

COMMUNITY BENEFITS REPORT

FISCAL YEAR 2017

Massachusetts Attorney General's Community Benefits Guidelines

The Attorney General's Community Benefits Guidelines for Nonprofit Acute Care Hospitals and The Attorney General's Community Benefits Guidelines for Health Maintenance Organizations include an outline of voluntary principles that encourage Massachusetts hospitals and HMOs to continue and build upon their commitment to addressing health and social needs within their communities.

The Guidelines represent a unique, non-regulatory approach that calls upon hospitals and HMOs to identify and respond to the unmet needs of the communities they serve by formalizing their approaches to community benefits planning, collaborating with community representatives to identify and create programs that address those needs, and issuing annual reports on their efforts. The Guidelines do not dictate the types of community benefits programs that hospitals and HMOs should provide. They do, however, suggest that hospitals and HMOs tap into their own and their communities' particular resources and areas of expertise to target and meet the needs of medically underserved populations.

The hospital and HMO Community Benefits Guidelines are the result of an extensive process of consultation and partnership between the Attorney General and representatives of the hospital and HMO industries, respectively, and community advocacy groups. These discussions took place at a time of ongoing debate in Massachusetts and around the nation as to whether nonprofit, tax-exempt hospitals were fulfilling their charitable missions. Several Massachusetts hospitals had, on their own initiative, adopted model community benefits guidelines developed by national hospital associations, and the Massachusetts Hospital Association was considering a long-term initiative to produce voluntary guidelines of its own.

The resulting Community Benefits Guidelines were the first of their kind to be issued by an Attorney General. The guidelines were modeled after community benefits guidelines developed by the Kellogg Foundation, the Catholic Hospital Association and the Voluntary Hospital Association, and community benefits legislation in several other states.

Source: Excerpt taken from the Official Website of the Attorney General of Massachusetts.

For full guidelines, please go to <http://www.mass.gov/ago/docs/healthcare/hospital-guidelines.pdf>.

Northeast Hospital Corporation's

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

Northeast Hospital Corporation's Community Benefit Plan

Northeast Hospital Corporation affirms its commitment to identifying and serving the health and wellness needs of its community through a Community Benefits Program. The foundation of this program is a collaborative initiative between NHC colleagues, community leaders, representatives of community agencies and community residents. Through collaborative planning and coalition building, NHC serves as a catalyst and a community leader striving to improve the health status of community members.

Community Benefit Advisory Board – 2017

Nancy Palmer – Chairwoman, Northeast Hospital Corporation Board of Trustees

Phil Cormier – CEO, Addison Gilbert and Beverly Hospitals

Nicole DeVita – COO, Addison Gilbert and Beverly Hospitals

Charles Favazzo – Trustee, Northeast Hospital Corporation

Robert Irwin – Trustee, Northeast Hospital Corporation

Peter Short, MD – Chief Medical Officer, Addison Gilbert and Beverly Hospitals

David DiChiara, MD – Assistant Chief Medical Officer, Addison Gilbert and Beverly Hospitals

Kimberly Perryman – Chief Nursing Officer, Addison Gilbert and Beverly Hospitals

Cynthia Donaldson – Vice President, Addison Gilbert Hospital and Lahey Outpatient Center Danvers

Lisa Neveling – Vice President, Business Development, Lahey Health

Christine Healey – Director, Community Relations, Lahey Health

Grace Numerosi – Regional Manager, Community Relations

Margaret Sallade – Project Director, DanversCARES Coalition

Key Accomplishments for Fiscal Year 2017

Julie LaFontaine – Executive Director, The Open Door Food Pantry

Margo Casey – Executive Director, North Shore United Way

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

- Hosted a total of 16 Senior Dine and Learn sessions (Senior Suppers), which ran at both Addison Gilbert Hospital and Beverly Hospital, reaching over 880 seniors.
- Addison Gilbert and Beverly Hospitals and our community partners, The Open Door in Gloucester and Beverly Bootstraps in Beverly, came together to continue the Emergency Food Bag Program for both communities.
- Over 275 seniors took part in the classes provided in partnership with the North Shore YMCA, including Osteo Exercise, Enhance Fitness, LIVESTRONG and Water Aerobics.
- Gave Speakers Bureau presentations to numerous community partners, including the Rockport and Gloucester Councils on Aging, and Danvers, Beverly, Rockport and Gloucester high schools.
- Provided \$50,000 in mini-grant funding to local community organizations whose programs meet our community priorities.
- Partnered with Gloucester High School and coordinated a school-based Health Fair & Information Day, providing health screenings and information to over 700 attendees.
- Participated in health fairs and several screening activities throughout the communities of Gloucester, Georgetown, Rockport, Manchester, Beverly and Danvers.
- Partnered with the American Cancer Society (ACS) and the North Shore YMCA to provide skin cancer prevention kits to over 1,000 campers in Beverly, Gloucester, Rockport and Ipswich for the ACS “Slip, Slop, Slap ... and Wrap” program.
- Over 50 seniors and multiple departments participated in the fall prevention program we sponsored and offered at the Rockport Council on Aging.

- Sponsored a free Dermatology Cancer Screening at Lahey Outpatient Center that screened over 40 people.

Fiscal Year 2017 Community Partners

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|-------------------------------------|---|
| Action Inc., Gloucester | Gloucester Fire Department |
| American Cancer Society | Gloucester High Risk Task Force |
| American Red Cross | Gloucester High School |
| Backyard Growers | Gloucester Police Department |
| Be Healthy Beverly | Gloucester Rotary |
| Beverly Bootstraps | Gloucester Stroke Club |
| Beverly Community Council | Greater Beverly Chamber of Commerce |
| Beverly Health Department | Haven from Hunger |
| Beverly High School | Healthy Gloucester Collaborative |
| Beverly Main Streets | Ipswich High School |
| Beverly Police Department | Ipswich YMCA |
| Beverly Rotary | Manchester Essex Rotary |
| Beverly Senior Center | Northeast Arc |
| Cape Ann Chamber of Commerce | North Shore Chamber of Commerce |
| Cape Ann Farmers Market, Gloucester | North Shore Community Health Network Area |
| Cape Ann YMCA | North Shore Health Project |
| Care Dimensions | North Shore Mall |
| Danvers Community Access Television | North Shore United Way |
| Danvers Farmers Market | PAARI |
| Danvers High School | Pathways for Children |
| Danvers Kiwanis Club | Peabody Area Chamber of Commerce |
| Danvers Police Department | Rockport Senior Center |
| Danvers Rotary | Rose Baker Senior Center, Gloucester |
| Danvers Senior Center | Salem State University |
| Danvers YMCA | SeniorCare |
| DanversCARES | Shaw's, Eastern Avenue, Gloucester |
| Endicott College | Sterling Center YMCA, Beverly |
| First Baptist Church of Beverly | The Open Door |
| Gloucester Board of Health | Wellspring House, Gloucester |

Plans for Reporting – Fiscal Year 2018

Community Health Needs Assessment: In FY18, NHC will continue to work with community partners and hospital leaders to address the needs identified in the 2016 Community Health Needs Assessment while taking into consideration the Statewide Priority Needs identified by the Executive Office of Health and Human Services:

Priority Area 1: Wellness, Prevention and Chronic Disease Management

Goal 1: Promote Wellness, Behavior Change and Engagement in Appropriate Care
(Physical, Mental, Emotional and Behavioral Health)

Goal 2: Increase Physical Activity and Healthy Eating

Goal 3: Identify Those With Chronic Conditions or at Risk; Screen, and Refer for Counseling/Treatment

Goal 4: Enhance Care Coordination, Counseling and Referral Services During/After Hospital Discharge

Priority Area 2: Elder Health

Goal 1: Promote General Health and Wellness

Goal 2: Promote Healthy Eating and Food Security

Goal 3: Improve Access to Care

Goal 4: Enhance Access to Health and Wellness Services Through Improved Transportation

Goal 5: Improve Chronic Care Management

Goal 6: Reduce Falls in Elders

Goal 7: Enhance Care Coordination, Counseling and Referral Services During/After Hospital Discharge

Goal 8: Enhance Caregiver Support and Reduce Family/Caregiver Stress

Goal 9: Decrease Depression and Social Isolation

Priority Area 3: Behavioral Health (Mental Health and Substance Use)

Goal 1: Promote Outreach, Education, Screening and Treatment for Those With Mental Health and Substance Use Issues in Clinical and Community-Based Settings

Goal 2: Increase Access to Mental Health and Substance Use (MH/SA) Services

Goal 3: Improve Integration of MH/SA and Primary Care Medical Services

Goal 4: Increase Awareness and Screening for Domestic Violence

Priority Area 4: Maternal and Child Health

Goal 1: Reduce the Number of Babies Born at Low Birth Weight (Particularly Those Born Addicted)

Goal 2: Increase Parental Support for At-risk Mothers and Fathers

Community Health Needs Assessment Overview

In FY16, Northeast Hospital Corporation, in conjunction with all hospitals in the Lahey Health System, completed the required triennial Community Health Needs Assessment (CHNA). The purpose of the CHNA is to inform and guide the hospital's selection of and commitment to programs and initiatives that address the health needs of the communities it serves. The assessment was conducted in partnership with John Snow Inc., a public health consulting and research organization.

Northeast Hospital Service Area: NHC's community benefits investments are focused on expanding access, addressing barriers to care, and improving the health status of residents living in 13 municipalities located in Essex County: Beverly, Boxford, Danvers, Essex, Gloucester, Hamilton, Ipswich, Manchester-by-the-Sea, Middleton, Peabody, Rockport, Topsfield and Wenham.

Methodology:

The CHNA was conducted in three phases, allowing Northeast Hospital Corporation to:

- Compile an extensive amount of quantitative and qualitative data
- Engage and involve key internal and external stakeholders
- Develop a report and detailed Community Health Improvement Plan (CHIP)
- Comply with all state and federal Internal Revenue Service community benefits requirements

Data Collection: Data sources included a broad array of publicly available secondary data, key informant interviews, community forums and the 2015 NHC Community Health Survey, which captured information from hundreds of random households in NHC's primary service area.

Quantitative Data Sources:

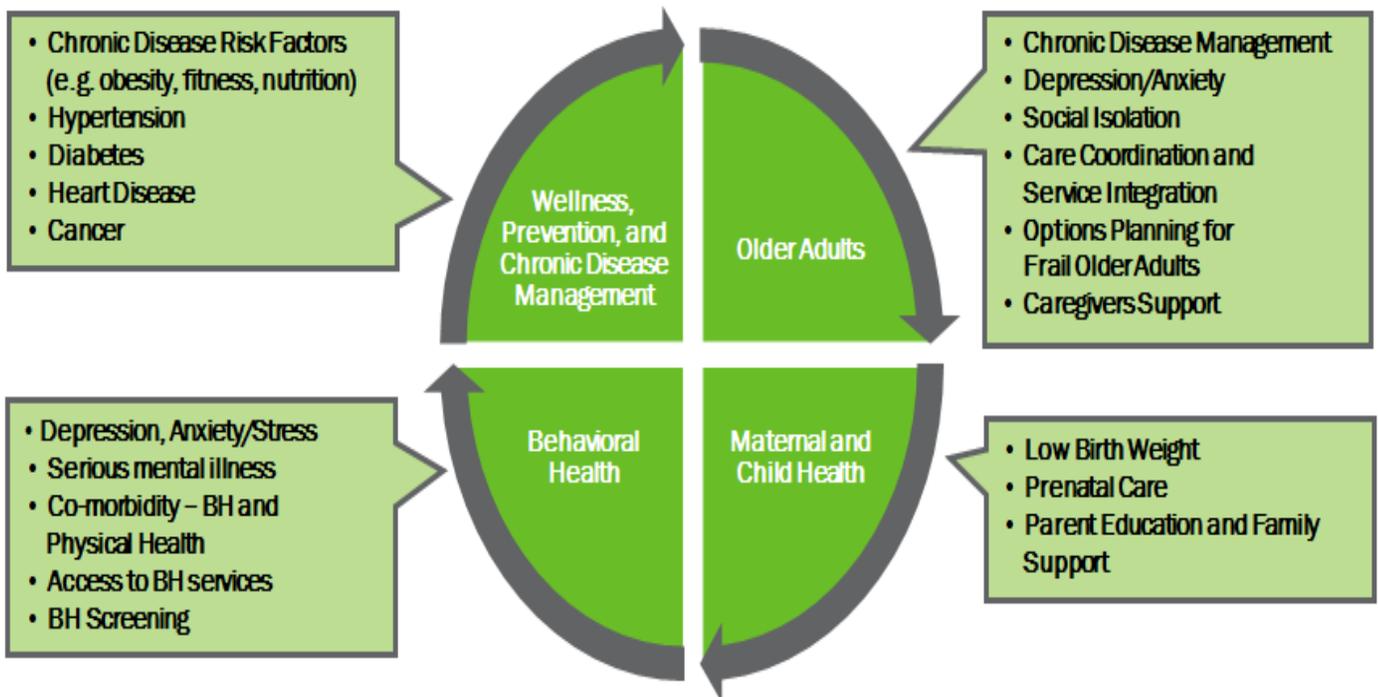
- Massachusetts Community Health Information Profile (MassCHIP)
- U.S. Census Bureau, American Community Survey 5-Year Estimates (2009-2013)
- Behavioral Risk Factor Surveillance System (BRFSS) (2012-2013 aggregate)
- CHIA Inpatient Discharges
- Massachusetts Health Data Consortium (MHDC) ED Visits
- MA Hospital IP Discharges (2008-2012)
- MA Cancer Registry (2007-2011)
- MA Communicable Disease Program (2011-2013)
- MA Hospital ED Discharges (2008-2012)
- Massachusetts Vital Records (2008-2012)
- Massachusetts Bureau of Substance Abuse Services (BSAS) (2013)
- Massachusetts Board of Health

Qualitative Data Sources: In order to obtain targeted data and understand what health issues are currently perceived by the community, interviews and listening sessions were conducted:

- Informant interviews with external stakeholders
- Random household surveys
- Community listening sessions

Priority Target Populations: NHC focuses its activities to meet the needs of all segments of the population with respect to age, race, ethnicity, income and gender identity to ensure that all residents have the opportunity to live healthy lives. However, based on the assessment’s quantitative and qualitative findings, there was broad agreement that NHC’s CHIP should target low-income populations (e.g., low-income individuals/families, older adults on fixed incomes, homeless), older adult populations (e.g., frail, isolated older adults), youth/adolescents (e.g., ages 13-18, those in middle school and high school) and other vulnerable populations (e.g., diverse racial/ethnic minorities and linguistically isolated populations) that are more likely than other cohorts to face disparities in access and health outcomes.

Community Health Priorities: NHC’s CHNA approach and process provided ample opportunity to vet the quantitative and qualitative data compiled during the assessment. NHC has framed the community health needs in four priority areas, which together encompass the broad range of health issues and social determinants of health facing the service area. These four areas are (1) Wellness, Prevention and Chronic Disease Management; (2) Elder Health; (3) Behavioral Health; and (4) Maternal and Child Health. NHC already has a robust CHIP that has been addressing all the issues identified, but this CHNA has provided new guidance and invaluable insight into quantitative trends and community perceptions that can be used to inform and refine NHC’s efforts. The following are the core elements of the updated CHIP.



Fiscal Year 2017 Community Benefit Programs

Health Priority #1 – Wellness, Prevention and Chronic Disease Management

School-Based Health Center at Gloucester High School

Program Description: The mission of the School-Based Health Center (SBHC) is to provide high-quality comprehensive health care to students in order to support optimal health and academic outcomes. The health clinic is a branch of Addison Gilbert Hospital and is supported in part by the Massachusetts Department of Public Health. The mission of the SBHC aligns closely with the priorities identified by Addison Gilbert in its most recent Community Health Assessment. For example, the SBHC improves access to behavioral health and substance abuse services by offering these services on-site, and integrates those services into primary medical care. The SBHC also identifies students with chronic conditions and helps them improve self-management of these conditions.

Goal: The SBHC joins with existing school services to provide comprehensive in-school health care that is easily accessible to students. The approach is to take care of the students' health and well-being while supporting attendance and achievement of academic success. The SBHC is a safe place where students are encouraged through a strength-based approach and motivational interviewing to discuss important personal topics such as stress, exercise, healthy eating, alcohol and drug use, friendship, sexual health, and any personal health issues they have questions about.

Result: The SBHC is staffed by a Nurse Practitioner, a Licensed Independent Clinical Social Worker and a Certified Community Health Worker. The SBHC provides an integrated model of care in its approach. Services offered include management of chronic illnesses such as asthma and diabetes; urgent care visits; immunizations; routine and sports physicals; health education; and confidential services, including reproductive health care and behavioral health services. As evidenced by its staffing structure, behavioral health care is a significant focus of the clinic, with individual therapy and group counseling services provided for issues such as depression, anxiety, stress management and substance use.

Partners: Massachusetts Department of Public Health, Gloucester High School, Gloucester Board of Health and Lahey Health Behavioral Services

Home Blood Draw – Mobile Phlebotomy

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

Goal: The goal of the Home Blood Draw Program is to increase access to phlebotomy services for homebound patients who have difficulty getting to a laboratory/drawing station due to illness or injury.

Outcome: Our Mobile Phlebotomy team provided homebound lab services to 4,500 patients. In addition to appreciating the convenience of the home blood draw, patients have reported reduced feelings of isolation as the visit with the phlebotomist provides them with a social opportunity. There is no charge to the patient for this service. Our service area includes the following towns: Beverly, Boxford, Danvers, Essex, Georgetown, Gloucester, Hamilton, Ipswich, Lynn, Lynnfield, Manchester-by-the-Sea, Marblehead, Middleton, Peabody, Rockport, Rowley, Salem, Saugus, Swampscott, Topsfield and Wenham.

Be Healthy Beverly

Description: Be Healthy Beverly is a community collaboration of city departments and community agencies, working together to facilitate sustainable initiatives to improve the health and well-being of the community. The Garden Program is the largest raised-bed educational program of its kind on the North Shore and consists of 15 vegetable gardens in total, three at each of the five elementary schools in Beverly. More than 365 third-graders visited the gardens during the school day. Horticultural professionals from Green City Growers of Somerville work with each school to teach students about gardening and growing their own food as part of the overall curriculum that ties into science, math and social studies subjects.

Goal: Each student was given an evaluation at the beginning and end of the program to determine what they've learned. They explored soil testing, pH balance, insect identification, plant identification, planting grids, solar conditions and weather patterns. Children were encouraged to try the vegetables they had grown, and sometimes the fresh produce was served in the cafeteria.

Outcome: The gardens were harvested during the summer months; 150 pounds of vegetables were harvested, and 32 pounds of fresh produce were made available to Beverly Bootstraps.

Community Partners: Greater Beverly YMCA, Beverly Public School, Beverly Bootstraps

Making the Healthy Choice the Easy Choice

Description: Making the Healthy Choice the Easy Choice supported the organizational goals and mission of The Open Door to alleviate the impact of hunger in our communities. The program used practical strategies to connect people to good food, to advocate on behalf of those in need and to engage others in the work of increasing food security.

Goal: The goal was to increase visits to the food pantry and total fruit and vegetable distribution. Low-income families, children and seniors increased consumption of nutritious food through our Gloucester and Ipswich food pantries for residents of Boxford, Essex, Gloucester, Hamilton, Ipswich, Manchester, Rockport, Rowley, Topsfield and Wenham.

Nutrition education through our Sample Centers (food samples distributed through food pantries, Mobile Markets, PowerSnack and Senior Soup and Salad) along with Nutrition and Crockpot Workshops increased both **access** to and **knowledge** of nutrition that improve health outcomes in line with all CHNA priorities.

Additionally, diaper distribution remained a priority, as diaper need is linked to poor child health outcomes along with maternal depression and behavioral health.

Outcome: Making the Healthy Choice the Easy Choice provided 5,909 people with 1,378,994 pounds of food representing 1,149,162 meals through our food pantries, including 468,858 pounds of produce.

Our annual retrospective survey held in October sampled 750 households and exceeded our expectations, showing that food pantry families chose healthier options (90%), ate more family meals at home (85%), ate healthier when shopping at the food pantry (84%), tried new fruits and vegetables (81%), and tried new recipes at home (74%).

We learned that *if* you provide good, healthy food, people *will choose* healthier food (89.59% of food pantry families agreed that they chose healthier options when shopping at the food pantry.) (Note: As of 2017, our food pantry guidelines no longer allow the distribution of sugary or diet beverages.) Our Healthy Choice Easy Choice Meal Kits have also been successful, with clients who not only learned how to make healthier options (e.g., vegetarian chili, healthier breakfast oatmeal with sweet potato) but then also cooked them in their own homes (73.78% of food pantry families agreed that they tried new recipes at home).

Community Partners: North Shore Postpartum Depression Task Force, Harvard Pilgrim Foundation, United Way, Greater Boston Food Bank, Backyard Growers, Three Sisters, Food Project, Trustees of Reservation, Gloucester High School, Gloucester Alternative Program (GAP), Compass, Wellspring House Inc. and Action Inc.

Mobile Market: Building Healthy Communities

Description: The Open Door's Mobile Market is a free farmers market that connects families to healthy food in a socially acceptable way in the communities where they live and learn. It reduces the impact of poor nutrition that leaves many low-income people vulnerable to major health consequences, including obesity, diabetes and heart disease. It provides nutrient-dense produce for free nutrition education and outreach. The program provides culturally appropriate fresh fruits, vegetables and protein choices at 12 sites in four public housing neighborhoods in Essex, Gloucester,

Ipswich and Rockport every week from June through November; to two schools with high numbers of students receiving free and reduced-price lunch, every week during the school year; to four senior centers monthly; and every week year-round at a Danvers hotel for homeless families and their children.

Participants choose 20 pounds of fresh produce for free at each visit and access point-of-service nutrition education, Supplemental Nutrition Assistance Program (SNAP, food stamp) outreach, good food taste tests, health and wellness checks, community outreach from local nonprofits and social service organizations, and Good Food Farm, a hands-on nutrition education exhibit for children.

Goal: The goals of Mobile Market are to provide those in need with fruits and vegetables, and to involve the entire household and community in promoting healthy eating and a healthy lifestyle.

Outcome: In 2017, The Open Door Mobile Market distributed **127,463 pounds** of fresh food including fruits, vegetables and healthy protein choices during 8,878 visits to **1,225 households** representing **2,509 people** in five cities and towns including **Gloucester, Rockport, Ipswich, Essex and Danvers**. (Note: A 15% increase in households year-on-year)

In the fall of 2017, we answered requests from the Ipswich Public School Department to expand Mobile Market to Winthrop Elementary School in Ipswich (plus an additional in-school Snack Program for students).

Our second expansion site of FY17 was at North Shore Community College in response to the 2016 NSCC Hunger Report that identified NSCC students had high levels of food insecurity. The Open Door collaborates with Beverly Bootstraps the Greater Boston Food Bank to provide a monthly Mobile Market at North Shore Community College, Danvers campus.

(Note: 2016 NSCC Hunger Report: *Of NSCC students surveyed, 53.5 percent of students have high or very high levels of food insecurity, with 37.5 percent skipping meals. Students from the towns of Gloucester, Lynn, Saugus and Salem were the most vulnerable with between 62-93 percent of students from those towns needing nutrition support services.*)

Community Partners: Essex, Gloucester, Ipswich and Rockport housing authorities; Essex, Gloucester, Ipswich and Rockport councils on aging; Essex, Gloucester, Ipswich and Rockport public health departments; Gloucester and Ipswich public school departments; Pathways for Children; Massachusetts Department of Transitional Assistance; Wellspring House Inc.; North Shore Health Project; HAWK; Children's Health Watch; American Heart Association; Boston Medical Center HealthNet Plan; Greater Boston Food Bank; North Shore Hunger Network

Beverly Bootstraps Mobile Market

Description: The Beverly Bootstraps Mobile Market offers fresh produce to residents of the Beverly Housing Authority. Each week from June to October, residents were able to access produce at no cost while also learning basic nutrition and recipes from clinical nutrition managers at Beverly and Addison Gilbert Hospitals. In addition to providing free and nutritious fruits and vegetables to those who might otherwise not be able to afford them, a wonderful thing about this program is the sense of community that has developed at the markets – not only the conversations that happen between

people while waiting in line, but also neighbors quite literally helping neighbors. A great example of this is a pair of teenage boys from one neighborhood who show up every week to help us set up the market.

Goal: To provide access to fresh produce while providing basic information about nutrition in a community setting. Knowing transportation is a barrier to access, the Mobile Market brings food to the housing authority location and its residents on a weekly basis. Additionally, participants can access SNAP information and other resources through Beverly Bootstraps such as Back to School Backpacks, heating assistance and education programs.

Outcome: During the year, 776 individuals and 452 households were served, and 42,482 pounds of fresh produce were distributed.

Community Partners: Beverly Bootstraps, Beverly Housing Authority, Greater Beverly YMCA

Emergency Department Prescription Food Bag Program

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

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

Outcome: Addison Gilbert Hospital distributed 80 Prescription Food Bags (22 of which were for diabetics). Once people went to use The Open Door Food Pantry, they became regular clients, and they made appointments with their client advocates for SNAP application assistance and recertification. Beverly Hospital distributed 72 Prescription Food Bags; 11 people were eligible to receive the gift card from Beverly Bootstraps.

Community Partners: Beverly Bootstraps, The Open Door Food Pantry

LIVESTRONG at the YMCA

Description: Beverly and Addison Gilbert Hospitals partnered with the Cape Ann, Ipswich and Greater Beverly YMCAs for the LIVESTRONG program for cancer survivors. LIVESTRONG is a small-group, evidence-based class that helps cancer survivors, or those in the midst of their treatment, believe in and achieve a healthier tomorrow and envision life after cancer. Classes are tailored for all cancer survivors, regardless of stage of diagnosis or treatment, and adapted for all fitness levels. Each session is two (90-minute) classes each week for 12 weeks. Staff members are

trained on the unique physical and emotional needs of cancer survivors, curriculum, and best practices. These staff members work with each participant to create an individual exercise program from pre-program assessment results and to teach and demonstrate exercise technique and safety considerations.

Goal: The program creates communities among cancer survivors and guides them through safe physical activity, helping them build supportive relationships leading to an improved quality of life.

Outcome: LIVESTRONG at the YMCA has an established research-based evaluation plan that uses pre- and post-assessment tests, including a detailed assessment of arm function, range of motion and lymph node prognosis; shoulder flexion, extension and abduction; and a thorough postural assessment. Body composition is also measured, which includes height, weight, body mass index, waist girth and hip girth. Program participants are asked to rate overall quality of life, ability to perform daily tasks, mobility, eating habits, fitness level, perceived body image, current energy levels and overall happiness.

Through the programs, participants reported:

- 20% improvement in endurance
- 21% improvement in physical function
- 10% improvement in depression symptoms
- 16% improvement in cancer-related fatigue

Community Partner: YMCA of the North Shore

Walk-in Blood Pressure Screening Program

Description: Addison Gilbert Hospital offers a free, weekly walk-in blood pressure clinic every Monday (minus holidays), from 1 to 3 p.m. in the Babson Wing of Addison Gilbert Hospital. In FY17, 98 clients made 650 visits to the screening location.

Goal: The goal of the program is to educate patients and offer information on additional resources to control their blood pressure. Nursing staff see patients, take blood pressures, review results and medications, and provide counsel if necessary. Nurses also ask patients if they would like their results to be shared with their primary care physician or nurse practitioner for follow-up care. They continue with teachings that encourage a balanced diet, exercise, healthy lifestyle, proper taking of medications and ongoing medical care.

Outcome: The guidelines for the clinic are from the Joint National Committee on the Prevention, Evaluation and Treatment of High Blood Pressure. The DASH diet is recommended.

Number of client visits: 650

Number of new clients: 33

Average number of clients seen weekly: 17

Active clients: 98

Age range of clients: 50-91

Number of clients advised to seek physician care: 17

Number of client visits per year

1 to 9 times: 92 (92%)
10 to 30 times: 17 (17%)
30 to 40 times: 4 (1%)

Community Partners: Internal initiative

Walk-in Blood Glucose Screening Program

Description: Addison Gilbert Hospital offered three free, monthly walk-in blood glucose screenings in conjunction with the free blood pressure screening. This screening took place in the Medical Nutrition Therapy office located in the Babson wing of the hospital.

Goal: The goal of the program is to help people diagnosed with diabetes or at risk for diabetes get a blood glucose check. The resulting values are used to provide education at the point of contact. Patients are offered the opportunity to have the data sent to their primary care physician or nurse practitioner for follow-up care. Basic nutrition education on diabetes prevention is provided to the participants.

Outcome: Thirty-two screenings took place in the three months it was offered. The program was canceled in January 2018 due to Department of Public Health guidelines.

Community Partners: Internal initiative

Skin Cancer Awareness and Prevention Community Outreach Campaign

Description: According to the American Cancer Society, skin cancer is the most common type of cancer in the United States. More skin cancers are diagnosed each year than all other cancers combined, and the number of skin cancer cases has been going up over the past few decades. Education and awareness can help prevent skin cancer from occurring, and if detected early, skin cancer can often be treated effectively. As a result, NHC launched a skin cancer awareness and prevention campaign in conjunction with the American Cancer Society's "Slip! Slop! Slap! ... and Wrap" national campaign. In order to maximize its reach, NHC identified and participated in key community events throughout the spring and summer where information could be distributed to the largest audiences possible. A partnership was also formed with the North Shore YMCA to supply sunscreen kits and information to all their campers. The staff reinforced the messaging through fun and interactive games and displays while distributing educational materials and skin cancer prevention items such as sunscreen, lip balm and UV-protection-approved sunglasses.

Goal: The overall goal of the skin cancer awareness and prevention campaign is to raise awareness of the risk factors associated with developing skin cancer and promote the importance of sun safety and early cancer detection.

Outcome: Over 2,000 people of all ages were reached at 12 different community events between April and August 2017 in the towns of Beverly, Danvers, Gloucester, Ipswich, Newburyport and Rockport.

Community Partners: North Shore YMCA, Trustees of Reservation, American Cancer Society

Lahey Health Community Conversations on Cancer

Program Description: In response to the needs identified in the CHNA, Lahey Health provided a free community education forum called Conversations on Cancer to educate community members on the prevention, early detection and treatment of cancer, and increase awareness about support and survivorship programs for those diagnosed with cancer. The cancer topics addressed at the forum included colon, breast, lung, gynecological, prostate and skin cancer. The program included educational sessions facilitated by physician leaders from the Lahey Health Cancer Institute, followed by a panel discussion. In addition, attendees had the opportunity to visit an exhibit hall where they could participate in various cancer screenings, hands-on demonstrations, and consultations with physicians and clinicians.

The screenings/exhibits included lung cancer prescreenings, skin cancer screenings, colon cancer prevention and screening education, breast cancer risk assessment consultations, and a gynecological cancer detection exhibit with hands-on demonstrations of the da Vinci robotic surgical system.

Goal: To educate community members about prevention, detection, treatment, management and support of cancer.

Outcome:

- 137 people from throughout Lahey Health's service area attended the event.
- The attendees were 69% women, 31% male.
- Of the 137 attendees, 34% reported having a friend or family member with cancer, 24% attended for general interest, 15% reported being survivors and 6% reported being currently in treatment.
- 27 people participated in the skin cancer screening; four were referred for additional follow-up.
- 30,000 people accessed educational information through social media education and outreach leading up to the event.

Partner: American Cancer Society

"Stop the Bleed" Campaign

Description: As a Level III Trauma Center, Beverly Hospital is committed to trauma prevention and educating our service area on preventable causes of death. According to the World Health Organization, uncontrolled post-traumatic bleeding is the leading cause of potentially preventable death among trauma patients and an important issue for us to address in our primary service area and beyond. In response, Beverly Hospital joined the American College of Surgeons and the Committee on Trauma's evidence-based Stop the Bleed campaign and started to educate local high schools, teachers, counselors, school nurses and first-responder students on how to apply

tourniquets. Instructors provide a hands-on and didactic program on bleeding control techniques to health care and non-health care workers and students. Participants learn about the various ways to control bleeding, whether they have only their two hands to use or have a full trauma first-aid kit available.

The Stop the Bleed campaign began in 2016 after the mass casualty event at Sandy Hook Elementary School, when the Joint Committee to Increase Survival from Active Shooter and Intentional Mass Casualty Events was convened by the American College of Surgeons. The committee met in Hartford, Connecticut, and came up with recommendations based on the premise that massive bleeding from any cause, but particularly from an active shooter or explosive event where a response is delayed can result in death. Similar to how the general public learns and performs CPR, the public must learn proper bleeding control techniques, including how to use their hands, dressings and tourniquets. Victims can die within five to 10 minutes from uncontrolled bleeding. The committee reviewed the Sandy Hook autopsies and realized that a large majority of victims had preventable causes of death from hemorrhaging.

Goal: To teach hemorrhage control techniques to immediate responders and civilians in a mass casualty or active shooter event, in a motor vehicle collision, and when there are home- or work-related injuries.

Outcome: We began the program in June 2017. We have held five major training sessions and were able to train and certify 72 individuals. In addition, we have collaborated with Lahey Hospital & Medical Center Burlington and helped train individuals.

Partners: Boy Scout Troop 57, Boxford; North Shore Community College EMT classes; Gloucester Senior Center; and Gloucester and Rockport high schools

Patient Financial Counselors

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

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

In response, Beverly and Addison Gilbert Hospitals employ Certified Application Counselors with MassHealth and the Health Connector that can screen patients and assist them in applying for state

aid. Patient access billing reps provide estimates to patients for their financial responsibility (copay, deductible, coinsurance, self-pay).

Goal: Meet with patients who are uninsured to screen and align them with state financial assistance and Lahey charity programs; support price transparency by providing estimates to patients of their financial responsibility

Outcome: The financial counselors serve approximately 40-50 patients per day, or about 13,000 patients per year.

Support Groups

Description: In FY17, NHC hosted 16 different monthly support groups at Addison Gilbert Hospital, Beverly Hospital and Lahey Outpatient Center, Danvers.

Goal: Continue to offer a variety of support groups to help educate, support and assist individuals and families who are going through difficult times. Support groups can inform, console and lift the spirit, which are all part of the healing process.

Outcome: Support groups include Ostomy, Crohn's Disease, Huntington Disease, Neuropathy, Surgical Weight Loss, Cardiac Rehab, Polycythemia Vera, Breast-feeding, Breast Cancer, Prostate Cancer, Melanoma, Alzheimer's, Stroke, Widowed Persons, Infant Loss, Diabetes. All support group programs are free and open to the community. The topics for these support groups directly relate to identified needs in the NHC service area. Cancer is the second leading cause of death in the United States, in the commonwealth and across NHC's community benefits service area. The chronic conditions of cardiovascular disease (heart disease), cancer and cerebrovascular disease (stroke) are the three leading causes of death in the United States, the commonwealth and all the cities/towns in NHC's community benefits service area.

Community Partners: Internal initiative

Health Priority #2 – Elder Health

Senior Dine and Learn Program

Description: Beverly and Addison Gilbert Hospitals, in partnership with Unidine, host a monthly senior meals program. We work to keep local senior citizens healthy and safe by hosting free education seminars that provide information on health and personal safety while providing a hot, nutritious meal.

Goal: In FY17, Beverly and Addison Gilbert Hospitals conducted eight monthly sessions each, serving over 880 elder adults. Highlighted topics included basic nutrition, medication review, fall prevention, stress management and coping skills, fitness tips, memory loss, reading nutrition labels, and winter safety tips. Each presentation was accompanied by a healthy and nutritious meal, prepared by the dining services team from Unidine at the Beverly and Addison Gilbert Hospitals cafeterias and served by hospital employees.

Community Partners: Unidine; Beverly, Gloucester and Rockport councils on aging; Gloucester Police Department

Caring Connection Through Technology

Description: The Caring Connections Through Technology program is focused on teaching homebound elders how to communicate via technology.

Goal: The goal of the Caring Connections Through Technology pilot program was to alleviate chronic feelings of isolation, loneliness and/or depression in 10 seniors who self-report having one or more of these feelings. This program matched the seniors with a volunteer who visited the senior, developed a relationship, provided them with a Surface Pro 4, and taught the senior how to use Skype, interactive games (such as Scrabble and card games) and cognition-strengthening apps. Internet access was also made available. The volunteer visited at least four times in a two-month period to ensure the senior understood how to use the new technology. These visits established a baseline relationship. A schedule was then set up for the volunteer to maintain weekly electronic contact with the senior.

Outcome: Caring Connections Through Technology was a small pilot program that served 11 older adults; one married couple was included in the program, increasing the participant count from the planned 10 to 11. Participants ranged in age from 65 to 92, with an average age of 82. All reports submitted included high degrees of satisfaction with the program and an increase in skill set, and two scored greater than 5 on the Geriatric Depression Scale (0-5 is normal). From the standpoint of teaching homebound elders to use technology to broaden their world, this was a highly successful program. In most cases, the volunteer-participant relationship was very strong and is expected to continue. For at least six of the participants and the volunteers working with them, in-person visits will continue. Throughout the duration of the program, in-person visits were preferred over electronic communication.

Community Partners: SeniorCare Inc. and Gloucester Council on Aging

Senior Nutrition Program

Description: Working in partnership with the Danvers Rotary, Danvers Council on Aging and Danvers Food Pantry, we established a new program that will offer coupon booklets to Danvers seniors to be used at the farmers market held on Wednesdays from June through August.

Goal: To increase access for senior residents of Danvers to local, farm-fresh produce, meats, fish, eggs and honey.

Outcome: The program was designed to reach 19.3% of the Danvers population over 65 years of age. In 2017, we saw 100% of the certificates distributed, and 80% of the vouchers were redeemed at participating farm vendors for fresh items.

Community Partners: Danvers Rotary, Danvers Farmers Market, Danvers Council on Aging

The Aging Mastery Program (AMP)

Description: The Aging Mastery Program (AMP) is an education and behavior change program designed to support seniors in “aging well.” The program philosophy is built on the belief that modest changes in lifestyle can result in big changes, thus empowering individuals to develop sustainable behaviors in multiple dimensions of well-being. Over 12 weeks of weekly sessions, the program incorporates evidence-based materials, guest speakers, group discussion, peer support and incentives/rewards.

The core curriculum covers 10 dimensions:

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

Community Partners: Beverly Council on Aging

Enhance Fitness

Description: Enhance Fitness is an evidence-based group exercise program for older adults that uses simple, easy-to-learn movements that motivate individuals (particularly those with arthritis) to stay active throughout their life. Each class session includes cardiovascular, strength training, balance and flexibility exercises and the fostering of strong social relationships between participants.

Goal: Participants are encouraged to attend three classes per week. Sixteen-week sessions are offered continuously throughout the year.

Outcome: Across the three locations (Beverly, Gloucester and Ipswich), 110 participants completed a total of 5,066 sessions. Participants were able to “achieve or maintain at average or above,” compared with age/gender match norms.

Community Partners: Greater Beverly, Ipswich and Cape Ann YMCA

Water Aerobics Classes

Description: This program is designed to keep older adults active using water-based movement for low-impact exercise. Adults who are not normally active can participate as an entry into fitness.

Goal: Group exercise classes conducted in the pool are designed to increase strength and fitness with low impact. Water aerobics has been shown to increase metabolism, improve cardiovascular fitness, increase strength, slow age-related loss of muscle mass and lessen the decrease in reaction time that comes with aging.

Outcome: The Aqua Adventure class, held once a week, had 48 participants who attended a total of 258 times. The Aqua Fit class, also held once a week, had 42 participants who attended a total of 515 times.

Community Partner: Cape Ann YMCA

Osteoporosis Prevention Exercise Class

Description: The osteoporosis prevention exercise class at Addison Gilbert Hospital, conducted in partnership with the Cape Ann YMCA, is designed to prevent or slow the development of osteoporosis. This program is based on a pilot program undertaken with Miriam Nelson, MD, and includes exercise, education and group support on a weekly basis.

Goal: To prevent or slow the development of osteoporosis.

Outcome: In FY17, Addison Gilbert Hospital hosted free one-hour classes each Tuesday and Thursday. The class average was 17 participants per session, with a total of 136 participation hours each month.

Community Partners: Cape Ann YMCA

Serving the Health Information Needs of Everyone

Description: The Serving the Health Information Needs of Everyone (SHINE) program and financial counselors provide health insurance counseling services to elderly and disabled adults. SHINE counselors are trained to handle complex questions about Medicare, Medicare supplements, Medicare health maintenance organizations, public benefits with health care components, Medicaid, free hospital care, prescription drug assistance programs, drug discount cards and long-term health insurance.

Goal: Every week a trained SHINE liaison is available at the Beverly and Gloucester councils on aging 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. The SHINE program is open to everyone and not limited to NHC patients.

Outcome: In FY17, SHINE counselors conducted 2,319 visits throughout the North Shore and Cape Ann.

Community Partners: Rose Baker Senior Center, Gloucester; Beverly and Rockport councils on aging; Cape Ann Farmers Market

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

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

Age is one of the most fundamental factors in determining scope of need. Cities tend to have more families with young children and young adult professionals than do more suburban or rural areas, and the Greater Boston area is no exception. Most of the communities in NHC's service area are suburban, and as a result, the median age is slightly older than the commonwealth's median age.

With respect to age, seniors (65+ years old) across all socioeconomic strata are inherently more at risk. This was a significant theme from the interviews and was also strongly conveyed by the quantitative data findings. NHC's community benefits service area also has a number of towns that defy the typical trend and have high proportions of established, relatively intransient populations of older adults. In Gloucester, 19.8% of the total population are seniors; in Rockport, 26.1%; in Manchester, 20.4%; and in Ipswich, 19.7%. These figures are significantly higher than both the commonwealth and county averages.

Health Priority #3 – Behavioral Health (Mental Health & Substance Use)

Healing to Housing Program

Description: Action Inc.'s Healing to Housing program offers critical behavioral health services to members of our community. This program supported the salary of the shelter counselor, who provided counseling and case management services throughout the year to homeless individuals staying at the Action Inc. emergency homeless shelter.

Goal: The goal is for the shelter counselor to provide counseling focused on substance use and behavioral health issues; assist clients with the development of moving-on plans; and make referrals to higher-level care, substance abuse treatment, and mentoring for housing and employment.

Outcome: Fifty-three emergency shelter guests moved into affordable housing; 26 homeless individuals were diagnosed with mental health and/or substance use disorder and received clinical counseling as they worked toward permanent housing. One hundred percent of formerly homeless clients who are now in housing were able to retain their housing and maintained or increased their income. The shelter counselor was able to help increase self-sufficiency and financial stability by assisting with benefit/income recertification and applications. All the tenants received weekly counseling and/or stabilization services.

Community Partners: Action Inc., the City of Gloucester High Risk Task Force, Gloucester Police Department, Gloucester EMS Department, Gloucester Board of Health, Grace Center, SeniorCare

Police-Assisted Addiction and Recovery Initiative (PAARI)

Description: PAARI supports the Gloucester Police Department (GPD) in its community-based efforts to create pathways to treatment for individuals struggling with substance use disorders. By building relationships with the hospitals in the area that provide treatment and recovery support services, and by documenting the services that each program provides, PAARI and GPD were equipped to make referrals to programs more quickly and successfully.

Goal: Through hiring an outreach worker and care advocate, support the GPD's efforts to aid individuals struggling with substance use disorders in entering treatment.

Outcome: PAARI was able to hire a full-time outreach worker and care advocate. From October 2016 to September 2017, this person provided support to 58 unique individuals with substance use disorders, and 113 additional unique individuals were reached through community events and trainings. PAARI has connected with the following programs/departments: Boston Treatment Center; Lahey Health Behavioral Services detox facilities in Tewksbury and Danvers; Lahey Transitions in Tewksbury; Lahey Ryan House in Lynn; HART House in Tewksbury; Lahey Ambulatory Services; the Opioid Treatment Program in Gloucester; the CHART Program at Addison Gilbert Hospital; the Lahey Opioid Treatment Program; and Danvers Treatment Center CSS.

In August 2017, the GPD and PAARI began working together to conduct home visits following nonfatal opioid overdoses that took place in Gloucester. In the first month of the program's operation, eight overdose home follow-ups were conducted.

The 58 unique individuals mentioned above represent a total of 151 interactions, for an average of 2.5 interactions per individual receiving support. The breakdown is as follows: 69 interactions to provide counseling, coaching and guidance; 24 interactions in which a direct referral or treatment suggestion was offered but not taken; 18 direct placements into first of two treatments; and 40 interactions to provide follow-up coaching and aftercare to help sustain recovery. Geographically, 33 people were from Gloucester; five people from Beverly; one person from Plum Island; two people from Lynn; six people from elsewhere in Massachusetts; and 11 people from outside Massachusetts.

Community Partners: Gloucester High Risk Task Force; Rose Baker Senior Center in Gloucester; Grace Center; Action Inc.; City of Gloucester; Learn 2 Cope in Gloucester and Salem

Parent University

Description: Parent University is a new, innovative and collaborative way to enhance parents' skill and understanding of social, emotional and behavioral health issues that impact youths ages 6-18.

It is estimated that 100 Danvers families were impacted and up to 150 children. A total of 16 workshops were offered by 25 faculty and presenters. Educational content was split between addressing pediatric health and wellness/behavioral health risk factors and academic programming of interest to parents. Twelve community vendors provided information on various services to parents.

Goal: Because the event included a variety of topics of interest, we were able to address the behavioral health and social/emotional needs of children in an engaging way for parents. The event also provided access to behavioral health resources through the vendor fair and choice of topics.

Outcome: DanversCARES implemented a post-event evaluation, and also met as a planning team to review participant feedback and list process improvements for next year. Over 75% said the information in the workshops was meaningful to them, and over 80% said they would use the information at home/with their child. Sixty-nine percent indicated that overall, the conference was excellent, and 31% said it was very good. We had several positive comments on the keynote speaker from Merrimack who spoke about a "Growth Mindset." We also had great comments about our "In Plain Sight" display on substance use and behavioral health issues, presented in collaboration with the public health and police departments. Overall, this was a hugely successful collaborative event.

Community Partners: DanversCARES, Danvers Public School, Danvers YMCA, Lahey Behavioral Health, Danvers Health Department

Youth at Risk Conference

Description: The Youth at Risk (YAR) conference is the region's only annual all-day conference for professionals who work with at-risk youth. The event features 38 breakout sessions as well as keynote speakers, program exhibitions and networking opportunities. We provided clinical expertise during breakout sessions and community resources in order to build the capacity of service providers. This event attracted 737 participants and volunteers. The YAR attendees represented over 350 organizations and 106 communities across the commonwealth.

Health Priority #4 – Maternal and Child Health

Connecting Young Moms Programs

Description: Connecting Young Moms programs offer comprehensive pre- and postnatal programs to young mothers and their children. For many, the programs offer a lifeline at this pivotal time in their lives. Connecting Young Moms is offered at no cost by the Beverly Hospital Social Work Department in collaboration with the Parent Education Department. Connecting Young Moms serves young mothers and mothers-to-be who have limited resources and often have little emotional and social support.

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

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

Goal: This free program is to be attended in the first or second trimester and focuses on healthy pregnancy. Topics include nutrition, body image and preterm labor.

Outcome: Approximately 100 women attended in FY17, plus their children, support people, fathers of the babies, etc.

Beverly Hospital "Cuddler" Program

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

Goal: The goal of the program is to support the growth and development of newborn babies during the critical early stages of life by providing them with comfort and a feeling of security through personal interaction and calming human touch.

Outcome: Eight trained volunteers spent 586 hours cuddling babies in the Beverly Hospital Special Care Nursery. We also have one harpist who spent 42 hours playing for the babies.

Child Passenger Safety Program

Description: The Rehabilitation and Sports Medicine clinical team leader and occupational therapist at Beverly and Addison Gilbert Hospitals offer free car seat inspections for the community at both hospitals.

Goal: The goals of the program are to provide car seats to low-income families, remove unsafe car seats from the streets, educate families on proper car seat use and ensure a safe transportation plan for all children in our community.

Outcome: In FY17, the Child Passenger Safety Program inspected over 107 car seats and provided 24 new car seats to community families in need.

FY17 Community Outreach Overview

In addition to our well-established community benefits program, NHC also has a diverse and far-reaching community outreach program that provides service and support to local communities in a variety of ways. Support includes participation in or support of food and clothing drives, health fairs, leadership on local nonprofit and community boards, and sponsorship of community events and initiatives.

Activities for FY17 included:

1. Community Speakers Bureau
2. Provided funding to support summer reading initiatives in Gloucester and Beverly
3. Sponsored four American Red Cross blood drives
4. Partnered with the Rockport Council on Aging on a Falls Awareness & Prevention event
5. Partnered with the Gloucester High School Diabetes Support Group
6. Provided a free supermarket guided nutrition tour
7. Held a Holiday Gift Drive and Mitten Tree
8. Held food drives to support the Beverly and Gloucester food pantries
9. Cape Ann Farmers Market
10. Gloucester Sidewalk Bazaar
11. Beverly Council on Aging Senior Day in the Park
12. Healthy Kid Day in Beverly, Gloucester and Ipswich
13. Danvers Kiwanis Bike Rodeo and helmet fitting
14. Beverly and Danvers Relay For Life
15. Sponsored several community events including Danvers Family Festival, Beverly's First Night, Rockport's First Night and Beverly Homecoming
16. Participated in 12 health fairs and several screenings across the North Shore and Cape Ann
17. Supported 17 road races with over 5,000 total participants

GLOSSARY OF TERMS

Community Benefits Guidelines: The Attorney General's Community Benefits Guidelines for Nonprofit Acute Care Hospitals and The Attorney General's Community Benefits Guidelines for Health Maintenance Organizations.

Community Benefits Manager: A hospital employee directly responsible for the development and management of a Community Benefits Program or Community Service Program.

Community Benefits Plan: A formal plan to address the health needs of an identified community, developed in accordance with the principles of the Community Benefits Guidelines with appropriate community participation, and approved by the hospital's or HMO's governing board.

Community Benefits Program: A program, grant or initiative developed in collaboration with community representatives or based upon a Community Health Needs Assessment that serves the needs of a Target Population identified in the hospital's or HMO's Community Benefits Plan.

Community Health Needs Assessment: A process through which a hospital or HMO, in partnership or consultation with representatives of its community, identifies community health needs using public health data, community surveys, focus groups, and other community-initiated information- and data-gathering activities, and/or other relevant health status indicators and data.

Community Service Program: A program, grant or other initiative that advances the health care or social needs of Massachusetts communities, but is not related to the priorities or Target Population identified in the hospital's or HMO's formal Community Benefits Plan.

Corporate Sponsorships: Cash or in-kind contributions that support the charitable activities of other organizations, and are not related to a Community Benefits Plan.

EXPENDITURES

Direct Expenses: May include (1) the salary and fringe benefits (or a portion thereof) of a Community Benefits Manager and his or her staff; (2) the value of employee time devoted to a Community Benefits Program or Community Service Program during paid work hours or leave time (calculated either at the rate of the employees' pay or using the averages set forth below in the definition of Employee Volunteerism); (3) any purchased services or supplies directly attributable to the Community Benefits or Community Service Program, including contractual and noncontractual agreements with other organizations or individuals to develop, manage or provide the benefit or service, including leases/rentals of equipment or building space; (4) the costs associated with generating Other Leveraged Resources; (5) dues, subsidies and other financial assistance aimed at making health coverage more affordable for the uninsured or those at risk of losing health coverage; and (6) grants to third parties in furtherance of a community benefit or community service objective.

Associated Expenses: May include (1) depreciation or amortization related to the use of major movable equipment purchased or leased directly for the Community Benefits or Community Service Program, and (2) a share of any fixed depreciation on a building or space therein used solely or in major part for a community benefit or service.

Determination of Need Expenditures: Direct or Associated Expenses related to Community Benefits Programs or Community Service Programs provided by a hospital in fulfillment of a specific determination of need condition established by the Massachusetts Department of Public Health pursuant to 105 CMR 100.

Employee Volunteerism: An employee's voluntary activities in connection with a hospital or HMO Community Benefits Program or Community Service Program that take place during unpaid time as the result of a formal hospital or HMO initiative to organize or promote voluntary participation in the particular activity among its employees. The value of free or reduced-fee direct health care or public health services volunteered by health care providers employed by the hospital or HMO should be calculated using either (1) the rate of the employees' pay, or (2) the average hourly rate for Massachusetts health care workers as calculated by the Centers for Medicare & Medicaid Services for the purpose of determining the Medicare Area Wage Index during the reported fiscal year.

Other Leveraged Resources: Funds and services contributed by third parties for the express purpose of supporting a hospital's or HMO's Community Benefits or Community Service Programs. These include (1) services provided by nonsalaried physicians or other individual providers free of charge to free-care-eligible patients in connection with a hospital's free-care program, or at no charge or reduced fee to low-income patients in connection with other hospital or HMO programs (calculated using a standard cost-to-charge ratio of .60); (2) grants received from private foundations, government agencies or other third parties for the specific purpose of supporting a hospital or HMO Community Benefits or Community Service Program; and (3) monies raised from or collected by third parties as the result of a fund-raising activity sponsored by a hospital or HMO in connection with a Community Benefits or Community Service Program. **Note:** These definitions identify the range of costs that hospitals and HMOs might appropriately include when calculating expenses related to their Community Benefits and Community Service Programs. They are not intended to impose an obligation on hospitals and HMOs to account for costs that they otherwise would not track. In those instances where costs are difficult to quantify, hospitals and HMOs should develop a reasonable estimate of their costs within the spirit of these guidelines. Hospitals and HMOs also should use discretion in categorizing costs that are not specified in the examples provided above.

HMO: As defined by Chapter 176G of the Massachusetts General Laws, means a company organized under the laws of the commonwealth, or organized under the laws of another state and qualified to do business in the commonwealth, that provides or arranges for the provision of health services to voluntarily enrolled members in exchange primarily for a prepaid per capita or aggregate fixed sum.

Hospital: A nonprofit acute care hospital, as defined by Chapter 118G of the Massachusetts General Laws, to include the teaching hospital of the University of Massachusetts Medical School and any

hospital licensed under Section 51 of Chapter 111, and which contains a majority of medical-surgical, pediatric, obstetric and maternity beds, as defined by the Department of Public Health.

Net Charity Care/Uncompensated Care Pool Contribution: As defined under Section 1 of Chapter 118G of the Massachusetts General Laws, the amount of “free care” provided by a hospital as determined by its annual assessment plus any shortfall allocation in connection with administering the Uncompensated Care Pool Trust Fund, or an HMO’s annual contribution to the Uncompensated Care Pool, as listed by the Massachusetts Division of Health Care Finance and Policy in its most current settlement for the reported fiscal year. Net Charity Care does not include hospital bad debt related to patients not eligible for free care; “shortfalls” related to Medicaid, Medicare or other health plan reimbursements that do not cover the full costs of a hospital’s services; or shortfalls related to an HMO’s coverage of Plan Members enrolled through a Medicaid or Medicare program.

Plan Members: The average of the total number of members, as defined in Chapter 176G of the Massachusetts General Laws, enrolled in an HMO’s health plans, as reported to the Division of Insurance in the four quarterly reports for the periods occurring during the reported fiscal year.

Target Population: The specific community or communities that are the focus of the hospital’s or HMO’s Community Benefits Plan. A target population can be defined (1) geographically (e.g., low- or moderate-income residents of a municipality, county or other defined region), (2) demographically (e.g., the uninsured, children or elders, an immigrant group), (3) by health status (e.g., persons with HIV, victims of domestic violence, pregnant teens) or (4) by an issue consistent with the Community Benefits Guidelines (e.g., community building, reducing disparities in access to quality health care).

Total Patient Care-Related Expenses: Expenses, including capital, related to the care of patients as reported by hospitals to the Division of Health Care Finance and Policy on Schedule 18 of the 403 Cost Report for the reported fiscal year.