Community Benefits Report

Fiscal Year 2022

Beth Israel Lahey Health
Beverly Hospital

Beth Israel Lahey Health
Addison Gilbert Hospital

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SECTION I: SUMMARY AND MISSION STATEMENT

Summary and Mission Statement:

Northeast Hospital Corporation (NHC), also known as Beverly and Addison Gilbert Hospitals (BH/AGH), is a member of Beth Israel Lahey Health (BILH). NHC 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 BILH. BILH was established with an appreciation for the importance of caring for patients and communities in new and better ways. 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.

At the heart of BILH is the belief that everyone deserves high-quality, affordable health care. This belief is what drives BILH to work with community partners across the region to promote health, expand access, and deliver the best care in the communities BILH serves. BH/AGH's Community Benefits staff are committed to working collaboratively with its communities to address the leading health issues and create a healthy future for individuals, families and communities. While BH/AGH oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure makes sure that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WECARE:*

- ***W**ellbeing - We provide a health-focused workplace and support a healthy work-life balance*
- ***E**mpathy - We do our best to understand others' feelings, needs and perspectives*
- ***C**ollaboration - We work together to achieve extraordinary results*
- ***A**ccountability - We hold ourselves and each other to behaviors necessary to achieve our collective goals*
- ***R**espect - We value diversity and treat all members of our community with dignity and inclusiveness*
- ***E**quity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.*

Beverly and Addison Gilbert Hospitals' Community Benefits Mission Statement: The Community Benefits Program at BH/AGH partners with community leaders and organizations to assess and meet the health care needs of the community. Strategies used in community benefits health activities include prevention, early detection, early intervention, long-term management, and collaborative efforts with the affiliated organizations that make up the BILH system. Health issues addressed encompass safety, chronic disease, infectious disease, substance abuse, mental health, maternal and child health, and elder health.

The following annual report provides specific details on how BH/AGH is honoring its commitment and includes information on the hospitals' Community Benefits Service Area (CBSA), community health priorities, target populations, 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 and development, implementation, and oversight of the Implementation Strategy.
- **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 the assessment, 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 the 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 services, business, academic, and community health) to advocate for, support, and implement effective health policies, community programs, and services.

The following annual report provides specific details on how BH/AGH is honoring its commitment and includes information on BH/AGH's CBSA, community health priorities, priority cohorts, community partners, and detailed descriptions of its Community Benefits programs and their impact.

Priority Cohorts

BH/AGH's CBSA includes the towns of Ipswich, Essex, Gloucester, Rockport, Manchester-by-the-Sea, Beverly, Danvers, Middleton, and Lynn. In FY 2022, BH/AGH conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included extensive data collection activities, substantial efforts to engage BH/AGH's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. While BH/AGH is committed to improving the health status and well-being of those living throughout its entire CBSA, per the Commonwealth's updated community benefits guidelines, BH/AGH's FY 2023 - 2025 Implementation Strategy (IS) will focus its Community Benefits resources on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved living in its CBSA.

Based upon BH/AGH's FY 2022 CHNA, the community characteristics that were thought to have the greatest impact on health status and access to care in its CBSA were issues related to age, race/ethnicity, language, disability status, and immigration status. Residents in the CBSA were predominantly white and born in the United States, but there were non-white, people of color, recent immigrants, non-English speakers, and foreign-born populations in all communities. There was consensus among interviewees and focus group participants that older adults, people of color, individuals with disabilities, recent immigrants and non-English speakers were more likely to have poor health status and face systemic challenges accessing needed services than young, white, English speakers who were born in the United States. While relatively small, these segments of the population were impacted by language barriers, cultural barriers, and stigma that limited access to appropriate services, posed health literacy challenges, exacerbated isolation, and may have led to discrimination and disparities in access and health outcomes. For its FY 2023 – 2025 IS, BH/AGH will work with its community partners to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, BH/AGH's Community Benefits investments and resources will focus on the improving the health status of the following priority cohorts:

- Youth
- Low-Resourced Populations
- Older Adults

- Racially, Ethnically and Linguistically Diverse Populations

Basis for Selection
Community health needs assessments; public health data available from government (public school districts, Massachusetts Department of Public Health, federal agencies) and private resources (foundations, advocacy groups); and BH/AGH's areas of expertise.

Key Accomplishments for Reporting Year
BH/AGH's most recent CHNA and IS were conducted and approved by the Board of Trustees during the fiscal year ended September 30, 2022. That CHNA and IS will inform the Community Benefits mission and activities of BH/AGH for the fiscal years ending September 30, 2023; September 30, 2024; and September 30, 2025. This report covers BH/AGH's fiscal year ending September 30, 2022. The previous CHNA and accompanying IS were approved by the NHC Board before September 30, 2019 and informed the BH/AGH's Community Benefits initiatives for the fiscal years ending September 30, 2020; September 30, 2021; and September 30, 2022. As such, the accomplishments and activities included in this section as well as in Section IV: Community Benefits Programs relate to the CHNA and Implementation Strategy approved as of September 30, 2019.
The key accomplishments listed below are based on priorities identified and programs contained in BH/AGH's FY19 Community Health Needs Assessment (CHNA) and FY20-22 Implementation Strategy (IS):

- ***Action Inc. Welcome Home Program*** – Through support from BH/AGH, permanent housing was secured and maintained for 11 chronically homeless individuals in FY22.

- ***Beverly Bootstraps –*** Supported Beverly Bootstraps to provide mobile markets at ten different housing sites, serving 4,323 low resourced, older adults.

- ***Breast Cancer Risk Assessment*** – In FY22, BH/AGH provided 3,767 free breast Cancer Risk Assessment (CRA) screenings to identify persons who may have a higher lifetime risk of developing breast cancer, and provided follow-up with all participants' physicians.

- ***Collaborative care Model*** – BH/AGH integrated behavioral health into more than ten primary care practices in FY22, reaching 2,120 patients.

- ***Community Home Blood Draw Program*** – BH/AGH staff provided home blood draws for 4,196 patients who were homebound due to illness, injury, or transportation issues.

- ***Compass Moms Do Care Program –*** In FY22 the Moms do Care program provided Case Management support for 89 pregnant or parenting women (77 of whom were new enrollees) with a history of substance use.

- ***The Open Door Medically Tailored Groceries Program*** - BH/AGH supported The Open Door to provide the Medically Tailored Groceries Program, which aims to alleviate hunger by ensuring that low-resourced and food-insecure individuals with or at risk of chronic illness have access to healthy foods along with free nutritional counseling and educational workshops. In FY22, 1,500 community members were enrolled in the program.

- ***Patient Financial Counseling*** - In FY22, BH/AGH continued to meet the health care needs of patients and assisted 67,500 patients. Patients served included those 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.

- ***Wellspring House "Pathways to Jobs" Program*** – BH/AGH supported Wellspring House to provide education, job training and career advising to 261 adults to help them obtain employment or transition to employment with higher wages.

Plans for Next Reporting Year

In FY 2022, BH/AGH conducted a comprehensive and inclusive CHNA that included extensive data collection activities, substantial efforts to engage BH/AGH's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. In response to the FY 2022 CHNA, BH/AGH will focus its FY 2023 - 2025 IS on four priority areas that collectively address the broad range of health and social issues facing residents living in BH/AGH's CBSA who face the greatest health disparities. These four priority areas are:

I. Equitable Access to Care
II. Social Determinants of Health
III. Mental Health and Substance Use
IV. Complex and Chronic Conditions.

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). [BH/AGH]'s priorities are also aligned with the priorities identified by the Massachusetts Department of Public Health (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 (i.e., built environment, social environment, housing, violence, education, and employment).

The FY 2022 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions being used to inform and refine BH/AGH's efforts. In completing the FY 2022 CHNA and FY 2023 - 2025 IS, BH/AGH, along with its other health, public health, social service, and community partners, is committed to promoting health, enhancing access and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identify, sexual orientation, disability status, immigration status, or age. As discussed above, based on the FY 2022 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that for BH/AGH's FY 2023 - 2025 IS, it will work with its community partners to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, BH/AGH's Community Benefits investments and resources will focus on the improving the health status, addressing disparities in health outcomes, and promoting health equity for its priority cohorts, which include youth; low-resourced populations; older adult, and racially, ethnically and diverse populations.

BH/AGH will continue to collaborate with and support community-based organizations, public health officials, and other key collaborators throughout its CBSA to execute the following programs/services to address the priority needs listed in its FY22 CHNA and FY23-FY25 IS:

I. Equitable Access to Care:

- Provide lab services at home for individuals who are homebound due to illness or transportation issues.

II. Social Determinants of Health:

- The Open Door, Beverly Bootstraps, and Backyard Growers to help alleviate food insecurity and promote healthy eating by providing healthy, low-cost food to communities along with nutrition consults and education sessions.
- Action Inc.'s Welcome Home Program to help individuals secure and maintain healthy and safe living conditions.

- Wellspring House Pathways to Jobs program to help low resourced adults find new employment, or employment with higher wages.

III. Mental Health and Substance Use:

- The Gloucester Police Department Teach to Reach Recovery Coach Training Program to increase access to recovery services and coaches.

IV. Complex and Chronic Conditions:

- North Shore YMCA's Enhance Fitness Program which provides free fitness classes for older adults to keep them active, and to reduce their risks for developing chronic disease.

Hospital Self-Assessment Form

Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), the BH/AGH Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 22. The BH/AG Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members who participated in BH/AGH's CHNA and asked them to submit the form to the AGO website.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team
As a member of Beth Israel Lahey Health, BH/AGH's Board of Trustees along with its clinical and administrative staff is committed to Beverly Hospital is committed to providing medical expertise and personalized care for an exceptional experience north of Boston. BH/AGH offers an extensive network of primary care physicians, state-of-the-art medical facilities, and emergency care; combining the latest advances in medicine with a truly remarkable and refreshing level of warmth and compassion.

BH/AGH's Community Benefits Department, under the direct oversight of BH/AGH's Board of Trustees, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations. Hospital senior leadership is actively engaged in the development and implementation of the BH/AGH's Implementation Strategy, ensuring that hospital policies and resources are allocated to support planned activities.

It is not only the BH/AGH's Board of Trustee members and senior leadership who are held accountable for fulfilling BH/AGH's Community Benefits mission. Among BH/AGH's core values are the recognition that the most successful Community Benefits programs are implemented organization wide and integrated into the very fabric of the hospital's culture, policies, and procedures. A commitment to Community Benefits is a focus and value manifested throughout BILH and BH/AGH's structure and reflected in how care is provided at the hospital and in affiliated practices.

While BH/AGH oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure makes sure that Community Benefits efforts, prioritization, planning, and strategy focus on equity and align and are integrated with local and system strategic and regulatory priorities to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WECARE:*

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The BH/AGH Community Benefits program is spearheaded by Marylou Hardy, Regional Community Benefits/Community Relations Manager. The Community Benefits/Community Relations Manager 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 Diversity, Equity and Inclusion Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of cohorts who have been historically underserved are considered every day in discussions on resource allocation, policies, and program development. This structure and methodology are employed to ensure that Community Benefits is not the purview of one office alone and to maximize efforts across the organization to fulfill the mission and goals of BILH and BH/AGH's Community Benefits program.

Community Benefits Advisory Committee (CBAC)
The BH/AGH Community Benefits Advisory Committee (CBAC) works in collaboration with BH/AGH's hospital leadership, including the hospital's governing board and senior management to support BH/AG's Community Benefits mission to work collaboratively with BH/AGH's communities to address the leading health issues and create a healthy future for individuals, families, and communities.

The CBAC provides input into the development and implementation of BH/AGH's Community Benefits programs in furtherance of BH/AGHs Community Benefits mission. The membership of BH/AGH's CBAC aspires to be representative of the constituencies and priority cohorts served by BH/AGH's programmatic endeavors, including those from diverse racial and ethnic backgrounds, age, gender, sexual orientation and gender identity, as well as those from corporate and non-profit community organizations.

The BH/AGH CBAC met on the following dates in FY22:

- December 14, 2021
- March 8, 2022
- May 10, 2022
- June 14, 2022 – Annual Public Meeting
- August 9, 2022
- September 8, 2022 – NHC Board of Trustees Meeting/Approval of FY22CHNA/IS

CBAC Members:

Nancy Palmer, Board Chair, Northeast Hospital Corporation Board of Trustees
Tom Sands, President, Beverly/Addison Gilbert Hospital
Marylou Hardy, Regional Manager Community Relations/Community Benefits, NHC
Christine Healey, Director, Community Relations/Community Benefits, BILH
Jason Andree, Vice President, Addison Gilbert Hospital and Lahey Outpatient Center Danvers
Karin Carroll, Director of Community Programs, North Shore Community Health
Andrew DeFranza, Executive Director, Harborlight Community Partners
David DiChiara, MD, Associate Chief Medical Officer, Beverly/Addison Gilbert Hospital
Dutrochet Djoko, Chair of Human Rights & Inclusion Committee, Danvers Board of Health
Cindy Donaldson, Resident, Beverly/Addison Gilbert Hospital
Mark Gendreau, MD, Chief Medical Officer, Beverly/Addison Gilbert Hospital
Peggy Hegarty-Steck, President & Executive Director, Action, Inc.
Brian Holmes, Medical Assistant Educator, Beth Israel Lahey Health Primary Care
Robert Irwin, Trustee, Northeast Hospital Corporation Board of Trustees
Julie LaFontaine, President and CEO, The Open Door
Chris Lovasco, President, YMCA of the North Shore
Whitney Mcneilly, Director, DanversCARES
Chessye Moseley, Trustee, NHC Board of Trustees
Karen Neva Bell, Trustee, NHC Board of Trustees
Valerie Parker Callahan, Director, Planning & Development, Greater Lynn Senior Services
Jonathan Payson, Trustee, NHC Board of Trustees
Kimberly Perryman, Chief Nursing Officer, Beverly/Addison Gilbert Hospital
Mike Tarmey, Vice President, Bayridge Hospital

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's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy were completed in close collaboration with BH/AGH's staff, community residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership and other key collaborators from

throughout its CBSA. BH/AGH's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of BH/AGH's mission. BH/AGH currently supports numerous of educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA. In this work, BH/AGH collaborates with many of its local community-based organizations, public health departments, municipalities and clinical and social service organizations. The following is a comprehensive listing of the community partners with which BH/AGH collaborated with on its FY 2020 – 2022 IS, and FY22 CHNA. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment Form (Section VII, page 22).

- Action Inc.
- American Cancer Society
- Backyard Growers
- Beverly Bootstraps
- Cape Ann Mass in Motion
- CHNA 13/14
- City of Beverly
- City of Gloucester
- DanversCares
- Gloucester School Dept.
- MetroNorth YMCA
- North Shore YMCA
- Pathways
- SeniorCare, Inc.
- The Open Door
- Town of Danvers
- Town of Essex
- Town of Ipswich
- Town of Manchester-by-the-Sea
- Town of Middleton
- Town of Rockport
- Wellspring House

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY 2022 Community Health Needs Assessment (CHNA) along with the associated FY 2023-2025 Implementation Strategy was developed over a twelve-month period from September 2021 to September 2022. 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 the BH/AGH's need to conduct a community health needs assessment, engage the community, identify priority health issues, inventory community assets, assess impact, and develop an Implementation Strategy. However, these activities are driven primarily by [BH/AGH]'s dedication to its mission, its covenant to cohorts who have been historically underserved, and its commitment to community health improvement.

As mentioned above, BH/AGH's most recent CHNA was completed during FY 2022. FY 2022 Community Benefits programming was informed by the FY 2019 CHNA and aligns with BH/AGH's FY 2020 – FY2022 Implementation Strategy. The following is a summary description of the FY 2022 CHNA approach, methods, and key findings.

Approach and Methods

The FY 2022 assessment and planning process was conducted in three phases between September 2021 and September 2022, which allowed BH/AG to:

- Assess community health, defined broadly to include health status, social determinants, environmental factors and service system strengths/weaknesses;
- Engage members of the community including local health departments, clinical and social service providers, community-based organizations, community residents and BH/AGH's leadership/staff;
- Prioritize leading health issues/population segments most at risk for poor health, based on review of quantitative and qualitative evidence;
- Develop a three-year Implementation Strategy to address community health needs in collaboration with community partners, and;
- Meet all federal and Commonwealth Community Benefits requirements per the Internal Revenue Service, as part of the Affordable Care Act, the Massachusetts Attorney General's Office, and the Massachusetts Department of Public Health.

BH/AGH's Community Benefits program is predicated on the hospital's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address inequities and socioeconomic barriers to accessing care, as well as the current and historical discrimination and injustices that underlie existing disparities. Throughout the CHNA process, efforts were made to understand the needs of the communities that BH/AGH serves, especially the population segments that are often disadvantaged, face disparities in health-related outcomes, and who have been historically underserved. BH/AGH's understanding of these communities' needs is derived from collecting a wide range of quantitative data to identify disparities and clarify the needs of specific communities and comparing it against data collected at the regional, Commonwealth and national levels wherever possible to support analysis and the prioritization process, as well as employing a variety of strategies to ensure community members were informed, consulted, involved, and empowered throughout the assessment process.

Between October 2021 and February 2022, BH/AGH conducted 25 one-on-one interviews with key collaborators in the community, facilitated 4focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 1500 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 2,000 community residents, clinical and social service providers and other community partners.

The articulation of each specific community's needs (done in partnership between BH/AGH and community partners) is used to inform BH/AGH's decision-making about priorities for its Community Benefits efforts.

BH/AGH works in concert with community residents and leaders to design specific actions to be collaboratively undertaken each year. Each component of the plan is developed and eventually woven into the annual goals and agenda for the [BH/AGH]'s Implementation Strategy that is adopted by the BH/AGH's Board of Trustees.

Summary of FY 2022 CHNA Key Health-Related Findings

Equitable Access to Care

- Individuals identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system level, meaning that the issues stem from the way in which the system does or does not function. System level issues included providers not accepting new patients, long wait lists, and an inherently complicated healthcare system that is difficult for many to navigate.
- There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forego or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.

Social Determinants of Health

- The social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions influence and define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to economic insecurity, education, food insecurity, access to care/navigation issues, and other important social factors.
- There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, survey, and listening sessions suggested these issues have the greatest impact on health status and access to care in the region, especially those related to housing, food security, and economic stability.

Mental Health and Substance Use

- Anxiety, chronic stress, depression, and social isolation were leading community health concerns. The assessment identified specific concerns about the impact of mental health issues for youth and young adults, the mental health impacts of racism, discrimination, and trauma, and social isolation among older adults. These difficulties were exacerbated by COVID-19.
- In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services.
- Substance use continued to have a major impact on BH/AGH's CBSA; the opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities, including mental health, housing, and homelessness. Individuals engaged in the assessment identified stigma as a barrier to treatment and reported a need for programs that address common co-occurring issues (e.g., mental health issues, homelessness).

Complex and Chronic Conditions

- Chronic conditions such as cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease contribute to 56% of all mortality in the Commonwealth and over 53% of all health care expenditures ($30.9 billion a year). Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society. For more detailed information, see the full FY 2022 BH/AGH Community Health Needs Assessment and Implementation Plan Report on the hospital's website.

SECTION IV: COMMUNITY BENFITS PROGRAMS

Priority Area: Social Determinants of Health & Access to Care **Program Name: Wellspring House "Pathways to Jobs" Program** **Health Issue: Additional Health Needs (Employment)**	
Brief Description or Objective	The Wellspring House "Accelerating Access to Higher Education" program provides intensive education, job training and readiness programs, and career advising to young adults to help them obtain employment or transition to employment with higher wages. The program incorporates three program areas: College Readiness courses, the MediClerk job training program, and Career Readiness program to help students advance in their careers and education by providing mentorship and resources for college, occupational education, or job search.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. By the end of FY22 more than 250 adults will participate in the program and actively work towards achieving their education and/or employment goals. 2. 20% of the participants will transition to new employment with higher wages. 3. 15% of the participants will apply for a degree, certificate, or other training program within 9 months of completing the program. 4. The program will successfully serve a diverse population and/or those impacted by inequities.
Goal Status	1. In FY22 261 adults completed the program and are actively working towards concrete education and/or employment goals. 2. Of the 261 participants: • 57 transitioned to a new job with higher wages • 49 applied for a degree, certificate, or training program • 41 earned a degree or certificate 3. The program served a population that was diverse in age, race, and gender: Gender:77% women, 22% men, 1% not specified Race: 57% white, 13% black, 3% Asian, 27% multiracial. Age: 18-24, 35% , 25-44 - 46%, 45-64 – 14%, and 65+ - 2%

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Area: Social Determinants of Health & Access to Care **Program Name: Serving Health Information Needs of Everyone (SHINE) Program** **Health Issue: Additional Needs (Access to Healthcare)**		
Brief Description or Objective	The Serving the Health Information Needs of Everyone (SHINE) program and financial counselors provide free health insurance counseling services to elderly and disabled adults to help navigate coverage options and benefits of various Medicare/Medicaid plans.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To help Medicare beneficiaries and their caregivers navigate their health insurance options. The counselors are also available to review current coverage, compare costs and benefits of available options, and assist those with limited resources in enrolling in helpful programs	
Goal Status	In FY22, SHINE counselors conducted 3,921 sessions for residents of the North Shore and Cape Ann; an 8% increase over FY20.	
Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Area: Social Determinants of Health & Access to Care **Program Name: Patient Financial Counseling** **Health Issue: Additional Health Needs (Access to Healthcare)**		
Brief Description or Objective	Significant segments of the population living in BH/AGH's CBSA, particularly low-income and racial/ethnic minority populations, face significant barriers to care. These groups struggle to access services due to lack of insurance or transportation, cultural/linguistic barriers, and a shortage of providers willing to serve Medicaid-insured or uninsured patients. To address these gaps, BH/AGH employs six MassHealth-certified Application Counselors who 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.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To meet with patients who are uninsured to assess their eligibility for and align them with state financial assistance and hospital-based financial assistance programs.	
Goal Status	Financial Counselors assisted 67,500 patients (inpatient and outpatient) in FY22. The patients served 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. The age ranges of patients and the percentage of patients within each age range were: 1-19 (23%), 20-39 (36%), 40-59 (27%), 60-69 (11%) 70-100 (2%) At the time of service, 13,130 were employed full time or part time, 15,145 were unemployed, 2,500 self-employed, 2,020 retired, 2,650 disabled, and 1,930 were full- or part-time students	
Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Area: Social Determinants of Health & Access to Care **Program Name: Home Blood Draw Program** **Health Issue: Chronic Disease & Additional Health Needs (Access to Care)**	
Brief Description or Objective	The BH/AGH Laboratory Homebound Phlebotomy Program provides free phlebotomy services in the home for patients who are homebound due to illness or injury, or those with transportation challenges.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	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 FY22, the Mobile Phlebotomy Team from BH/AGH Laboratory scheduled and performed 4,196 free homebound lab visits. Patients have reported reduced feelings of isolation because the visit with the phlebotomist provided them with a social opportunity, and the ability to comply with necessary testing. Patient population served is primarily the elderly and disabled.
Program Year: Year 3	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Area: Social Determinants of Health & Access to Care **Program Name: The Open Door Medically Tailored Groceries Program** **Health Issue: Additional Needs (Access to Healthy Foods)**	
Brief Description or Objective	The MTG program is an innovative program to help adults with, or at risk of, chronic illness, and struggling with food insecurity, better manage their health with access to free, diet specific, nutritious food. In addition the program provides nutrition counseling, educational workshops, and help with meal planning and preparation.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. Manage nutrition boxes targeted for clients to better manage health/diet 2. Reach at least 1,000 community members through counseling and/or nutrition workshops 3. Provide free nutrition counseling for food insecure low-income people at risk of chronic disease. 4.Distribute at least 3,000 pounds of free food.
Goal Status	1. More than 1,500 people participated in the program in FY22, receiving individual nutrition counseling and/or nutrition education via in person or online sessions. 2. 3,376 pounds of free, healthy food was distributed to community members and families.
Program Year: Year 3	**Of X Years: Year 3** / **Goal Type: Outcomes Goal**

Priority Area: Social Determinants of health & Access to Care **Program Name: Action Inc. Welcome Home Program** **Health Issue: Housing Stability**	
Brief Description or Objective	Through support from BH/AGH, Action Inc., this 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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	The overall goal of the program is to provide chronically homeless people with permanent housing; to help clients maintain that housing; to ensure clients are connected to mainstream health care services; to improve clients' overall health; to improve our clients' mental and behavioral health specifically; and to help clients achieve their self-identified goals for the future. 1.Place 8 chronically homeless individuals into permanent supportive housing by the end of FY22. 2.95% of formerly homeless clients in the program will retain their housing. 3.95% of formerly homeless clients in the Welcome Home program will receive care from a PCP.
Goal Status	1.Eleven chronically homeless people secured permanent housing in FY22. 2.96% of formerly homeless clients in the program have retained their housing through this program or by exiting to another permanent housing destination (i.e., Section 8 voucher). 3.91% of formerly homeless clients in the program received care from a PCP. Some clients have found it challenging to visit their PCP during the pandemic.
Program Year: Year 3	**Of X Years: Year 3** / **Goal Type: Outcomes Goal**

Priority Area: Social Determinants of Health & Access to Care **Program Name: Interpreter Services** **Health Issue: Additional Needs (Access to Healthcare)**	
Brief Description or Objective	BH/AGH 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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To provide culturally responsive care through Interpreter Services Department.
Goal Status	In FY22, NHC interpreters reported a total of 11,480 encounters: 10,719 at Beverly Hospital and 761 at Addison Gilbert Hospital. The top three languages were: Spanish – 1747, Portuguese – 721, Albanian - 172
Program Year: Year 3	**Of X Years: Year 3** / **Goal Type: Outcomes Goal**

Priority Area: Social Determinants of Health & Access to Care **Program Name: Beverly Bootstraps Mobile Market** **Health Issue: Additional Needs (Food Access)**	
Brief Description or Objective	Through financial support from Beverly/Addison Gilbert Hospital a summer mobile market was offered at the Beverly Senior Center to bring a free, fresh produce along with nutrition information to residents of Beverly Housing and seniors at the Beverly Council on Aging. In addition, BH/AGH provided funding to support the Senior Home Delivery Program, initiated to ensure low-income seniors in Beverly would receive bags of food that they otherwise would have had to leave their home to acquire at either our Food Pantry or the local grocery store, placing them at an increased risk of exposure to COVID-19.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. To provide a free fresh traveling farmers market to Beverly Housing clients and seniors during the summer and fall of 2022. 2. To provide low income residents home delivery of meals
Goal Status	1. In FY22, 26 mobile markets were held, serving 183 households, with 9,456 pounds of food. Due to Covid restrictions at the Beverly Senior Center, the markets were held at housing facilities in Beverly including Apple Village, Turtle Creek, and Turtle Woods. 2. In FY22, 4,323 low-resourced, older adults were served through mobile markets at three different housing sites in Beverly and/or through home deliveries made to these sites.
Program Year: Year 3	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Area: Social Determinants of Health & Access to Care **Program Name: Connecting Young Moms** **Health Issue: Additional Health Needs (Access to Health Care)**	
Brief Description or Objective	The Connecting Young Moms (CYM) program offers comprehensive pre- and postnatal programs to young mothers and their children with limited resources or emotional/social support. The prenatal component of the CYM program is the Childbirth Preparation Series, designed to prepare expectant mothers and their support people for labor and delivery. The postnatal component is a support group specifically for teens and young women and their children. Until mid-March, the group met in person and child care was provided. From mid-March through the end of the year, the program has been delivering postnatal services remotely. Topics include healthy relationships, challenges of young parenthood, balancing parenting/work/education, child development, and coping with the isolation, stress, job loss, and other challenges associated with COVID-19. The CYM program also provides extensive resource and referral support to women who do not fully join the program, and those not actively participating.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. Increase the number of referrals into the program 2. Reduce barriers to participation and connection by transitioning support groups to a hybrid model.

Goal Status	1. There were 77 new referrals in FY22, a 29% increase over FY21. Of those, 50% identified as being part of an ethnic group and 38% were 20 years old or younger. 2. In June, 2022, CYM successfully transitioned to a virtual/in-person hybrid model.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Area: Social Determinants of Health & Access to Care
Program Name: City of Beverly Summer Literacy Program
Health Issue: Additional Needs (Access to Healthcare)

Brief Description or Objective	The Summer Literacy Program provided learning opportunities and enrichment experiences to children reading below grade level and at risk of experiencing summer learning loss. Building a Better Beverly, in partnership with Beverly Public Schools and the Greater Beverly YMCA, provided a six-week, free summer learning program to approximately 180 children entering first, second, and third grade. The day camp included three hours of literacy instruction in the morning and a traditional summer camp experience in the afternoon. Children received instruction on spelling, grammar, vocabulary, self-selected reading, and small-group guided reading. Programming at Sterling YMCA also included enrichment activities such as arts and crafts, music, team-building activities, swimming, and more.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	The goals of the program are to help children in grades 1-3 achieve grade-level literacy, and provide a summer camp opportunity to help these children grow healthy and happy.
Goal Status	In FY22, 180 students in grades 1-3 participated in the program. Of the 180 students, 100% of maintained or improved their literacy foundational skills, and over 75% of students made ambitious gains in their early literacy skills.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Area: Chronic Disease/Complex Conditions
Program Name: Breast Cancer Risk Assessment
Health Issue: Chronic Disease

Brief Description or Objective	Recognizing the risk for breast cancer is not the same for all women, BH/AGH implemented a free risk assessment using a tablet screening tool to help women evaluate their lifetime risk for breast cancer. The assessment includes an evaluation using the tool, and results, which are shared with the person's physician, are reviewed in a follow up consultation to determine if they might benefit from a higher level of screening beyond regular checkups and mammograms.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Goal: To identify persons who may be at higher lifetime risk of developing breast cancer and to provide screening follow-up to their physicians.
Goal Status	In FY22, BH/AGH conducted 3767 free screenings in Beverly, Addison Gilbert Hospital, and the Danvers Outpatient Center, an 18% increase over FY21. Of those screened, 1148 women were identified with a high-risk mutation and 710 women were identified with a high lifetime risk of breast cancer. Follow-up consultations were provided after each screening, and results were shared with the participant's physicians so they could discuss the recommended follow-up evaluation and care. Demographic Profile: 20-39: 171 40-59: 937 59-60: 1010 60-69: 1036 70-79: 555 80 +: 58

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Area: Chronic Disease/Complex Conditions
Program Name: School Based Health Center at Gloucester High School
Health Issue: Chronic Disease & Additional Needs (Food Access)

Brief Description or Objective	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. This program increases access to healthcare by providing high-quality, comprehensive health care to students on-site at Gloucester High School 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 a grant from the Massachusetts DPH. Services 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. In addition, the SBHC is a safe place where students are encouraged through a strengths-based approach and motivational interviewing to discuss important personal topics such as stress, exercise, healthy eating, alcohol and drug use, friendship, sexual health, and other personal health issues. The SBHC provides an integrated model of care in its approach, staffed by a Nurse Practitioner, a Licensed Independent Clinical Social Worker, and a Certified Community Health Worker. To address the community's food insecurity issues impacted by Covid, the SBHC collaborated with the Open Door to implement a Free Food Locker, a program designed to provide students, who returned to in-person learning, the opportunity to bring free food home to their families.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1.Provide high-quality, comprehensive health care to students to support optimal health and academic outcomes. 2.Reduce barriers to food access by providing at least 500 food orders reaching at least 50 students via the free food pantry, offered in collaboration with The Open Door. 3.Facilitate at least 40 outreach activities reaching 500 students or more.

Goal Status	1.In FY22 the clinic conducted 975 nurse practitioner visits (a 42% increase over FY21) and 830 social worker visits (a 23% increase over FY21), and completed 1958 assessments. 2.Provided 520 food orders serving 55 students and families and made 290 free food deliveries to students and their families. 3.Organized 43 outreach activities (a 51% increase over FY21) reaching 545 students..

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Area: Chronic Disease/Complex Conditions
Program Name: North Shore YMCA Enhance Fitness Program
Health Issue: Chronic Disease

Brief Description or Objective	Over the past two decades, obesity rates in the United States have doubled for adults. Overall fitness and physical activity reduce the risk for many chronic diseases, are linked to good emotional health, and help prevent disease. Through a partnership with the North Shore YMCA, Enhance Fitness classes are offered for free at the YMCA and various locations in the community. Enhance Fitness 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 engaging in 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 sixteen-week session. Due to COVID restrictions, in FY21 classes were conducted virtually via Zoom.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. Provide 1 Enhance Fitness sessions virtually via Zoom reaching at least 50 participants 2. Provide three free in-person sessions at the Ipswich, Beverly, and Cape Ann YMCAs. 3. Increase participants' general health, physical ability, and physical activity level.
Goal Status	1. One virtual session was held reaching 45 participants, a 50% over FY21. 2. Three In-person sessions were held at reaching 68 participants, a 13% increase over FY21. 3. 69 participants completed a pre and post evaluation producing the following results: • 54% improved leg strength • 67% increased upper body strength • 13% improved mobility/balance <u>Demographic Profile:</u> • Gender: 72% Female, 27% Male • Age: 98% 65 or older • Race: 81% White, 3% Asian, 16% Unknown

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Area: Chronic Disease/Complex Conditions **Program Name: Oncology Nurse Navigators** **Health Issue: Additional Needs (Access to Healthcare)**	
Brief Description or Objective	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.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	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.
Goal Status	In FY22 the Oncology Nurse Navigators at BH and AGH dedicated 7,931 to assist more than 900 patients and their families or caregivers, a 10% increase over FY21.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Chronic Disease/Complex Conditions **Program Name: Skin Cancer Awareness and Prevention Community Campaign** **Health Issue: Chronic/Complex Conditions**	
Brief Description or Objective	According to the American Cancer Society, skin cancer is the most common type of cancer in the U.S. More skin cancer cases are diagnosed in the U.S. each year than all other cancers combined, and the number of 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, Beverly and Addison Gilbert Hospitals launched a skin cancer prevention campaign to raise awareness of the risk factors associated with skin cancer, provide easy-to-remember sun protection strategies, and promote the importance of sun safety and early detection. In order to maximize the impact, BH/AGH participated in several large community events throughout the year. At each event, sun safety messaging was reinforced using fun and interactive games and displays. In addition, all participants received sun safety tool kits, which included educational information from the American Cancer Society, sunscreen, lip balm, and UV protective sunglasses. As part of this outreach campaign, BH/AGH provided a free skin cancer screening event at Addison Gilbert Hospital.

Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1.Reach at least 1,000 community members to raise awareness of the risk factors associated with skin cancer, provide easy-to-remember sun protection strategies, and promote the importance of sun safety and early detection. 2.Provide a free full body skin cancer screening to help community members detect skin cancer.	
Goal Status	1. More than 4,000 people of all ages received sun safety information and skin protection tools (i.e. sunscreen, lip balm, and sunglasses) in 5 different community events in Beverly (1), Danvers (1), and Gloucester (3). 2. 45 community members participated in a free full body skin cancer screening conducted by dermatologists on staff at AGH, led by Gary S. Rogers M.D., Director of Surgery and Oncology. Of the 45 individuals screened 16 were referred for additional follow up with a dermatologist.	
Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Area: Chronic Disease/Complex Conditions **Program Name: High Risk Intervention Team** **Health Issue: Chronic Disease**		
Brief Description or Objective	The High Risk Intervention Team (HRIT) is a multidisciplinary team with pharmacists, social workers, and recovery coaches that provides a multitude of services to high-risk clients to support their complex needs, including medication education, home visits, accompaniment to medical appointments, coordinating discharge care, assistance with obtaining insurance, coordinating mental health and recovery services for substance use disorders, housing needs, accessing food, and any and all interventions designed to assist patients to be cared for in their homes or community setting. The HRIT also makes post-acute care and home visits. In addition, a recovery coach on the team is designated to the emergency department to work directly with patients with substance use disorder that present to the ED. The recovery coach is able to provide immediate recovery options.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	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 served a monthly average of 60 patients at AGH and 345 at BH on an ongoing basis. Of these patients 80% have a public payor (Medicare or Medicaid) and 40% had a mental health diagnosis or substance use disorder.	
Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Area: Substance Dependency **Program Name: Online Youth Risk Survey** **Health Issue: Substance Use Disorder & Mental Health**		
Brief Description or Objective	BH/AGH supported the Gloucester Health Department to develop and administer an online tool for administering the Gloucester Health Department's Youth Risk Behavior Study (YRBS) for public school students in grades 6-12.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By the end of FY22: 1. At least 15 people will enroll in and complete the training. 2. Increase job training and workforce development opportunities.	
Goal Status	In FY22: 1. 18 people enrolled in the program, and 16 completed the entire program. 2. 45% (9) of the program participants are currently employed in local social services agencies throughout Gloucester. 3. 16 participants who completed the program were trained to be recovery coaches	
Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Area: Substance Dependency **Program Name: Gloucester Police Department Teach to Reach Program** **Health Issue: Substance Use Disorder**		
Brief Description or Objective	BH/AGH supported the Gloucester Police Department to administer the Teach to Reach program designed to increase peer to peer recovery coach services and job training and workforce development opportunities in the community.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By the end of FY22: 1.Gloucester and Rockport schools will have administered the YRBS online. 2.Gloucester Health Department will receive full data tables and analysis from JSI and share with the Gloucester Public School staff.	
Goal Status	In FY22: 1.1166 Gloucester students and 337 Rockport students completed the YRBS using the online tool. 2.Gloucester Health Department received full data tables and analysis from JSI and shared with the Gloucester Public School staff	
Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Area: Substance Dependency **Program Name: High Risk Intervention Team Addiction Consult Program** **Health Issue: Substance Use Disorder**	
Brief Description or Objective	Beverly/Addison Gilbert Hospital's High Risk Intervention team (HRIT) implemented the Addiction Consult Program to provide assistance to patients with opioid use disorder. The Addiction Consult Service is a team approach where staff from the HRIT work together with medical staff to provide inpatient addiction consults, medication management, and assistance with referrals to outpatient recovery and treatment in the community and/or with recovery coaches on the HRIT. The majority of those served arrive at the hospital from one of the local detox centers or from a local jail or correctional facility.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To provide inpatient addiction consults to patients at AGH and BH to better manage withdrawal and/or connect them with recovery support in the community.
Goal Status	The Addiction Consult Service reached over 220 patients in FY22.
Program Year: Year 3	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Area: Substance Dependency **Program Name: Pathways for Children Youth at Risk Conference** **Health Issue: Substance Use Disorder**	
Brief Description or Objective	The Youth at Risk Conference is a day-long event consisting of key note speakers, workshops, and an educational Expo. The event is targeted to practitioners and non-profit organizations who work with youth. The financial support provided by BH/AGH helps makes the event affordable for attendees.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population/Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. Attract more than 500 attendees. 2. To achieve a 95% satisfaction rate from attendees who complete a post program evaluation.
Goal Status	1. In FY22, there were 630 attendees representing over 257 organizations and 69 communities. Nearly 1/3 of attendees are from organizations serving Essex County's gateway cities, which have populations with below average incomes and adult education levels. 2. As per the post event evaluations, 98% reported that the workshops they attended met or exceeded their needs and expectations, and that they would recommend YAR to others.
Program Year: Year 3	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Area: Mental Health **Program Name: North Shore YMCA SEAL Program** **Health Issue: Mental Health**		
Brief Description or Objective	The Social Emotional Artistic Learning (SEAL) program teaches children core social emotional competencies and coping skills through art to help them manage emotions, learn empathy and maintain healthy relationships.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. To serve 1,300 children by the end of FY22. 2. Participants will demonstrate improved social-emotional competencies as a result of the program	
Goal Status	1. 1,554 children participated in the SEAL program in FY22. 2. 100% of participants showed a decrease of negative behaviors exhibited, along with an increase in spontaneous acts of kindness, politeness, and positive peer interaction.	
Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Area: Mental Health **Program Name: Behavioral Health Crisis Consultation** **Health Issue: Mental Health**		
Brief Description or Objective	To provide 24/7/365 behavioral health crisis evaluation in the emergency department (ED) and throughout other hospital units for individuals experiencing mental health and substance use related crisis. Services are payer agnostic and provided via in-person or telehealth by a multidisciplinary team of qualified professionals, including Psychiatrists, independently licensed and Master's level clinicians, Nurse Practitioners, Registered Nurses, Certified Peer Specialists, and Family Partners. The services include initial assessments for risks, clinical stabilization, treatment initiation, care coordination, and ongoing evaluation to ensure appropriate level of care placement.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to clinical and non-clinical support services for those with mental health and substance use issues, by providing behavioral health services in the hospital.	
Goal Status	A multidisciplinary team, comprised of qualified behavioral health providers, psychiatry, family partners, and peer specialists, is employed to provide behavioral health crisis consultations in the Emergency Department or medical floors of the hospital. In FY22 the team served a total of 1339 patients at AGH/BH: 598 patients at AGH and 741 patients at Beverly Hospital.	
Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Area: Mental Health **Program Name: Greater Lynn Senior Services Project Uniper** **Health Issue: Mental Health & Chronic Disease**	
Brief Description or Objective	Beverly/Addison Gilbert Hospital provided financial support to Greater Lynn Senior Services to support Project Uniper, a program whereby installation of the Uniper software to their televisions, provides virtual programs to alleviate social isolation and provide tools for health monitoring, health self-management, and education, as well as telehealth visits with visits with counselors.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	The overall goal is to reduce social isolation and improve social emotional wellbeing. In FY22 the program aims to: 3. Reach and support at least 50 individuals throughout Beverly, Lynn, and Greater Cape Ann. 4. Engage at least 50% of the participants in one or more activities 5. Engage participants to use the tools at least once per week.
Goal Status	1. 90 individuals from Beverly, Lynn, and Cape Ann had Uniper installed on their televisions and actively participated in the program. 2. An increased number of older adults and diverse populations were reached in FY22: a. Race: 53% white, 9% black, 2% Asian, 2% Multiracial, 33% unknown b. Age: 80% 65 +, 9% 45-64, 11% unknown c. Gender – 78% female/ 22% Male 3. 64% were active users 4. 5% used the tools every week.
Program Year: Year 3	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Area: Substance Dependency **Program Name: Medication Disposal Boxes** **Health Issue: Substance Use Disorder**	
Brief Description or Objective	Beverly Hospital provides a medication disposal box 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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population/Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To provide a safe and convenient way for residents to dispose of unwanted or unused medications.
Goal Status	In FY22, Beverly Hospital safely collected and disposed of 3,808 pounds of expired or unwanted medications, a 63% increase over FY21.
Program Year: Year 3	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Area: Substance Dependency
Program Name: Compass Moms do Care Program
Health Issue: Substance Use Disorder

Brief Description or Objective	The Moms do Care Program provides support for pregnant and parenting women with a history of substance use. The program offers prenatal and postnatal medical care, medication-assisted treatment for addiction, "peer mom" recovery coaches, a team lead social worker (LICSW) for team supervision and complex case management, and two care managers to facilitate support groups and therapy as well as recovery support. The goals are to promote recovery in pregnant and parenting women, improve perinatal care of the mother-baby dyad, support women through the DCF process, and improve dyadic outcomes. These goals are achieved 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 is its structured support groups made up of other women in the program and "graduates" who continue to work on their sobriety as mothers. In FY22, in-person groups and services were resumed. There are now several groups a week including pre-natal, parenting, early intervention, and recovery groups. Intensive work is also done with local DCF offices with the goal of a DCF response that is timely, transparent, and trauma-informed.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	For pregnant women, the goals are sufficient prenatal and postnatal care, recovery without substance use, maintain custody of infants, and referral for behavioral health services and hepatitis C treatment (if applicable). The goal is for at least 80% of women participating in the program to be discharged with the baby in their custody. For parenting women, the goals are to maintain recovery and retain/regain infant custody. For their infants, the goal(s) are reduced length of stay for treatment of neonatal abstinence, discharge in maternal custody, and early intervention referral
Goal Status	In FY22 89 pregnant or parenting moms participated in the program. Clients enrolled in the program reported they 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 84% of the time.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Area: Mental Health **Program Name: Collaborative Care Model** **Health Issue: Mental Health**	
Brief Description or Objective	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 healthcare access across all patient populations. In the 2019 Beverly and Addison Gilbert Hospital Community Health Needs Assessment, 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. In an effort to improve access to behavioral health, Beth Israel Lahey Health has committed to the implementation of the Collaborative Care Model (CoCM) in employed primary care practices over a 5-year period (starting in March 2019). Collaborative Care is a nationally recognized integrated model that specializes in providing behavioral health services in the primary care setting. The services are provided by an embedded licensed behavioral health clinician and they include short-term brief interventions, case review with a consulting psychiatrist, and care coordination. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treating a variety of behavioral 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 within the primary care setting. A consulting psychiatrist may advise the primary care provider on medications that may be helpful. In FY21, success included hiring and training Behavioral Health clinicians.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To increase access to mental health services by incorporating the Collaborative Care Model in Primary Care practices throughout the BILH service area.
Goal Status	In FY22 the program was implemented in 10 sites in the BH/AGH CBSA, serving a total of 2,120 patients (a 7% increase over FY21) in the following cities/towns: Beverly (936), Danvers (479), Manchester by-the-Sea (282), Gloucester (252), and Ipswich (163),
Program Year: Year 3	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Area: Mental Health **Program Name: Pathways for Children Nurturing Program** **Health Issue: Mental Health**	
Brief Description or Objective	BH/AGH supported Pathways for Children to facilitate the Nurturing program, a nationally recognized, evidence-based family education program designed to prevent child abuse and neglect by increasing knowledge of parenting skills, child development, and community services and resources. The program is offered to at-risk families with children ages birth-12.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population/Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	1.Serve at least 25 parents and their children. 2.Participants will demonstrate increased parenting skills and increased knowledge of age-appropriate child development, evidenced by improvement in at least two AAPI nurturing parenting constructs and responses on final program evaluations. 3.Participants will benefit from improved self-esteem, increased community knowledge and involvement, and reduced social isolation, evidenced by responses on final evaluations and at least 1 referral made per family to a community resource by program facilitator
Goal Status	1.57 families participated in the program in FY22. 2.90% of the participants demonstrated improvement in more than two constructs of the Adult Adolescent Parenting Inventory (AAPI v.2). The majority of final scores fell into the "high average" category for all constructs measuring parenting attitudes. 3.Facilitators made at least one referral per family to an external resource

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Area: Mental Health
Program Name: Behavioral Health Community Outreach
Health Issue: Mental Health & Substance Use Disorder

Brief Description or Objective	Provides counseling, treatment, and community support services programs for adults and children with mental health issues and/or those recovering from substance use disorder. Services Include outpatient individual or group therapy, psychiatric services and pharmacological care, individual and group counseling, addiction treatment, school based programs, driver alcohol education programs, and court evaluations. In addition, counselors coordinate care and connect patients with community resources to help secure safe and affordable transportation and housing, medical insurance, and financial assistance.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits
Program Goal(s)	To help adults, children, and families struggling with mental health issues and/or substance use disorder by providing treatment, support, and resources.
Goal Status	In FY22 a total of 3,596 people were served through the following: - 227 students participated in substance use recovery programs, a 13% increase over FY21. - 38,159 counseling sessions were held in Beverly, Gloucester, and Danvers reaching 1580 people. - 556 people received treatment at the Danvers opiate treatment center. - 928 people received treatment at the Danvers Detox Center - Intensive Care Coordination and Family Support and Training was provided to 305 youth meeting serious emotional disturbance criteria.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Program Name: Infrastructure to Support Community Benefits Collaborations Across BILH Hospitals **Health Issue: All**		
Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital have worked together to plan, implement, and evaluate Community Benefits programs. Staff worked together to plan the FY22 Community Health Needs Assessment, and each created an Implementation Strategy that is uniform across all of the hospitals. Community Benefits staff continued to understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH continues to refine the Community benefits Database (CBD), as part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2022: 1. Plan and implement the Community Health Needs Assessment and create the Implementation Strategy to address the priorities that is approved by the hospital's Board of Trustees. 2. In partnership with MGB, create and implement a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public health, and BILH Community Benefits data to more accurately capture and quantify CB/CR activities and expenditures.	
Goal Status	1. All ten BILH hospitals received Board of Trustee approval on their CHNA and IS by September 30, 2022. 2. All FY22 regulatory reporting data was entered into the Community Benefits Database (CBD).	
Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

SECTION V: EXPENDITURES

Item/Description	FY22 Amount	FY22 Amount to Community Organizations
Direct Clinical Services	$10,356,990.00	$0.00
Community-Clinical Linkages	$105,146.00	$0.00
Total Population/Community Wide Interventions	$499,074.00	$263,827.00
Access/Coverage Supports	$1,318,313.00	$81,510.00
Infrastructure to Support CB Collaborations	$23,365.00	$0.00
Total by Program Type (NHC Net)	**$12,302,888.00**	**$345,337.00**
Chronic Disease	$1,664,762.30	$134,274.00
Mental Health/Mental Illness	$647,972.30	$40,520.00
Substance Use Disorders	$1,308,568.10	$32,978.00
Housing Stability/Homelessness	$56,682.80	$45,000.00
Additional Health Needs Identified by the Community	$8,624,902.50	$135,883.00
Total by Health Need (NHC Net, must equal B7)	**$12,302,888.00**	**$388,655.00**
Leveraged Resources	**$5,127,482.92**	
Total Direct CB Programming	**$17,430,370.92**	
HSN Assessment	$2,085,560.48	
HSN Denied Claims	$919,438.57	
Free/Discount Care	$0.00	
Total Net Charity Care Expenditures	**$3,004,999.05**	
Total CB Expenditures	**$20,435,369.97**	
Additional Information		
Net Patient Services Revenue	**$394,055,000.00**	
CB Expenditure % of Net Patient Services Revenue	**5.19%**	
Optional Information		
Bad Debt	**$2,845,216.41**	
Bad Debt Certifications	**$2,845,216.41**	
PILOT Payments	**NA**	

SECTION VI: CONTACT INFORMATION

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Beverly & Addison Gilbert Hospitals
Community Benefits & Community Relations
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Marylou.hardy@bilh.org

SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Form – Year 1

Note: This form is to be completed in the Fiscal Year in which the hospital completed its triennial Community Health Needs Assessment

I. Community Benefits Process:

1. Community Benefits in the Context of the Organization's Overall Mission:
   - Are Community Benefits planning and investments part of your hospital's strategic plan? ☒Yes ☐No
   - If yes, please provide a description of how Community Benefits planning fits into your hospital's strategic plan. If no, please explain why not.

     BH/AGH is a member of Beth Israel Lahey Health (BILH). While BH/AGH oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure ensures that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission –to promote health, expand access, and deliver the best care in the communities BILH serves.

2. Community Benefits Advisory Committee (CBAC)
   - Members (and titles):

Nancy Palmer, Board Chair, Northeast Hospital Corporation Board of Trustees
Tom Sands, President, Beverly/Addison Gilbert Hospital
Marylou Hardy, Regional Manager Community Relations/Community Benefits, NHC
Christine Healey, Director, Community Relations/Community Benefits, BILH
Jason Andree, Vice President, Addison Gilbert Hospital and Lahey Outpatient Center Danvers
Karin Carroll, Director of Community Programs, North Shore Community Health
Andrew DeFranza, Executive Director, Harborlight Community Partners
David DiChiara, MD, Associate Chief Medical Officer, Beverly/Addison Gilbert Hospital
Dutrochet Djoko, Chair of Human Rights & Inclusion Committee, Danvers Board of Health
Cindy Donaldson, Resident, Beverly/Addison Gilbert Hospital
Mark Gendreau, MD, Chief Medical Officer, Beverly/Addison Gilbert Hospital
Peggy Hegarty-Steck, President & Executive Director, Action, Inc.
Brian Holmes, Medical Assistant Educator, Beth Israel Lahey Health Primary Care
Robert Irwin, Trustee, Northeast Hospital Corporation Board of Trustees
Julie LaFontaine, President and CEO, The Open Door
Chris Lovasco, President, YMCA of the North Shore
Whitney Mcneilly, Director, DanversCARES
Chessye Moseley, Trustee, NHC Board of Trustees
Karen Neva Bell, Trustee, NHC Board of Trustees
Valerie Parker Callahan, Director, Planning & Development, Greater Lynn Senior Services
Jonathan Payson, Trustee, NHC Board of Trustees
Kimberly Perryman, Chief Nursing Officer, Beverly/Addison Gilbert Hospital

Mike Tarmey, Vice President, Bayridge Hospital

- Leadership:

Tom Sands, President, Beverly/Addison Gilbert Hospital
Jason Andree, Vice President, Addison Gilbert Hospital and Lahey Outpatient Center Danvers
David DiChiara, MD, Associate Chief Medical Officer, Beverly/Addison Gilbert Hospital
Mark Gendreau, MD, Chief Medical Officer, Beverly/Addison Gilbert Hospital
Kimberly Perryman, Chief Nursing Officer, Beverly/Addison Gilbert Hospital
Mike Tarmey, Vice President, Bayridge Hospital

- Frequency of meetings:
  BH/AGH's CBAC met five times during FY 2022 due to the implementation of the FY22 CHNA, including the annual CBAC meeting on June 14th.
  - December 14, 2021
  - March 8, 2022
  - May 10, 2022
  - June 14, 2022 – Annual Public Meeting
  - August 9, 2022

3. Involvement of Hospital's Leadership in Community Benefits:
   Place a checkmark next to each leadership group if it is involved in the specified aspect of your Community Benefits Process.

	Review Community Health Needs Assessment	Review Implementation Strategy	Review Community Benefits Report
Senior leadership			
Tom Sands, President, Beverly/Addison Gilbert Hospital Jason Andree, Vice President, Addison Gilbert Hospital and Lahey Outpatient Center Danvers David DiChiara, MD, Associate Chief Medical Officer, Beverly/Addison Gilbert Hospital Mark Gendreau, MD, Chief Medical Officer, Beverly/Addison Gilbert Hospital Kimberly Perryman, Chief Nursing Officer, Beverly/Addison Gilbert Hospital Mike Tarmey, Vice President, Bayridge Hospital	☒	☒	☒
Hospital board			
Nancy Palmer, Board Chair, NHC BOT Mark Gendreau, MD, Chief Medical Officer, BH/AGH	☒	☒	☒

Peggy Hegarty-Steck, President & Executive Director, Action, Inc. Robert Irwin, NHC Board of Trustees Chessye Moseley, NHC Board of Trustees Karen Neva Bell, Trustee, NHC Board of Trustees Jonathan Payson, Trustee, NHC Board of Trustees			
Staff-level managers Karin Leppanen, Nurse Manager, Oncology Sheila Laffey, Director, AGH High Risk Intervention Team Martha Anastis, Administrative Director, Center for Healthy Aging Rebecca Imperiali, Vice President of Philanthropy Liz Mullane, Director of Campaign Initiatives, BH/AGH Philanthropy Andrea Quinn, Director of Operations, Northeast Medical Courtney Almond, Director of Emergency Services	☒	☒	☒
Community Representatives on CBAC Abu Toppin, Beverly Cindy Donaldson, Gloucester	☒	☒	☒

For any check above, please list the titles of those involved and describe their specific role:

At BILH, our belief that everyone deserves high-quality, affordable health care is at the heart of who we are and what drives our work with our community partners. The organizations that are now part of BILH have always been deeply committed to serving their communities. Working collaboratively with our community partners, our Community Benefits Committee (CBC) and the Community Benefits team, such commitment is shared by staff at all levels within BH/AGH.

Hospital Board:

- Nancy Palmer, Board Chair, NHC Board of Trustees – participated in meetings with CBC, participated in all phases of the FY22 CHNA (including the prioritization process), and guided development of the FY23-FY25 Implementation Strategy.
- Peggy Hegarty-Steck, President & Executive Director, Action, Inc. participated in all phases of the FY22 CHNA (including the prioritization process), and guided development of the FY23-FY25 Implementation Strategy.
- Robert Irwin, participated in all phases of the FY22 CHNA (including the prioritization process), and guided development of the FY23-FY25 Implementation Strategy.
- Chessye Moseley, participated in all phases of the FY22 CHNA (including the prioritization process), and guided development of the FY23-FY25 Implementation Strategy.
- Karen Neva-Bell, participated in all phases of the FY22 CHNA (including the prioritization process), and guided development of the FY23-FY25 Implementation Strategy.
- Jonathan Payson,

- BH/AGH Community Benefits Advisory Committee - oversaw CHNA and Implementation Strategy process

Senior Leadership:

- Tom Sands, President - provided input on identifying CBSA, CHNA and Implementation Strategy; participated in meetings with CBC; participated in prioritization process; participated in Key Informant Interview.
- Jason Andree, Vice President, BH/AGH - participated in all phases of the FY22 CHNA (including the prioritization process), and guided development of the FY23-FY25 Implementation Strategy.
- Kimberly Perryman, Chief Nursing Officer - participated in all phases of the FY22 CHNA (including the prioritization process), and guided development of the FY23-FY25 Implementation Strategy.
- Mark Gendreau, M.D., BH/AGH Chief Medical Officer, participated in all phases of the FY22 CHNA (including the prioritization process), and guided development of the FY23-FY25 Implementation Strategy.

Staff-level Managers:

- Nancy Kasen, BILH VP of Community Benefits and Community Relations, and Community Benefits team - designed, managed and conducted CHNA, managed prioritization process, drafted Implementation Strategy
- Karin Leppanen, Nurse Manager, Oncology – provided input for the FY22 and development of the FY23-FY25 Implementation Strategy
- Sheila Laffey, Director, AGH High Risk Intervention Team - provided input for the FY22 and development of the FY23-FY25 Implementation Strategy
- Martha Anastis, Administrative Director, Center for Healthy Aging - provided input for the FY22 and development of the FY23-FY25 Implementation Strategy
- Rebecca Imperiali, Vice President of Philanthropy - provided input for the FY22 and development of the FY23-FY25 Implementation Strategy
- Liz Mullane, Director of Campaign Initiatives, BH/AGH Philanthropy - provided input for the FY22 and development of the FY23-FY25 Implementation Strategy
- Andrea Quinn, Director of Operations, Northeast Medical - provided input for the FY22 and development of the FY23-FY25 Implementation Strategy
- Courtney Almond, Director of Emergency Services - provided input for the FY22 and development of the FY23-FY25 Implementation Strategy
- BILH Community Benefits Committee (CBC) - guided the process for the system

4. <u>Hospital Approach to Assessing and Addressing Social Determinants of Health</u>

- How does the hospital approach assessing community needs relating to social determinants of health? (150-word limit)

BH/AGH undertook a robust, collaborative and transparent assessment and planning process. The approach involved extensive quantitative and qualitative data collection and substantial efforts to engage community residents, with special emphasis on population segments often left out of assessments. The assessment was supported by BH/AGH's Community Benefits Advisory Committee. The Community Benefits Advisory Committee is comprised of community members, service providers, and other stakeholders that either live in and/or work in BH/AGH's CBSA. BH/AGH's Implementation Strategy (IS) reflects the hospital and the CBAC's prioritization of the

following social determinants of health: economic stability, food insecurity, housing affordability, workforce development and the creation of employment opportunities.

- How does the hospital incorporate health equity in its approach to Community Benefits? (150-word limit)

  BH/AGH and BILH are committed to health equity, the attainment of the highest level of health for all people, required focused and ongoing societal efforts to address avoidable inequalities, socioeconomic barriers to care, and both historical and contemporary injustices. Throughout BH/AGH's assessment process, BH/AGH worked to understand the needs of populations that are often disadvantaged, face disparities in health-related outcomes, and are deemed most vulnerable. BH/AGH's IS is rooted in health equity and was developed with a focus on reaching the geographic, demographic and socioeconomic segments of populations most at risk, as well as those with physical and behavioral health needs in the hospital's CBSA.

- How does the hospital approach allocating resources to Total Population or Community-Wide Interventions? (150-word limit)

  The BH/AGH's IS includes a diverse range of programs and resources to addresses the prioritized needs within the BH/AGH Community Benefits Service Area. The majority of BH/AGH's community benefits initiatives are focused on cohorts and sub-populations due to identified disparities or needs. BH/AGH's strategies include increasing access to safe, affordable housing, alleviating food insecurity, promoting healthy eating and active living, increasing access to health services by reducing barriers to care, supporting initiatives that provide job readiness opportunities, Promote equitable care, and education and support for those living with, or at risk for developing chronic disease. Additionally, BH/AGH collaborates with many community partners to own, catalyze and/or support total population and community-wide interventions including mobile food markets, free fitness classes, housing assistance programs and services, and mental health and substance use treatment and support.

Community Engagement

5. Organizations Engaged in CHNA and/or Implementation Strategy

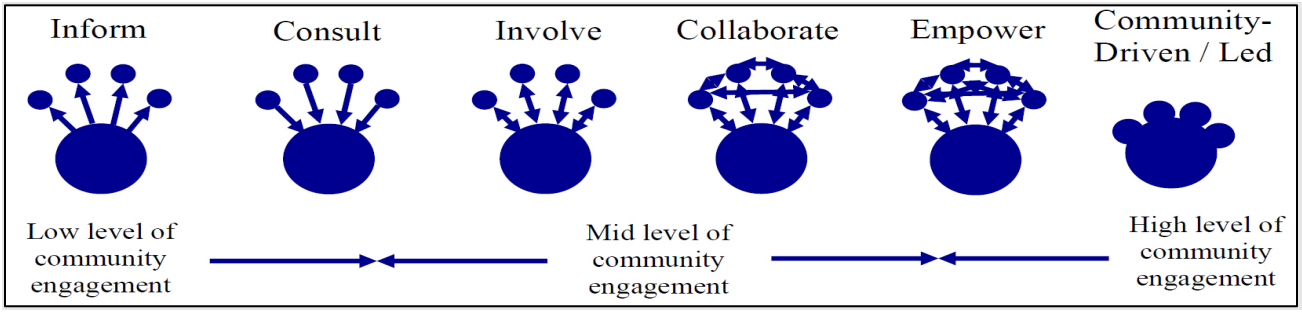
   Use the table below to list the key partners with whom the hospital collaborated in assessing community health needs and/or implementing its plan to address those needs and provide a brief description of collaborative activities with each partner. Note that the hospital is not obligated to list every group involved in its Community Benefits process, but rather should focus on groups that have been significantly involved. Please feel free to add rows as needed.

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
North Shore YMCA.	Chris Lovasco, CEO	Social service organizations	CBAC Member
The Open Door	Julie LaFontaine, CEO	Social service organizations	CBAC Member
SeniorCare	Scott Trenti, Executive Director	Social service organizations	CBAC Member

Harborlights Community Partners	Andrew DeFranza, Executive Director	Housing Organization	CBAC Member
Action Inc.	Peggy Hegarty-Steck	Social service organizations	CBAC Member
Beverly Bootstraps	Susan Gabriel, Executive Director	Social Services organization	Community Partner

6. Level of Engagement Across CHNA and Implementation Strategy

   Please use the spectrum below from the Massachusetts Department of Public Health[1] to assess the hospital's level of engagement with the community.



For a full description of the community engagement spectrum, see page 11 of the Attorney General's Community Benefits Guidelines for Non-Profit Hospitals.

A. Community Health Needs Assessment

Please assess the hospital's level of engagement in developing its CHNA and the effectiveness of its community engagement process.

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in assessing community health needs	Empower	Goal was met.	Collaborate
Collecting data	Empower	Goal was met – BH/AGH built capacity for community residents to co-facilitate/facilitate focus groups and breakout sessions during listening sessions.	Collaborate
Defining the community to be served	Collaborate	Goal met - Starting several months before launching the CHNA, BH/AGH worked with its CBAC to identify the community, those to be engaged and ways to engage them.	Collaborate
Establishing priorities	Empower	Goal met - Working with BILH, BH/AGH actively engaged with the CBAC and the community to identify and select priorities.	Collaborate

- For categories where community engagement did not meet the hospital's goal(s), please provide specific examples of planned improvement for next year:

[1]

BILH and BH/AGH are committed to continuing to build our capacity to engage with the community and to foster community member capacity for facilitation and evaluation.

B. Implementation Strategy

Please assess the hospital's level of engagement in developing and implementing its plan to address the significant needs documented in its CHNA and the effectiveness of its community engagement process.

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Collaborate	Goal met – community listening sessions with breakout sessions facilitated by community members, with active CBAC engagement in prioritization discussions and decisions.	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Inform	Goal met – FY 2022 was the last year of BH/AGH's FY 2020 – 2022 Implementation Strategy (IS) and its CBAC was informed regarding how CB resources were allocated. BH/AGH will collaborate with its CBAC to select programs to invest its resources in for the FY 2023 – 2025 IS.	Collaborate
Implementing Community Benefits programs	Collaborate	Goal met – FY 2022 was the last year of BH/AGH's FY 2020-2022 Implementation Strategy (IS). BH/AGH will be collaborating with the community on new and existing programs for its FY 2023-2025 IS.	Collaborate
Evaluating progress in executing Implementation Strategy	Involve	Goal met - BILH and BH/AGH held multiple evaluation workshops to build evaluation and data capacity of community organizations, CBAC members and community residents.	Collaborate
Updating Implementation Strategy annually	Inform	Goal met – FY 2022 was the last year of the current FY2020-2022 IS. BILH and BH/AGH are working to develop, track and share data on a routine basis with the CBAC.	Collaborate

- For categories where community engagement did not meet the hospital's goal(s), please provide specific examples of planned improvement for next year:

  Click or tap here to enter text.

7. Opportunity for Public Feedback

   Did the hospital hold a meeting open to the public (either independently or in conjunction with its CBAC or a community partner) at least once in the last year to solicit community feedback on its Community Benefits programs? If so, please provide the date and location of the event. If not, please explain why not.

   BH/AGH holds a public community benefits public meeting every year. The Fy22 meeting was held on June 14, 2022.

BH/AGH has a comprehensive Implementation Strategy (IS) to respond to identified community health priorities. BH/AGH engaged with the leadership team and the community to identify and select priorities for the new (FY2023-2025) IS. The IS was shared with the CBAC, the leadership team, adopted by the Board of Trustees and widely distributed.

8. Best Practices/Lessons Learned

The AGO seeks to continually improve the quality of community engagement.

- What community engagement practices are you most proud of? (150-word limit)

BH/AGH is most proud of its committed CBAC and the long-standing relationships it has with many community-based organizations, the public health department, and other government partners. BH/AGH is proud of their collaboration with these and other organizations that allowed BH/AGH to engage with hard-to-reach cohorts. BH/AGH is particularly proud of how it was able to reach community members who had not previously been engaged.

- What lessons have you learned from your community engagement experience? (150-word limit)

Working collaboratively with other hospitals, community-based organizations, public health agencies, and area coalitions enhances the level and quality of BH/AGH's community engagement efforts.

II. Regional Collaboration

1. Is the hospital part of a larger community health improvement planning process?

☒Yes ☐No

- If so, briefly describe it. If not, why?

For its FY 2022 CHNA, Beth Israel Lahey Health (BILH) took the unique approach of designing and implementing a system-wide, highly coordinated CHNA and prioritization process across each of the system's 10 licensed hospitals, including BH/AGH, encompassing 49 municipalities and six Boston neighborhoods. While BH/AGH focuses its Community Benefits resources on improving the health status of those in its CBSA experiencing the significant health disparities and barriers to care, this system-wide approach enhances opportunities for collaboration and alignment with respect to addressing unmet need and maximizing impact on community health priorities. Together, BILH hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact.

2. If the hospital collaborates with any other filer(s) in conducting its CHNA, Implementation Strategy, or other component of its Community Benefits process (e.g., as part of a regional collaboration), please provide information about the collaboration below.

- Collaboration:

BH/AGH worked collaboratively with each of the 9 other hospitals in the BILH system to design and implement a system-wide, highly coordinated CHNA and prioritization process across each of the system's 10 licensed hospitals.

- Institutions involved:
  - Anna Jaques Hospital
  - Beth Israel Deaconess Hospital - Milton
  - Beth Israel Deaconess Hospital - Needham
  - Beth Israel Deaconess Hospital - Plymouth
  - Beth Israel Deaconess Medical Center
  - Beverly and Addison Gilbert Hospitals
  - Lahey Hospital and Medical Center
  - Mount Auburn Hospital
  - New England Baptist Hospital
  - Winchester Hospital
- Brief description of goals of the collaboration:

  BH/AGH collaborated with the other 9 hospitals in the BILH system to add rigor to the hospitals' assessments and planning processes, promoting alignment across hospital efforts and strengthening relationships between and among BILH hospitals, community partners and the community-at-large.

- Key communities engaged through collaboration:

  BH/AGH collaborated with the other 9 hospitals in the BILH system to engage the 49 municipalities and six Boston neighborhoods who were part of the individual Community Benefits Service Areas from each of the licensed hospitals.

- If you did not participate in a collaboration, please explain why not:

  Click or tap here to enter text.