disproportionate and often avoidable inequities that exist within communities and reinforce the importance of understanding the demographic makeup of a community to identify populations more likely to experience adverse health outcomes. The NHC service area is quite diverse. While many municipalities are predominantly white, there are significant populations of Asian and Hispanic/Latino residents throughout the service area. Language barriers pose significant challenges to providing effective and high-quality health and social services. To address this need, and in recognition that language and cultural barriers are major barriers to accessing health and social services and navigating the health system, NHC offers an extensive interpreter services program that provides interpretation (translation) and assistance in over 60 different languages, including American Sign Language, and hearing augmentation devices for those who are hard of hearing. The interpreter services program also routinely facilitates access to care, helps patients understand their course of treatment, and helps patients adhere to discharge instructions and other medical regimens. NHC also

routinely translates materials such as legal consents for treatment, patient education forms, and discharges in order to continue to reduce barriers to care.

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: All
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Additional Program Description:** Not Applicable
**Program Type:** Access/Coverage Support
**DoN Health Priorities:** Social Environment
**EOHHS Focus Issues:** Not Applicable
**Health Issues:** Language/Literacy, Access to Health Care, Hearing, Cultural Competency
**Goals:** Provide culturally responsive care through Interpreter Services Department.
**Goals Status:** In FY19, NHC interpreters reported 11,414 encounters at Beverly Hospital (including Lahey Outpatient Center Danvers and 1,121 encounters at Addison Gilbert Hospital).
**Type of Goal:** Operational Goal
**Time Frame Year:** 1
**Time Frame Duration:** 3
**Community Partners:** Not Applicable

***Oncology Nurse Navigator***

**Brief Description:** The Oncology Nurse Navigator is an RN with oncology-specific clinical knowledge. These Navigators offer individualized support and assistance to patients and their caregivers to help them make informed decisions about their care and to overcome barriers to optimal care. The Navigator contributes to the Hospital's mission by providing cancer patients with coordinated care through a holistic and collaborative approach that includes communication and coordination with the patient's family and/or caregivers along with a multidisciplinary team consisting of physicians, nurse practitioners, oncology nurses, and social workers. The Navigator works in collaboration with the clinical team to develop clinical pathways for appropriate care, and acts as the contact clinical person in resolving all patient-related concerns. The Navigator ensures all medical information has been received by physicians, reviews all medical information prior to a patient visit, and discusses any concerns with the provider prior to the patient visit. The Navigator maintains contact with referring and other collaborating physicians to keep them up to date on the patient's care plan. In addition, the Nurse Navigator connects patients with resources, including health care and support services, in their communities and assists them in the transition from active treatment to survivorship.

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: All
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Access/Coverage Supports
**Additional Program Descriptors:** Not Applicable
**DoN Health Priorities:** Not Applicable
**EOHHS Focus Issues:** Chronic Disease with a focus on Cancer, Heart Disease, and Diabetes

**Health Issues:** Breast Cancer, Cervical Cancer, Colorectal Cancer, Lung Cancer, Multiple Myeloma, Ovarian Cancer, Prostate Cancer, Skin Cancer, Access to Health Care

**Goals:** The goal is to guide patients through the complexities of the disease, direct them to health care services for timely treatment and into survivorship, and actively identify and help address barriers to care that might prevent them from receiving timely and appropriate treatment.
**Goals Status:** In FY19, the Hematology-Oncology Nurse Navigators dedicated more than 3,100 hours to provide assistance to more than 350 individual patients and their families or caregivers.
**Type of Goal:** Operational Goal
**Time Frame Year:** 1
**Time Frame Duration:** 3
**Community Partners:** American Cancer Society

***Breast Cancer Risk Assessment***

**Brief Description:** In the BH/AGH service area, eight of the 13 towns that are part of our primary service area reported statistically higher incidence rates of cancer (all cancer types) than the average in the commonwealth. The highest cancer incidence rate per 100,000 population was in Middleton (647), followed by Boxford (600), Manchester-by-the-Sea (595), Hamilton (594), Peabody (575), Danvers (575), Ipswich (572), and Gloucester (564). These rates compare to 509 for the commonwealth and 531 for Essex County. Specifically, breast cancer hospitalization rates for women were statistically higher than the commonwealth's across nearly all the primary service area's cities/towns. Moreover, according to the BH/AGH Community Health Survey, rates of mammography screening for women over 40 were slightly higher within the past two years than they had been prior to that: 88.4% in the BH/AGH primary service area, compared with 85% in the commonwealth. The risk for breast cancer is not the same for all women, and some women need more advanced screening beyond the standard recommendations. In response to this identified community need, NHC has implemented an assessment screening tool to help community residents determine whether they may be at risk for breast cancer. Using an electronic tablet, people are able to confidentially answer questions that help determine whether they may be at higher risk for breast cancer. The assessment, evaluation, and follow-up are all provided at no cost to the participant. Results are given to their physician, who can help them determine whether they might benefit from a higher level of screening beyond regular checkups and mammograms.

**Target Population:**
- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: Women
- Age Group: Adults
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Direct Clinical Services
**Additional Program Descriptors:** Prevention
**DoN Health Priorities:** Not Applicable
**EOHHS Focus Issues:** Chronic Disease with a focus on Cancer, Heart Disease, and Diabetes
**Health Issues:** Breast Cancer
**Goal:** The goal of providing the breast CRA screening is to identify persons who may be at a higher lifetime risk for developing breast cancer and provide screening follow-up to their physicians.
**Goal Status:** In FY19, NHC conducted 14,093 free screenings identifying the following:
- 556 patients with a high lifetime risk for breast cancer.
- 13,537 patients with an average lifetime risk for breast cancer.

**Type of Goal:** Operational Goal
**Time Frame Year:** 2
**Time Frame Duration:** 3
**Community Partners:** American Cancer Society

***LIVESTRONG***

**Brief Description/Objective:** Over the past several decades, the number of cancer survivors has dramatically increased — from 3 million (1.5% of the U.S. population) in 1971 to 9.8 million in 2001 to 14.5 million (4.6%) in 2014. Projections indicate that the number of cancer survivors will reach at least 19 million by 2024. According to data from the Centers for Disease Control and Prevention, nearly 5,000 people suffer from cancer in Essex County, which includes the North Shore YMCA's service area.

To address this issue, BH/AGH has partnered with the YMCA of the North Shore in Beverly and Ipswich to provide four sessions of the LIVESTRONG program for cancer survivors. LIVESTRONG is a small-group, evidence-based class that helps cancer survivors, or those in the midst of cancer treatment, believe in and achieve a healthier tomorrow and envision life after cancer. Classes are tailored for all cancer survivors, regardless of stage of diagnosis or treatment, and adapted for all fitness levels. Two trained and certified instructors run each session for 12 weeks, with eight to 10 participants meeting twice a week. Staff members are trained on the unique physical and emotional needs of cancer survivors, as well as on curriculum and best practices. They work with each participant to create an individualized exercise program from pre-program assessment results, and then teach and demonstrate exercise technique and safety considerations. This individualized attention helps participants meet their goals and overcome their specific barriers.

LIVESTRONG at the YMCA has an established research-based evaluation plan that uses pre- and post-assessment tests. The detailed assessments evaluate arm function, range of motion, and lymph node prognosis; shoulder flexion, extension, and abduction; and posture. Program participants are asked to rate overall quality of life, ability to perform daily tasks, mobility, eating habits, fitness level, perceived body image, current energy levels, and overall happiness.

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: All
- Race/Ethnicity: All
- Language: English
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Total Population or Community-Wide Interventions
**Additional Program Descriptors:** Not Applicable
**DoN Health Priorities:** Not Applicable
**EOHHS Focus Issues**: Chronic Disease
**Health Issues:** Health Behaviors, Physical Activity, Breast Cancer, Cervical Cancer, Colorectal Cancer, Lung Cancer, Multiple Myeloma, Ovarian Cancer, Prostate Cancer, Skin Cancer, Mental Health,

**Goal 1:** Create communities among cancer survivors and guide survivors through safe physical activity, helping them build supportive relationships that lead to an improved quality of life.
**Goals Status 1:** In FY19, 35 people over four classes, three at Beverly and one at Ipswich's YMCA, participated in the program.
**Type of Goal:** Operational Goal
**Time Frame Year:** 3
**Time Frame Duration:** 3

**Goal 2:** Improve program participants overall quality of life, ability to perform daily tasks, mobility, eating habits, fitness level, perceived body image, current energy levels, and overall happiness.

**Goal Status 2**: Pre- and post-assessment data is collected to show participants' progress over the 12 weeks in the areas of cardiovascular endurance, strength, flexibility, mobility, and behavioral health. Among participants who graduated, the results were as follows:

- 9% increased their cardiovascular endurance.
- 22% increased their physical functioning.
- 27% experienced improvement in feelings of depression.
- 30% experienced improvement in cancer-related fatigue.

**Type of Goal:** Outcome Goal
**Time Frame Year:** 3
**Time Frame Duration:** 3

**Community Partners:** YMCA of the North Shore

***CORNER STONE***

**Brief Description:** Corner Stone is a collaborative health and wellness program providing essential daily living support to cancer patients, cancer survivors, and their immediate families. The YMCA of the North Shore provides these families with a complimentary one-year, full-privilege membership as well as specialized education and peer support opportunities. Participants receive a free one-year membership for them and their immediate family. They are able to use everything the Y has available (fitness floor/classes, pool, gym/basketball, gymnastics, child care) as often as they like, at their convenience, as well as participate in all family and educational events. We plan to continue to offer one-year, full-privilege YMCA memberships to any family residing in our service area that has been affected by cancer within the past five years. In 2020, we plan to partner with BILH experts to offer several educational presentations and other learning opportunities.

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: All
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Access/Coverage Supports
**Additional Program Descriptors:** Not Applicable
**DoN Health Priorities:** Not Applicable
**EOHHS Focus Issues:** Chronic Disease with a Focus on Cancer, Heart Disease, and Diabetes
**Health Issues:** Breast Cancer, Cervical Cancer, Colorectal Cancer, Lung Cancer, Multiple Myeloma, Ovarian Cancer, Prostate Cancer, Skin Cancer, Access to Health Care, Physical Activity, Child Care

**Goals:** Initial goal was to enroll 1,500 members into the program in the first year, and we were able to reach 2,134.
**Goals Status:** The total number of members in the Corner Stone program was 2,134; the total utilization (number of scans into the facility) was 9,999; thus, the average usage per Corner Stone member was 4.7 visits (4.7 scans per member).
**Type of Goal:** Operational Goal
**Time Frame Year:** 1
**Time Frame Duration:** 3

**Community Partners:** YMCA of the North Shore

***Skin Cancer Awareness and Prevention Community Outreach Campaign***

**Brief Description:** According to the American Cancer Society, skin cancer is the most common type of cancer in the U.S. More skin cancers are diagnosed in the U.S. each year than all other cancers combined, and the number of skin cancer cases has been on the rise over the past few decades. Education and awareness can help prevent skin cancer from

occurring and promote early detection; if detected early, skin cancer can often be treated effectively. Recognizing this, NHC launched a skin cancer awareness and prevention campaign in conjunction with the American Cancer Society's "Slip! Slop! Slap! … and Wrap" national campaign. In order to maximize its reach, NHC identified and participated in key community events throughout the spring and summer where information could be distributed to the largest audiences possible. A partnership was also formed with the YMCA of the North Shore and the Trustees of Reservations to supply sunscreen kits and information to all their campers in Gloucester and Ipswich. The staff reinforced the messaging through fun and interactive games and displays while distributing educational materials and skin cancer-prevention items such as sunscreen, lip balm, and UV-protection-approved sunglasses. This year we added the Massachusetts Department of Children & Families (DCF) Foster Care Program supporting children in the foster care system on Cape Ann.

**Target Population:**

- Regions Served: Beverly, Danvers, Gloucester, Ipswich, Middleton, Rockport, Essex, and Manchester-by-the-Sea
- Gender: All
- Age Group: All
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Total Population or Community-Wide Initiative
**Additional Program Descriptors:** Community Education
**DoN Health Priorities:** Not Applicable
**EOHHS Focus Issues:** Chronic Disease
**Health Issues:** Skin Cancer

**Goal:** The overall goal of the skin cancer awareness and prevention campaign is to raise awareness of the risk factors associated with developing skin cancer and promote the importance of sun safety and early cancer detection.
**Goal Status:** Over 2,000 people of all ages were reached at community events between April and September 2019 in the towns of Beverly, Danvers, Gloucester, Ipswich, Middleton, Rockport, Essex, and Manchester-by-the-Sea.
**Type of Goal:** Operational Goal
**Time Frame Year:** 3
**Time Frame Duration:** 3
**Community Partners:** American Cancer Society, Department of Children & Families, Cape Ann Office, YMCA of the North Shore, Action, Inc., Danvers Cares

***Increasing Access to Care: Transportation Program***

**Brief Description/Objective:** While social determinants of health affect all populations, community and organizational experts expressed concern that seniors may feel these effects more acutely. Many older adults live on fixed incomes with limited funds for medical expenses, and are less able to afford the high costs associated with negative health outcomes. Transportation was also consistently mentioned as a major barrier to senior well-being, as many elders no longer drive and find themselves with fewer transportation options.
In response, BH/AGH provides a variety of ways to help bridge the gaps that can be caused by lack of transportation. In FY19, we provided over 400 vouchers for patients without access to transportation.
Additionally, Bay Ridge Hospital provides a part-time shuttle driver to assist patients with transportation services. Many of these patients are receiving intensive outpatient services designed to provide an alternative to acute inpatient treatment. Specific services can include daily treatment meetings and individual, family, group, and psychopharmacological intervention.

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: Adults, Elderly

- Race/Ethnicity: All
- Language: English
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Access/Coverage Supports
**Additional Program Descriptors:** Not Applicable
**DoN Health Priorities:** Not Applicable
**EOHHS Focus Issues:** Not Applicable

**Health Issues**: Access to Transportation, Access to Health Care, Senior Health Challenges
**Goals:** The goal of the Transportation Program is to increase access to health services by providing transportation to individuals with no means of transportation due to medical or financial issues.
**Goals Status:**

- AGH provided over 240 free taxi rides to those who could not otherwise transport themselves home.
- BH provided over 160 free taxi rides to those who could not otherwise transport themselves home.

**Type of Goal:** Operational Goal
**Time Frame Year:** 3
**Time Frame Duration:** 3
**Community Partners:** Tri-City Services, Tom's Taxi, TG's Taxi, Gloucester Taxi and Livery Services

***Support Groups***

**Brief Description:** NHC offers a variety of monthly support groups for patients dealing with various diseases, conditions, and concerns to help inform, console, and lift the spirits of participants:

- Alzheimer's/Caregivers
- Bariatric Surgery Support Group
- Newly Diagnosed Breast Cancer Group
- Breast Cancer Survivors
- Melanoma Support Group
- Diabetes Support Group
- Stroke Support Group
- Happiest Baby on the Block
- Prostate Cancer Support Group
- Look Good Feel Better Program
- Ostomy Support Group
- Nursing Mothers
- Infant Loss Support Group
- Widow Persons Support Group

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: All
- Race/Ethnicity: All
- Language: English
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Total Population or Community-Wide Interventions
**Additional Program Descriptors:** Support Group
**DoN Health Priorities:** Social Environment

**EOHHS Focus Issues:** Substance Use Disorders; Mental Illness and Mental Health; Chronic Disease with a focus on Cancer, Heart Disease, and Diabetes
**Health Issues:** Substance Use Disorders, Mental Health, Chronic Disease, Alzheimer's, Overweight and Obesity, Breast Cancer, Skin Cancer, Diabetes, Stroke, Prostate Cancer, Cancer, Parenting Skills, Bereavement
**Goals:** To provide emotional support to patients during difficult times, and to provide education about available community resources.
**Goals Status:** In FY19, NHC conducted support groups for different diseases/conditions/concerns.
**Type of Goal:** Operational Goal
**Time Frame Year:** 3
**Time Frame Duration:** 3

**Community Partners:** Not Applicable

## ELDER HEALTH

***Senior Dine and Learn Program***
**Brief Description:** Age is a fundamental factor to consider when assessing individual and community health status. Older individuals typically have more physical and mental health vulnerabilities and are more likely to rely on immediate community resources for support than are young people. The percentage of the population over 65 is high or significantly high in all municipalities in our service area compared to the commonwealth. The percentage of the population over 85 is significantly higher in Gloucester, Beverly, and Danvers.
Key informants and focus group/forum participants in the BH/AGH CHNA expressed concern about social isolation and depression among older adults, especially frail elders who live alone or who do not have a regular caregiver. Other concerns for the older adult population included issues around cognitive decline, mobility, and disease management/navigation of the health system, especially for those with multiple chronic conditions. To address these issues, BH/AGH, in partnership with Unidine and the local Councils on Aging, hosts a monthly senior meals program. We work to keep local senior citizens healthy and safe by hosting free education seminars on health and personal safety while providing a hot, healthy, and nutritious meal in a community setting that allows for social engagement and interaction. Highlighted topics included basic nutrition, medication review, fall prevention, stress management and coping skills, fitness tips, memory loss, and osteoporosis prevention. Each presentation was accompanied by a healthy and nutritious meal prepared by the dining services team from Unidine at the BH/AGH cafeterias and served by hospital employees. When surveyed and asked what they liked most about the program, the majority answered, "Good food, wonderful speakers, and good company."

**Target Population:**
- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: Elderly
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status**: Not Applicable
**Program Type:** Total Population or Community-Wide Interventions
**Additional Program Descriptors:** Community Education, Prevention
**DoN Health Priorities:** Social Environment
**EOHHS Focus Issues:** Not Applicable
**Health Issues:** Senior Health Challenges/care coordination, Mental Health, Stress Management, Access to Healthy Food, Alzheimer's Disease, Arthritis, Cardiac Disease, Chronic Pain, Diabetes, Hypertension, Osteoporosis, Pulmonary Disease, Stroke, Home Injuries, Other Injuries, Nutrition, Physical Activity

**Goal:** In FY19 BH/AGH will conduct monthly health education sessions serving the elderly population.
**Goal Status:** In FY19, BH/AGH conducted seven monthly sessions each, serving over 840 elder adults from the communities of Gloucester, Rockport, Manchester by the Sea, Beverly, and Danvers. BH/AGH plans to increase the number of sessions and the capacity in FY20 in hopes to reach an additional 150 seniors.
**Type of Goal:** Operational Goal
**Time Frame Year:** 3
**Time Frame Duration:** 3
**Community Partners:** Unidine; Beverly, Gloucester, and Rockport Councils on Aging.

***Danvers Senior Nutrition Program***
**Brief Description:** Working in partnership with the Danvers Rotary, Danvers Council on Aging, and Danvers Food Pantry, we established a program that offers coupon booklets to Danvers seniors to be used at the farmers market held on Wednesdays, June through August. The program allows for community engagement, social interaction, and healthy food alternatives.
**Target Population:**
- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: Elderly
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Total Population or Community-Wide Intervention
**Additional Program Descriptor:** Not Applicable
**DoN Health Priorities:** Social Environment
**EOHHS Focus Issues:** Chronic Disease with a focus on Cancer, Heart Disease and Diabetes
**Health Issues:** Access to Healthy Food, Nutrition, Obesity/Overweight, Senior Health Challenges/Care Coordination

**Goal:** To increase access for senior residents of Danvers to local, farm-fresh produce, meats, fish, eggs, and honey.
**Goal Status:** The program was designed to reach 19.3% of the Danvers population over 65 years of age.
In 2019, we saw 400 certificates distributed, and 90% of the vouchers were redeemed at participating farm vendors for fresh items.
**Type of Goal:** Operational Goal
**Time Frame Year:** 1
**Time Frame Duration:** 3
**Community Partners:** Danvers Rotary, Danvers Farmers Market, Danvers Council on Aging

***The Aging Mastery Program***
**Brief Description:** The Aging Mastery Program is an education and behavior change program designed to support seniors in "aging well." The program philosophy is built on the belief that modest changes in lifestyle can result in big health changes, thus empowering individuals to develop sustainable behaviors in multiple dimensions of well-being. This program has been implemented widely in Massachusetts with the support of Massachusetts Council on Aging. As clearly identified in the BH/AGH CHNA, the older adult population is the fastest-growing age group. Per the local Beverly census, in 2016, the number of people 60 years and older living in Beverly has surpassed the number of children (18 and under) living in Beverly by 1,230. Older adults are at greater risk of developing chronic conditions. People in general are unprepared for increased longevity and the challenges that may be associated with aging.

Over 12 weekly sessions, the program incorporates evidence-based materials, guest speakers, group discussion, peer support, and incentives/rewards.
The core curriculum covers 10 dimensions:

1. Navigating Longer Lives: The Basics of Aging Mastery
2. Fall Prevention
3. Exercise and You
4. Sleep
5. Healthy Eating and Hydration
6. Financial Fitness
7. Advance Planning
8. Healthy Relationships
9. Medication Management
10. Community Engagement

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: Elderly
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Total Population or Community-Wide Interventions
**Program Descriptor Tags:** Health Education
**DoN Health Priorities:** Not Applicable
**EOHHS Focus Issues:** Chronic Disease with a focus on Cancer, Heart Disease, and Diabetes
**Health Issues:** Physical Activity, Access to Health Care, Nutrition, Senior Health Challenges/Care Coordination
**Goal:** Provide sessions that incorporates evidence-based materials, guest speakers, group discussion, peer support, and incentives/rewards.
**Goal Status:** Participants have successfully increased social connectedness, financial security, physical activity, healthy eating habits, understanding of preventive benefits, communication with health care providers, and utilization of advance planning skills.
**Type of Goal:** Outcome Goal
**Time Frame Year:** 3
**Time Frame Duration:** 3
**Community Partner:** Beverly Council on Aging

***Community-Based Exercise Classes: Enhance Fitness***

**Brief Description/Objective:** Over the past two decades, obesity rates in the United States have doubled for adults. This trend has spanned all segments of the population, regardless of age, sex, race, ethnicity, education, income or geographic region. Some segments have struggled more than others, but no segment has been unaffected. Overall fitness and physical activity reduce the risk for many chronic diseases, are linked to good emotional health, and help prevent disease. One way that BH/AGH is addressing this health need is through our partnership with the North Shore YMCA to offer free Enhance Fitness classes in the community. Enhance Fitness is a nationally offered program at YMCAs across the country. It is an evidence-based health intervention offsetting the effects of aging and chronic illness as well as minimizing fall risk. Participants work on cardio and muscular strength, balance, flexibility, and stability, all while fostering a supportive social community. Classes meet three days per week, and sessions run for eight weeks. Fitness checks are done at the beginning and end of each eight-week session. In FY19, the YMCA was able to offer sessions of Enhance Fitness at the Ipswich YMCA, Beverly YMCA, and Gloucester, Beverly & Rockport Senior Center. The goal is to continue to work with our community partners into FY20.

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: Elderly
- Race/Ethnicity: All
- Language: English
- Environment Served: All

**Additional Target Population Status:** None
**Program Type:** Total Population or Community-Wide Interventions
**Additional Program Descriptors:** Community Education, Prevention
**DoN Health Priorities:** Social Environment
**EOHHS Focus Issues:** Chronic Disease with a focus on Cancer, Heart Disease, and Diabetes
**Health Issues:** Cardiac Disease, Diabetes, Hypertension, Overweight and Obesity, Physical Activity, Senior Health Challenges/Care Coordination
**Goal 1:** Offer free Enhance Fitness classes in the community through a partnership with the YMCA
**Goals Status:** 239 people were served by this program among the four locations. The majority of the participants were female and between the ages of 60 and 89.
**Type of Goal:** Operational Goal
**Time Frame Year:** 2
**Time Frame Duration:** 3

**Goal 2:** Increase in general health, physical ability, and physical activity of participants.
**Goal Status 2**: Enhance Fitness is an evidence-based fitness program, and participants were provided with a pre- and post-class survey that demonstrated the following:

- An average of 79% improved to "above average" leg strength according to age-predicted norms.
- An average of 74% improved to "above average" or maintained at "average" upper body strength according to age-predicted norms.
- An average of 37% improved mobility/balance.

**Type of Goal:** Outcome Goal
**Time Frame Year:** 2
**Time Frame Duration:** 3
**Community Partners:** YMCA of the North Shore; Gloucester, Rockport, Ipswich, and Beverly Councils on Aging

***By Your Side Program***
**Brief Description:** Research has shown that homebound elders often suffer from some combination of physical and mental health disorders. Access to needed counseling is significantly impacted by lack of available providers, the condition of the consumer physically (frail and homebound), and often the consumer's own mental health condition, preventing the consumer from receiving treatment in a clinic or at a physician's office. The By Your Side program is for adults coping with behavioral health issues that have created threats to physical and mental health caused by isolation, depression, and anxiety. The program will help these elders develop and maintain healthy lifestyles while empowering them to self-advocate. By receiving ongoing health education and medication review, these elders will become better informed about their conditions, and that will help reduce disparities in care. Additionally, by continuing to provide education on behavioral health and social isolation, the program will reduce the stigma and other roadblocks to patients receiving access to needed care. North Shore Elder Services contracted with a master's-level clinician to provide behavioral health counseling to low-income consumers residing in the Fairweather Apartments in Beverly or Danvers who would otherwise be unable to receive therapy.
**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: Elderly
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Total Population or Community-Wide Interventions
**Additional Program Descriptors:** Prevention
**DoN Health Priorities:** Social Environment
**EOHHS Focus Issues:** Mental Illness and Mental Health
**Health Issues:** Mental Health, Depression, Access to Health Care, Senior Health Challenges/Care Coordination,
**Goal:** The goal of the program is to provide in-home behavioral health counseling to older adults unable to access needed behavioral health counseling or treatment. To provide a better quality of life for elders experiencing chronic mental health behaviors with the aim to reduce social isolation of the residents in the buildings**.**
**Goal Status:** A total of 20 residents were enrolled in therapy during the 10-week program.
**Type of Goal:** Operational Goal
**Time Frame Year:** 1
**Time Frame Duration:** 3
**Community Partners:** North Shore Elder Services, Salem State University School of Nursing, Fairweather Residences in Beverly and Danvers

***Cape Ann Seniors on the GO — Cape Ann Regional Transportation Program***
**Brief Description:** To expand regional transportation for senior citizens in order to improve health outcomes through increased access to healthy food and physical activity while simultaneously reducing social isolation and promoting mental well-being. The project will improve efficiency across municipal borders to eliminate transportation barriers and the cost burden for low-income seniors aged 65+ on Cape Ann. The intention is to create a unified schedule of fixed routes from each community's senior housing units to three areas of focus: 1) farmers markets, 2) grocery stores, and 3) parks/facilities for physical activity. It is understood that poor nutrition and lack of physical activity lead to chronic disease conditions and obesity. The Cape Ann Mass in Motion coalition, comprising Gloucester, Rockport, Essex, and Manchester-by-the-Sea, intends to leverage existing partnerships with senior-serving agencies, transportation providers, and housing authorities in addition to new public/private partnerships with food and exercise providers to move the needle on health indicators for the aging population on Cape Ann.

The Cape Ann region (Gloucester, Rockport, Essex, and Manchester-by-the-Sea) has a population of 44,381 year-round residents, with a higher percentage of residents age 65+ than the state average. Metropolitan Area Planning Commission projects as many as 40% of the region's population will reach the 65+ demographic by the year 2030. Of the senior population on Cape Ann, 31% live alone. The aging population is also impacted by low income, with 22% of Cape Ann homeowners age 65+ making under $20,000 annually, and 35% percent of individuals living in rental units spending more than one third of their income on housing, leaving little room for expenses like food and transportation.

A schedule was created to for pickup locations and destinations that enhance service delivery to seniors for healthy food and physical activity. Residents secure a seat on a bus for a scheduled outing, and each community's designated bus conducts pickups at designated senior housing facilities in the communities of Gloucester, Rockport, Essex, and Manchester-by-the-Sea. Residents are then transported to the region's food pantry, mobile market, farmers markets, or grocery stores to improve their access to nutritious food items. Also, seasonally, preplanned transport to the Gloucester Boulevard, Cape Ann trails, or other facilities for recreational opportunities, such as birdwatching, hiking, or Bocce tournaments, are incorporated into the buses' schedule to address physical inactivity among the target population.

**Food access locations visited:** Market Basket (Gloucester and Rowley), Shaw's, Stop-n-Shop, Trader Joe's, Wegman's, Cape Ann Farmers Market, Marini Farms, lunches at councils on aging, The Open Door Food Pantry.

**Physical Activity Locations Visited:** Gloucester Boulevard, fitness classes at councils on aging, Cape Ann Lanes, and Gordon College indoor walking track.

**Target Populations:**
- Regions Served: Gloucester, Rockport, Manchester by the Sea, Essex
- Gender: All
- Age Group: Elderly
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Disability Status
**Program Type:** Access/Coverage Support
**Additional Program Descriptors:** Not Applicable
**DoN Health Priorities:** Built Environment
**EOHHS Focus Issues:** Not Applicable
**Health Issues:** Access to Transportation, Access to Healthy Food, Physical Activity, Nutrition, Obesity, Transportation, Mental Health, Senior Health Challenges/Care Coordination
**Goal:** Will provide transportations to enhance service deliver to seniors for healthy food and physical activity.
**Goals Status:** Over 155 trips provided, with 71 unique riders who utilized the service.
**Type of Goal:** Operational Goal
**Time Frame Year:** 1
**Time Frame Duration:** 3
**Community Partners:** City of Gloucester, Cape Ann Mass in Motion, Cape Ann Transportation Authority, SeniorCare

## BEHAVIORAL HEALTH (Mental Health and Substance Use)

***High Risk Intervention Team***
**Brief Description:** The High Risk Intervention Team (HRIT) is a multidisciplinary team with pharmacists, social workers, RNs, community health workers, and recovery coaches. This team provides a multitude of services to high-risk clients to support their complex needs, including but not limited to medication education and pill box setup, home visits, accompaniment to Primary Care Physician (PCP) appointments, rounds in Skilled Nursing Facility (SNF) facilities to coordinate discharge care, assistance with obtaining insurance, assistance getting needed community and mental health services, assistance with recovery services for substance use disorders, assistance with housing needs, assistance obtaining food sources, and any and all interventions designed to assist patients to be cared for in their homes or community setting.

The High Risk Intervention Team will also make post-acute care and home visits. Health Promotion Advocates will provide ED-SBIRT education and prevention by reinforcing healthy patient behaviors and reducing high-risk substance use behaviors for all patients in the Emergency Department.

**Target Population:**
- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: Adults

- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Direct Clinical Services
**Additional Program Descriptors:** Prevention
**DoN Health Priorities:** Not Applicable
**EOHHS Focus Issues:** Chronic Disease
**Health Issues:** Mental Health, Substance Use, Cardiac Disease, Diabetes, Hypertension, Access to Health Care, Uninsured/Insured, Affordable Housing, Homelessness, Access to Healthy Food
**Goal:** The HRIT will serve the community population with the highest risk for readmission to BH/AGH, including those with four or more admissions in the past 12 months, those with readmissions within 30 days, and those with socially complex needs (Medicaid, Medicare, homelessness, and substance use disorder history).
**Goal Status:** The HRIT serves a monthly average of 90 patients at AGH and 330 at BH on an ongoing basis.
**Type of Goal:** Operational Goal
**Time Frame Year:** 3
**Time Frame Duration:** 3

***Recovery Coaches in the Emergency Room***

**Brief Description:** The role of a Recovery Coach is to provide supportive services described below to individuals who present in an emergency department (ED) for an opiate overdose as well as individuals seeking services for substance use disorders, regardless of insurance status. The Recovery Coaches follow all enrolled patients and those who receive a buprenorphine kit from a medical provider in our EDs. The Recovery Coaches ensure that the patients enrolled are contacted to schedule a follow-up appointment in the Lahey Enhanced Assessment Program (LEAP) clinic. Recovery Coaches work closely with hospital ED staff.

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: All
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Direct Clinical Services
**Additional Program Descriptors:** Not Applicable
**DoN Health Priorities:** Not Applicable
**EOHHS Focus Issues:** Substance Use Disorders, Mental Illness and Mental Health
**Health Issues:** Mental Health, Substance Use, Access to Health Care, Opioid Use, Uninsured/Underinsured
**Goal:** Provide recovery supports to those who present in the ED.

- Be a member(s) of the ESP team that provides nonclinical support and shall not be used in a clinical capacity.
- Be supervised by a licensed ESP Director or Clinician with substance use disorder training and experience, LADC preferred.
- Be a peer, preferably with lived addiction experience.
- Complete the Bureau of Substance Abuse Services (BSAS) Recovery Coach Academy or the Connecticut Community Addiction Recovery (CCAR) training prior to working with individuals in the ED and within one month of hire.
- Meet with an individual who presents in the ED post-overdose if the individual agrees.

- Serve as a recovery guide and role model in the management of recovery, help the individual identify and overcome barriers to recovery, connect the individual with recovery support services, and encourage hope, optimism, and health.
- Provide support with problem solving and advocacy to help individuals meet their recovery goals.
- Obtain necessary releases of information signed by the individual in order to provide short-term follow-up support.
- Provide education on overdose prevention and the use of naloxone to the individual, and offer the individual an overdose-prevention kit.
- Provide short-term telephonic (or text) follow-up support, coaching, and assistance to help the individual access treatment or recovery support services if agreed upon by the individual.
- Be knowledgeable about the substance use disorder service system, and link the individual to treatment and recovery resources including but not limited to Acute Treatment Services (ATS), sober housing, benefits, and Naloxone education.
- Conduct a warm handoff of the individual to appropriate treatment or recovery services including a Community Support Program (CSP) to encourage continued treatment and recovery support in the community.
- Provide education to individuals and family members on the recovery process; and act as a resource for any individual who presents to the ED seeking services for a substance use disorder.

**Goal Status:** BH/AGH now has three full-time recovery coaches.
**Type of Goal:** Operational Goal
**Time Frame Year:** 2
**Time Frame Duration:** 3
**Community Partners:** Not Applicable

***Medication Disposal Box Program***
**Brief Description:** As part of our CHIP commitment to helping address prescription drug misuse, Beverly Hospital is now providing a medication disposal kiosk to safely dispose of expired or unwanted medication. Medications can be dropped off 24 hours a day, seven days a week in the Emergency Room Waiting Area and are safely disposed of in accordance with Drug Enforcement Administration regulations. According to the National Institute on Drug Abuse (NIDA), an estimated 54 million people have used medications for nonmedical reasons at least once in their lifetime. Opioids are among the most misused prescriptions, with 75% of those who abuse them reporting their first opioid was a prescription. The NIDA reports that unintentional opioid pain reliever deaths have quadrupled since 1999, and that nearly 80% of heroin users reported using prescription opioids prior to heroin.
**Target Population:**
- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: All
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Total Population or Community-Wide Intervention
**Additional Program Descriptors:** Not Applicable
**DoN Health Priorities:** Built Environment
**EOHHS Focus Issues:** Substance Use Disorders
**Health Issues:** Mental Health, Substance Use Disorders, Opioid Use
**Goal:** To provide a safe and convenient way for residents to dispose of unwanted or unused medications.
**Goal Status:** In FY19, Beverly Hospital collected and disposed of 1,000 pounds of medications, which was a 100% increase over medication collected and discarded in FY18.
**Type of Goal:** Operational Goal
**Time Frame Year:** 3

**Time Frame Duration:** 3

**Community Partners:** Not Applicable

***Project RISE***

**Brief Description:** The goal of Project RISE is to benefit North Shore currently and previously homeless families by creating access to mental health care, trauma recovery support, and treatment for current and past substance misuse. In its first year of operation, Project RISE delivered holistic, mobile counseling and case management to households across the North Shore area that were known to be suffering from the effects of trauma and substance misuse. Families were referred for services throughout the year by Wellspring's Family Shelter and Homelessness Prevention staff and three other local organizations: North Shore Community Action Programs, Citizens Inn, and Emmaus House.

Wellspring has come to understand how important it is to integrate access to quality clinical mental health and substance misuse services within our pre-existing programs. Anxiety, depression, substance misuse, and other pressing psychiatric issues are major barriers limiting parents' ability to make progress in their lives. Every one of the families served by Project RISE reported that they needed services to address posttraumatic stress. Of those, 40% of the families met the diagnostic criteria for posttraumatic stress disorder.

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: All
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Total Population or Community-Wide Interventions
**Additional Program Descriptors:** Prevention
**DoN Health Priorities:** Housing
**EOHHS Focus Issues:** Mental Health
**Health Issues:** Mental Health, Substance Use, Homelessness, Access to Health Care, Stress Management, Violence and Trauma

**Goal:** Wellspring's and the Institute of Health and Recovery's (IHR) goal for year 1 was to work with 20+ families.
**Goal Status:** Ultimately, Project RISE served 38 families in the first year, exceeding the goal by 90%.
In the first year of this collaborative project, the two major tasks were to A) set up a "home base" office at Wellspring and B) hire and train staff. Both of these tasks were accomplished. IHR finalized screening and assessment procedures as well as evaluation tools. Wellspring participated in steering committee meetings and Continuum of Care and Stakeholder groups. The newly hired and trained staff routinely conduct screenings and assessments during their case management duties. They also help connect families to financial and other entitlement benefits, and provide referrals and linkages to community services. Data collection activities will be ongoing over a five-year period.

We are already seeing excellent results for the families being served by Project RISE. With the added benefit of mental health supports, parents are succeeding more quickly and more meaningfully in their efforts to stabilize their families and secure permanent housing. Treatment is helping them to follow through with the numerous and complicated steps to save funds over an extended period of time, pursue housing opportunities in a very tight housing market, and pursue new employment. Just the week prior to the drafting of this report, two families moved on from Wellspring's Gloucester family shelter location into long-term housing. Both families have utilized the clinical services funded through Project RISE.

**Type of Goal:** Operational Goal
**Time Frame Year:** 1
**Time Frame Duration:** 3
**Community Partners:** Wellspring House, Institute of Health and Recovery, Gloucester Housing Authority, Gloucester High School, North Shore Community College, Lynn Housing, Neighborhood Development

***Welcome Home Program***

**Brief Description:** The Welcome Home Program provides permanent housing and supportive services to chronically homeless individuals and families in accordance with the Housing First model. To participate in the program, clients must have long histories of homelessness and at least one disabling condition. Housing First is an evidence-based model that was created on a simple belief that people cannot successfully manage their health within the instability of homelessness. Historically, housing programs would require individuals to demonstrate sobriety, employment, or other "achievements" before they could be "rewarded" with an apartment. Housing First programs believe that housing is a human right and a critical health intervention. Housing First believes people should be given an apartment *first* so they have a stable place to live and from which they can more successfully work on maintaining sobriety, gaining employment, and improving their health.

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: Adults
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Total Population or Community-Wide Interventions
**Additional Program Descriptors:** Prevention
**DoN Health Priorities:** Housing, Built Environment
**EOHHS Focus Issues:** Chronic Disease, Housing Stability/Homelessness, Substance Use Disorders
**Health Issues:** Chronic Disease, Affordable Housing, Homelessness, Income and Poverty, Substance Use, Access to Health Care, Mental Health

**Goal:** The goals of the Welcome Home Program are as follows: to provide chronically homeless people with permanent housing; to help our clients maintain that housing; to ensure our clients are connected to mainstream health care services; to improve our clients' overall health; to improve our clients' mental and behavioral health specifically; to help our clients increase their income; and to help clients achieve their self-identified goals for the future. This program specifically services chronically homeless individuals, who are often considered the hardest to serve due to the high rates of mental illness, substance use disorder, and co-occurring disorders among this subpopulation.
**Goal Status:** In FY19, 93% of clients received care from a PCP, 94% of clients attended follow-up appointments or followed through on referrals from a PCP, emergency department usage decreased by 40% among our clients, and 98% of clients remained in their housing or exited to other permanent housing destinations.
**Type of Goal:** Operational Goal
**Time Frame Year:** 1
**Time Frame Duration:** 3
**Community Partners:** Action Inc., the City of Gloucester High Risk Task Force, Gloucester Police Department, Gloucester EMS Department, Gloucester Board of Health, Grace Center, SeniorCare

***Collaborative Care Model***

**Brief Description:** The National Alliance on Mental Illness (NAMI) reports that one in four individuals experiences a mental illness each year, underscoring a critical need for mental health care access across all patient populations. In the 2019 BH/AGH CHNA, mental health — including depression, anxiety, stress, serious mental illness, and other conditions — was overwhelmingly identified as one of the leading health issues for residents of the service area. Further, individuals from across the health service spectrum discussed the burden of mental health issues for all segments of the population, specifically the prevalence of depression and anxiety.

Beth Israel Lahey Health Behavioral Health Services (BILHBS) provides individual and group therapy for mental health and substance use issues; addition treatment; family services; mobile crisis teams for behavioral health and substance-related emergencies; inpatient psychiatric care plus home and school based programs for children and teens. This past year, BILHBS in collaboration with Lahey Health Primary Care adopted the Collaborative Care Model (CoCM). The model will be expanded to additional communities throughout the Beth Israel Lahey Health service area. Collaborative Care is a nationally recognized primary care-led program that specializes in providing behavioral health services in the primary care setting. The services are provided by a licensed behavioral health clinician and include counseling sessions, phone consultations with a psychiatrist, and coordination and follow-up care. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treating a variety of medical and mental health conditions.

The primary care provider and the behavioral health clinician develop a treatment plan that is specific to the patient's personal goals. The behavioral health clinician uses therapies that are proven to work in primary care. A consulting psychiatrist may advise the primary care provider on medications that may be helpful. FY19 successes included hiring and training behavioral health clinicians.

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: Adults
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Direct Clinical Services
**Additional Program Descriptors:** Prevention
**DoN Health Priorities:** Social Environment
**EOHHS Focus Issues**: Mental Illness and Mental Health
**Health Issues:** Mental Health, Depression, Stress Management, Access to Health Care
**Goal:** Expand the model to additional communities throughout the Beth Israel Lahey Health service area.
**Goal Status:** Served 10 primary care practices, reaching 1,747 patients.
**Type of Goal:** Operational Goal
**Time Frame Year:** 1
**Time Frame Duration:** 3
**Community Partners:** Not Applicable

## MATERNAL AND CHILD HEALTH

***Connecting Young Moms Programs***

**Brief Description:** Connecting Young Moms programs offer comprehensive pre- and postnatal programs to young mothers and their children. For many, the programs offer a lifeline at this pivotal time in their lives. Connecting Young Moms is offered at no cost by the Beverly Hospital Social Work Department in collaboration with the Parent Education Department. Connecting Young Moms serves young mothers and mothers-to-be who have limited resources and often have little emotional and social support. This free program is to be attended in the first or second trimester and focuses on healthy pregnancy.

This is a support group specifically for teens and young women and their children. The group meets at Beverly Hospital in the Women's Health and Medical Arts Building every Tuesday and Thursday from 1 to 3 p.m. Child care is provided by Beverly Hospital volunteers. Topics include healthy relationships, challenges of young parenthood, balancing parenting/work/education, and child development.

One component of the Connecting Young Moms programs is the Childbirth Preparation Series. This program is specifically for teens and young women and their support people, and the group meets at Beverly Hospital every Tuesday for seven weeks. It is designed to follow the Healthy Pregnancy workshop and prepares expectant mothers and their support people for labor and delivery.

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: Teenagers, Adults
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable

**Program Type**: Total Population or Community-Wide Interventions

**Additional Program Descriptors:** Community Education, Support Group

**DoN Health Priorities:** Social Environment

**EOHHS Focus Issues:** Not Applicable

**Health Issues:** Child Care, Family Planning, Parenting Skills, Stress Management

**Goal:** Through a team approach, staff will commit to bringing health and parenting education, community resources, and peer support to help young mothers develop healthy and positive parenting skills.

**Goal Status:** Connecting Young Moms offered five prenatal sessions throughout the year to 65 young mothers plus their children, fathers of the babies, and support people.

**Type of Goal:** Operational Goal

**Time Frame Year:** 3

**Time Frame Duration:** 3

**Community Partners:** Not Applicable

***The Nurturing Program for Parents***

**Brief Description:** The Nurturing Program® for Parents of School Aged Children and the Nurturing Program® for Parents of Infants, Toddlers and Preschoolers ran concurrently in order to accommodate the increased participant interest from the community. Parents learned about nurturing parenting, with particular attention paid to nurturing/attachment, knowledge of parenting/child development, parental resilience, social connections, concrete services, and social-emotional competence of children. Children learned comparable skills at age-appropriate levels through puppets, role play, music, art activities, and leader-led discussions. Each week, parents and their children came together for dinner at the midpoint of the evening's session. We found that dinner was a powerful opportunity to share strategies with families, as the children were eager to show what they had learned and made in their classrooms as well as discuss what they had enjoyed about their day and what they had not. From there, families used the skills they had

been learning in a group to brainstorm ideas on ways to help children have more successful days in the future. In 2019, caregivers learned healthier parenting approaches through the development of attachment, empathy, appropriate discipline, self-awareness, and empowerment. They developed connections with other participants, reflected on their past experiences, and practiced incorporating their new parenting knowledge and skills going forward. Their children, when able to attend, learned comparable skills at age-appropriate levels through puppets, role play, music, art activities, and leader-led discussions. Given the complex social and emotional histories of our participants (including trauma, depression, social isolation, involvement with DCF, and more), we ensured that each parent group was facilitated by at least one licensed social worker. Due to the sensitive nature of topics that can arise in the Nurturing Program, we prioritized creating safe, comfortable environments with highly skilled support. Within this environment, we closely followed the Nurturing Program curriculum, tailoring content to specific situations when necessary, in order to provide families with lessons and themes that built on each other from week to week. Group facilitators engaged caregivers in implementing their newly learned parenting skills through role plays, group activities, and discussion of family homework assignments.

The family dinner, held at the midpoint of each weekly session, represented a powerful opportunity to share parenting and relationship approaches with families. Facilitators observed parent-child interactions, provided individualized feedback to families, and documented these conversations. Staff also met with parents during home visits to discuss families' needs and expectations further.

To help participants maintain the social connections they had developed during the program, we offered them the opportunity to share their contact information with others in the group. Staff compiled the information into a document for families to reference.

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: All
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type**: Total Population or Community-Wide Interventions
**Program Descriptor Tags:** Community Education
**DoN Health Priorities:** Not Applicable
**EOHHS Focus Issues:** Not Applicable
**Health Issues:** Child Care, Parenting Skills, Education/Learning

**Goal 1:** There are five major goals of the Nurturing Program: to increase parents' knowledge of parenting skills, to increase parents' use of learned parenting skills, to increase parents' knowledge of age-appropriate child development, to increase social connections between parents and caregivers, and to increase parents' knowledge of community services and resources. Meeting these goals reduces the risk of child abuse and neglect, reduces parenting stress and social isolation, and addresses relevant aspects of caregiver history (such as trauma and depression) through group discussion and referrals to external resources when necessary.
**Goal Status 1:** Pathways for Children was able to offer two 15-week Nurturing Programs in 2019: one at the Cape Ann (Gloucester) facility in spring 2019 and one at the North Shore (Beverly) facility in fall 2019. Through these two offerings, 31 parents and their 30 children attended the Nurturing Program, an evidence-based family education curriculum designed to prevent/remediate child abuse and neglect, for 2.5 hours once per week for 15 weeks.
**Type of Goal:** Operational Goal
**Time Frame Year:** 1
**Time Frame Duration:** 3
**Goal 2**: Measure outcomes of the Nurturing Program through several means. Before the start of each 15-week curriculum, facilitators completed home visits with participants to assess the families' baseline needs/functioning and

to administer the Adult Adolescent Parenting Inventory (AAPI) pre-test. The AAPI post-test was administered at the conclusion of the 15 weeks to measure changes in parenting attitudes and approaches over the course of the program. Additionally, participants completed the Parent Evaluation at five-week intervals to measure their subjective experiences of each session and of the program, including whether they found the session(s) helpful, what they learned, what they liked, and what they did not like.
**Goal Status 2**: All graduating Cape Ann parents demonstrated improvement in one or more constructs of the AAPI from the pre-test to the post-test, and 80% improved in two or more constructs. The group average improved from below average to the average range in every construct with the exception of positive discipline, which increased from the average range to above average. Graduation for our North Shore Nurturing Program took place in January 2020, and we anticipate similar AAPI results from that group.

At five-week intervals throughout the program, parents completed surveys to share their feedback, and we were able to incorporate their suggestions and thoughts into the following sessions. For example, one parent in week 10 stated that she appreciated "learning to validate feelings and appropriately talk about them with your children and others." Another parent used the survey to request a "heads up for certain things. The week [when we discussed] 'spanking' was tough stuff to talk about and watch."

Through the final evaluations and reflective discussion at graduation, participants provided concrete examples of how the Nurturing Program helped improve their family functioning via enhanced communication strategies, effective positive discipline approaches, and a greater understanding of empathy. One parent stated, "I have learned about tactics on how to treat and act around my family and daughter." Another wrote, "I have made a family. I wish I could keep the program longer."

Both our Cape Ann and North Shore programs this year involved several families working through custody issues, and the Nurturing Program curriculum, facilitators, and peer groups were able to provide significant support as they adjusted to their evolving family dynamics and structure. In our Cape Ann group of 19 adults and 26 children, three parents regained custody of their children over the course of the program, and two of those parents were able to have their children join them for the graduation ceremony due to their successful progress toward reunification. The involved foster families also joined the biological parents at graduation to help bridge the gap and facilitate the reunification process.

In our current North Shore group of 12 parents, only two have custody of their children. Further, many of the participants' children are placed with foster families outside the region, so they have been unable to join the group, making our child participation numbers (four children total) markedly lower than parent participation for the first time. Although much of the curriculum and at-home assignments center on caregiver-child interaction, we have found that, with adjustments to the group activities to accommodate the unexpected family changes, the program content remains relevant and engaging for these families. In particular, we have adapted the curriculum to address the trauma these families experienced surrounding the removal of their children, as the parents have wanted and needed to process their feelings and reflect on their histories while they look toward hopeful future reunification.
**Type of Goal:** Outcome Goal
**Time Frame Year:** 1
**Time Frame Duration:** 3
**Community Partners:** Children's Friend and Family Services, Early Intervention, Department of Children & Families, Probate Court, Head Start, Wellspring House, The Open Door, Family Dinner Project

***The Compass Program/Moms Do Care Initiative***
**Brief Description:** The Compass Program/Moms Do Care Program services mothers pregnant or with children up to the age of 3 with a history of Opioid Use Disorder (OUD). The program includes an ob-gyn medical director and offers prenatal care, medication-assisted treatment for addiction, "peer mom" recovery coaches, a Licensed Social Worker, and a mental health counselor to provide weekly support groups and therapy as well as constant follow-up to support recovery. The overall program goals are to promote recovery in pregnant and parenting women, improve perinatal care

of the mother-baby dyad, and improve dyadic outcomes. We aim to achieve these goals through a multidisciplinary approach focused on improved maternal substance use treatment, trauma-informed and evidence-based maternal and neonatal care, and increased support for substance-exposed newborns and their families. A key element of Compass/Moms Do Care is its structured support groups made of other women in the program and "graduates" who continue to work on their sobriety as mothers of young children. Clients enrolled in the program were more likely to initiate prenatal care in the first trimester, attend a postpartum visit, and initiate postpartum contraception. They were discharged from the hospital with the baby in their custody 70% of the time.

**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: Female
- Age Group: All
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type**: Direct Clinical Services
**Program Descriptor Tags:** Support Groups, Prevention
**DoN Health Priorities:** Social Environment
**EOHHS Focus Issues:** Substance Use Disorders
**Health Issues:** Parenting Skills, Opioid Use, Substance Use, Mental Health

**Goals:** For pregnant women, the goals are sufficient prenatal and postnatal care, recovery without substance use, and referral for behavioral health services and hepatitis C treatment (if applicable). For their infants, our goals are reduced length of stay for treatment of NAS, discharge in maternal custody, and early intervention referral. We reach them primarily through OB provider referral, but also through ER referral and referral from community programs.
**Goal Status:** To date, the program has served over 75 moms. Currently there are 37 Moms Do Care.
Women enrolled in the Compass/Moms Do Care Program:

- Are more likely to establish pregnancy care in the first trimester.
- Are more likely to be on medication assisted treatment.
- Are more likely to attend a postpartum visit and obtain contraception.
- Have a higher rate of psychiatric comorbidity.
- Are engaged with the program for an average of nine months, with a range of 1-28 months.

Babies born to women enrolled in Compass/Moms Do Care:

- Have a higher risk of preterm delivery.
- Are more likely to need treatment for NAS.
- Are more likely to be placed in DCF custody.
- Have low breastfeeding rates.

These issues likely reflect the fact that the program cares for higher-risk clients.

**Type of Goal:** Operational Goal
**Time Frame Year: 2**
**Time Frame Duration:** 3

**Community Partners:** Massachusetts Department of Children & Families, DPH, Early Intervention, WIC

***<u>Child Passenger Safety Program</u>***
**Brief Description:** The Rehabilitation and Sports Medicine Department has three certified child passenger safety technicians on staff at BH/AGH who offer free car seat inspections for the community at both hospitals.
**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All

- Age Group: All
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Total Population or Community Wide Interventions
**Additional Program Descriptors:** Prevention
**DoN Health Priorities:** Built Environment
**EOHHS Focus Issues:** Not Applicable
**Health Issues:** Child Care, Auto / Passenger Injuries

**Goals:** To provide car seats to low-income families, remove unsafe car seats from the streets, educate families on proper car seat use, and ensure a safe transportation plan for all children in our community.
**Goal Status:** In FY19, the Child Passenger Safety Program inspected 107 car seats and provided 26 new car seats to community families in need.
**Type of Goal:** Operational Goal
**Time Frame Year:** 3
**Time Frame Duration:** 3
**Community Partners:** Not Applicable

***"Cuddler" Program***
**Brief Description:** Cuddling is an important part of a baby's development. This is especially true for newborns in the Special Care Nursery and ones who are experiencing neonatal abstinence syndrome. Families find comfort during this difficult and emotional time knowing their babies are being held and cared for by our exceptional neonatal nurses and dedicated volunteers. These "cuddlers" spend time rocking, holding, and soothing babies to provide them with comfort, warmth, and human connection.
**Target Population:**

- Regions Served: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester by the Sea, Middleton, Rockport, Topsfield and Wenham
- Gender: All
- Age Group: All
- Race/Ethnicity: All
- Language: All
- Environment Served: All

**Additional Target Population Status:** Not Applicable
**Program Type:** Direct Clinical Services
**Additional Program Descriptors:** Prevention
**DoN Health Priorities:** Not Applicable
**EOHHS Focus Issues:** Not Applicable
**Health Issues:** Child Care
**Goal:** The goal of the program is to support the growth and development of newborn babies during the critical early stages of life by providing them with comfort and a feeling of security through personal interaction and calming human touch.
**Goal Status:** Trained volunteers spent more than 410 hours cuddling babies in FY19.
**Type of Goal:** Operational Goal
**Time Frame Year:** 3
**Time Frame Duration:** 3

## Section V: Expenditures

| Item/Description | Amount | Subtotal Provided to Outside Organizations (Grant/Other Funding) |
|---|---|---|
| **CB Expenditures by Program Type** | | |
| Direct Clinical Services | $3,482,387.04 | $9,000.00 |
| Community-Clinical Linkages | $14,100.00 | |
| Total Population or Community Wide Interventions | $501,201.52 | $233,533.95 |
| Access/Coverage Supports | $7,444,896.51 | $20,000.00 |
| Infrastructure to Support CB Collaborations | $239,552.00 | |
| Total Expenditures by Program Type | $11,682,137.07 | $262,533.95 |
| **CB Expenditures by Health Need** | | |
| Chronic Disease | $3,658,902.08 | $148,899.95 |
| Mental Health/Mental Illness | $4,887,371.99 | $40,067.00 |
| Substance Use Disorders | $2,387,480.86 | $29,067.00 |
| Housing Stability/Homelessness | $83,888.00 | $24,000.00 |
| Additional Health Needs Identified by the Community | $664,494.15 | $20,500.00 |
| Total by Health Need | $11,682,137.08 | $262,533.95 |
| **Leveraged Resources** | $1,230,093.15 | |
| Total CB Programming | $12,912,230.22 | |
| **Net Charity Care Expenditures** | | |
| HSN Assessment | $1,913,716.66 | |
| HSN Denied Claims | $29,721.50 | |
| Total Net Charity Care | $1,943,438.16 | |
| Total CB Expenditures | $14,855,668.38 | |
| **Additional Information** | | |
| Net Patient Services Revenue | $408,458,000.00 | |
| CB Expenditure as % of Net Patient Services Revenue | 3.64% | |

## Section VI: Contact Information

Grace Giambanco Numerosi, Regional Manager, Community Benefits/Community Relations
Grace.Numerosi@bilh.org