Table of Contents

3 Massachusetts’ Attorney General Community Benefit Guidelines
4 Northeast Hospital Corporation’s Community Benefits Mission Statement
4 Northeast Hospital Corporation’s Community Benefits Plan
5 Northeast Hospital Corporation’s Community Benefit Committee Fiscal Year 2013
6 Key Accomplishments for Reporting Fiscal Year 2013
7 Plans for Reporting Fiscal Year 2014
8 Fiscal Year 2013 Community Partners
9 Community Health Needs Assessment Overview
12 Summary of Highlighted Programs for Fiscal Year 2013
12 Beverly Bootstraps Mobile Market
12 Walk-In Blood Pressure Clinic(s)
13 Beverly Hospital Senior Citizen Dine and Learn Program
14 Addison Gilbert Hospital ED-SBIRT Program
16 Addison Gilbert Hospital / Gloucester Public Schools Diabetes Program
17 First Parish Church, Beverly Meals Program
17 Northeast Hospital Corporation Community Collaborative Grant
18 Pioneering Healthier Communities (Be Healthy Beverly)
19 ImPACT Baseline Concussion Testing
20 Serving Health Information Needs of Elders (SHINE)
21 Skin Cancer Clinic
22 Speakers Bureau
22 Massachusetts Opioid Abuse Prevention and Collaborative Program (MOAPC)
23 Support Groups
23 Community Outreach Overview Fiscal Year 2013
25 Fiscal Year 2013 Required Financials
26 Massachusetts’ Attorney General Glossary of Terms
Massachusetts’ Attorney General 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 (HMO) 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 the 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 hospital Guidelines were modeled after community benefits guidelines developed by the Kellogg Foundation, the Catholic Hospital Association and the Voluntary Hospital Association, as well as community benefits legislation in several other states. The HMO Guidelines are similar to the hospital Guidelines, and were prompted by recognition of the increased role that HMOs were playing in the healthcare system.

Northeast Hospital Corporation’s Community Benefits Mission Statement

The Community Benefits Program at Northeast Hospital Corporation is a program established to partner with community leaders and organizations to assess and meet the healthcare 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 Northeast Health System. Health issues addressed encompass safety, chronic disease, infectious disease, substance abuse and behavioral health.

Also included with the Community Benefits Mission Statement are the mission statements of Northeast Health System and Northeast Hospital Corporation. The corporate Mission Statement is founded in the concepts of quality, caring and community.

(Approved by the Community Benefits Committee, July 17, 2010)

Northeast Hospital Corporation’s Community Benefits Plan

The importance of the Community Health Needs Assessment and our collective efforts to address the healthcare needs of the North Shore have never been greater. The economic downturn has had a tremendous impact on thousands of individuals and families throughout the region. Northeast Hospital Corporation looks forward to continuing to work in partnership with the communities we serve and with health-related organizations throughout the North Shore to meet the area’s healthcare needs and improve the overall health status of the community.

NHC, with the help of Northeast Health System affiliates, will focus its community benefits plan around the four state-wide priorities highlighted below, which have been set forth by the Attorney General’s Office:

- Chronic Disease Management for disadvantaged populations
- Reducing health disparities
- Promoting wellness of vulnerable populations
- Supporting healthcare reform

The Community Benefits Committee at NHC will ensure the organization conducts health needs assessments for its 16 town/city primary service area as mandated by the Attorney General.

The Target Population(s) are broken down into six distinct groups: Health Issues, Types of Programs, Sex, Race/Ethnicity, Age and Insured Status.
Programs in Place

Screenings, clinics and seminars were developed in the following areas: skin cancer, oral cancer, Pap smear, depression, diabetes, bone density, blood pressure, flu and CPR. In addition, risk assessments were developed for cardiovascular, osteoporosis, diabetes, body mass index and breast cancer.

A number of disease management initiatives have been instituted, including cardiac rehabilitation, heart failure management, pulmonary rehabilitation, osteoporosis management, vascular health and women’s health screenings. In 2003, NHC created the Lifestyle Management Institute (LMI). The LMI provides programs and education on how to live a healthy lifestyle, and proactively identifies populations with, or at risk of developing, certain medical conditions. The LMI offers a full range of services to the community, including risk assessment, prevention education, diagnostic testing, coordinated medical treatment and continuous monitoring. Effective disease management—particularly when using appropriate medical protocols—reduces the number of hospital admissions and emergency room visits, shortens the length of hospital stays and improves the overall health and quality of life for people with chronic illness.

1. Within each of the chronic disease areas, an initiative was developed to identify and manage the treatment of each patient and family.

2. A database has been developed by the LMI for patient maintenance and appropriate follow-up.

(Approved by the Community Benefits Committee, July 17, 2010)
Key Accomplishment for Reporting Fiscal Year 2013

Addison Gilbert and Beverly Hospitals successfully completed a three-phased Community Health Needs Assessment. The goal of this assessment was to: 1) identify primary health concerns; and 2) explore ways that the Hospitals, health and social service agencies, and the community at-large can work together to improve the health and well-being Cape Ann and North Shore residents.

Beverly Hospital partnered with Beverly and Ipswich high schools to provide baseline concussion testing to student athletes who participate in fall sports. Implementing Immediate Post Concussion and Cognitive Testing (ImPACT) we successfully screened over 300 student athletes.

Addison Gilbert Hospital’s Emergency Department Screening, Brief Intervention and Referral to Treatment (ED-SBIRT) program was awarded a $170,000 grant from the Peter and Elizabeth C. Tower Foundation to expand upon the existing ED-SBIRT program. In FY’14 Addison Gilbert Hospital will hire a second Health Promotion Advocate and will begin screening a pediatric population.

Addison Gilbert and Beverly Hospitals joined the communities of Beverly, Danvers and Gloucester as the healthcare partner on a successfully funded grant proposal to participate in the Massachusetts Opioid Abuse Prevention Collaborative Program.

Addison Gilbert Hospital was awarded a $100,000 grant through the Massachusetts Executive Office of Health and Human Services to partner with the Gloucester Family Health Center to strengthen the continuity of care for patients who currently do not have a documented primary care physician.

Lahey Outpatient Center, Danvers (formerly Beverly Hospital at Danvers) partnered with the Sterling Center YMCA to implement a program which allowed us to introduce Y members to registered dietitians who screened the members to determine their risk factors for diabetes, cardiovascular disease and obesity. Those that were identified as being at risk for one or more of these health issues were invited to participate in the Healthy Living & Nutrition Initiative. Participants received nutritional counseling, appropriate education for their diagnosis and fitness consultation, including a personalized nutrition and exercise plan. Each participant was also offered one free session with a personal trainer.

Beverly Hospital funded and partnered with Beverly Bootstraps on a mobile market programming to low-income housing in the City of Beverly. A total of 428 households and 770 individuals were served, and 37,513 pounds of fresh produce was provided.

We provided 55 Speakers Bureau presentations within our primary service area. Our Speakers Bureau is made up of physicians, social workers, nurses and other clinical staff who offer information and discussion on a variety of key health topics and issues.

We provided 50 free blood pressure clinics at Addison Gilbert Hospital and 1,202 individuals attended our weekly sessions. Out of the 1,202 individuals, 45 needed further care.

Addison Gilbert Hospital partnered with Gloucester Public Schools on a diabetes support group for students at Gloucester High School. This program included monthly support group sessions, healthy cooking demonstrations and peer to peer support. These sessions were facilitated by clinical staff and the dining services team from Unidine Corporation.
We provided 14 free, non-fasting glucose clinics at Addison Gilbert Hospital and 117 individuals attend our weekly sessions. Out of the 117 individuals, 23 needed further care.

As part of our partnership with the Beverly YMCA, Beverly Hospital worked with numerous community partners in the City of Beverly to expand upon the fruit and vegetable bars in each of the five elementary schools in Beverly by adding raised-bed gardens for each school. This effort is part of the Pioneering Healthier Communities Grant/Be Healthy Beverly initiative, and funding for the gardens was provided by Beverly Hospital.

Addison Gilbert and Beverly Hospitals offered free skin cancer clinics. In partnership with the American Cancer Society and Melanoma Foundation each individual received a thorough and comprehensive examination. We saw a total of 47 individuals and 20 needed further evaluation.

Our SHINE (Serving the Health Insurance Needs of Everyone) counselors managed 1,803 clients across the North Shore and Cape Ann communities.

Northeast Hospital Corporation funded four $10,000 grants for innovative, community-based initiatives in one of three key areas: 1) promoting mental and behavioral health education, 2) chronic disease prevention or management, and 3) improving access to health services in the community.

**Plans for Reporting Fiscal Year 2014**

- Expansion of the Unidine/Beverly Hospital Senior Supper initiative to include Addison Gilbert Hospital, Unidine, Rockport Council on Aging and the Gloucester Council on Aging.

- Expansion of Immediate Post Concussion Management Model Testing (ImPACT) to Gloucester High School, Manchester Essex Regional High School and Hamilton Wenham Regional High School. Expansion would include providing funding to each school for the purchase of the initial license and 300 baseline tests.

- Build the capacity and framework for the expansion of the Emergency Department Screening, Brief Intervention and Referral to Treatment program piloted in the Addison Gilbert Hospital Emergency Department to Beverly Hospital, Lahey Medical Center, Peabody and Lahey Hospital & Medical Center, Burlington

- Secure $150,000 in leveraged resources (public/private grant funding) to implement community-based health initiatives that focus on access to care, chronic disease, mental health and substance abuse in pediatric, adult and elder populations.

- Successfully implement the Addison Gilbert Hospital/Cape Ann YMCA diabetes pilot program, in addition to finalizing the pilot study meeting the deadline for application for the YMCA of the USA diabetes program.

- Establish a monthly walk-in blood pressure clinic at Lahey Outpatient Center, Danvers. This program will be managed by the Diabetes Care Center team and will occur on the first Friday of each month. This program will mirror the existing program at Addison Gilbert Hospital.
• Finalize a community-based collaborative program specifically in care transition from Addison Gilbert Hospital back into the community setting. The goal is to implement at least two initiatives that will address the issue of care coordination and re-hospitalization.

• Fulfill the Peter and Elizabeth C. Tower Foundation grant for the Addison Gilbert Hospital ED-SBIRT program. Prior to October 1, 2014, the hiring of a second Health Promotion Advocate (HPA) should be complete, as well as each HPA being successfully trained in Pediatric ED-SBIRT protocols.

• Continue organizational progress as it relates to the long-term goals stated for each of the community benefit programs.

**Fiscal Year 2013 Community Partners**

Beverly Community Council  
Sterling Center YMCA Beverly  
Ledgewood Rehabilitation and Skilled Nursing Center, Beverly  
Essex Park Rehabilitation, Beverly  
Beacon Hospice, Beverly  
Beverly High School  
Beverly Senior Center  
BevCam  
Herrick House, Beverly  
First Baptist Church of Beverly  
Beverly Resource Group  
Cape Ann Chamber of Commerce  
Danvers Senior Center  
First Church of Danvers  
Center for Healthy Aging, Danvers  
Peabody Institute Library of Danvers  
Stop & Shop, Danvers  
Danvers Rotary  
St. John’s Preparatory School, Danvers  
Kiwanis Club of Danvers  
Danvers Community YMCA  
North Shore Community College, Danvers  
Essex Senior Center  
Action Inc., Gloucester  
Gloucester Stroke Club  
Rose Baker Senior Center, Gloucester  
Shaws, Eastern Ave., Gloucester  
Rotary Club of Gloucester  
Hamilton Wenham Regional High School  
Hamilton Wenham Rotary Club  
Ipswich Council on Aging  
Ipswich YMCA  
Ipswich Senior Center  
Bridgewell, Lynnfield  
Lynnfield Senior Center  
Lynnfield Council on Aging  
Marblehead Council on Aging  
Marblehead Senior Center  
Jewish Community Center of the North Shore, Marblehead  
Flint Public Library, Middleton  
Middleton Council on Aging  
Middleton Senior Center  
Peabody Senior Center  
Peabody Institute Library  
Peabody Glen Health Care Center  
Peabody Council on Aging  
Brooksby Village, Peabody  
Rockport Rotary Club  
Rockport Senior Center  
Salem Council on Aging  
Topsfield Council on Aging  
Wenham Council on Aging  
Enon Village, Wenham  
Greater Beverly Chamber of Commerce  
Peabody Area Chamber of Commerce  
Healthy Gloucester Collaborative  
GetFit Gloucester  
North Shore Chamber of Commerce  
Cape Ann TV, Channel 12 Public Access  
Danvers Community Access Television  
Northeast Massachusetts Red Cross, Peabody
Lahey Hospital & Medical Center • Fiscal Year 2013 Community Benefits Report

Community Health Needs Assessment Overview

In October 2011, John Snow Inc. (JSI) was contracted by Northeast Hospital Corporation to conduct a comprehensive needs assessment that would identify the major concerns and priorities on the North Shore so that NHC could develop community health programming and services that would more effectively meet the needs of the community. The assessment process is intended to ensure that its services and community health programs remain responsive to the communities they serve and that strong partnership are built and renewed with the communities and other stakeholders in the area. While quantitative data is pulled for all communities in NHC’s primary service area, a more thorough assessment—including qualitative findings—were offered in the following communities: Essex, Gloucester, Hamilton, Ipswich, Manchester, Rockport and Wenham. The following is a summary of the process and methods used during the three-phase assessment. The report and roll-out plan were completed in October 2012 and presented to the communities in January 2013.

Phase I – Preliminary Needs Assessment

- Conduct a preliminary needs assessment that relies on publicly available data.
- Conduct a series of structured key informant interviews internally with select staff and board members.

Phase II – Targeted Community Engagement

- Conduct a series of structured key informant interviews externally with community leaders, health and social service providers and other key stakeholders in the community.
- Collect primary data directly from the community residents through a series of community mail surveys.
- Develop a final Needs Assessment Report and conduct a strategic planning retreat.

Phase III – Strategic Plan Development and Reporting

- Consolidate all of the project findings and deliverables into a comprehensive Community Needs Assessment and Community Engagement Strategic Plan that will include:
  - A list of the community healthcare needs and priorities identified overall and by the community.
  - Supporting documentation and data.
  - Recommending priority health needs and a set of preliminary programmatic recommendations for review.
- Develop a reporting strategy; develop a series of presentations/materials; present to the community.

Sources of Information

- Massachusetts Community Health Information Profile (MassChip) system as well as other national, state and local sources
- Community Health Survey which consisted of 24 pages; 2,400 random households were selected to participate
- Key informant interviews with town/city leadership and public health professionals

Needs Identified

The most significant issues with respect to access to care were related to dental services, particularly for adults, and mental health and substance abuse services for low-income and middle-income brackets. In addition, a significant proportion of the region’s population struggled to access prescription drugs, due primarily to the cost of co-pays and deductibles. Access to care was also affected by transportation and cost barriers, which were by far the two most significant barriers to care for those in the region. These issues have a particularly strong impact on low-income and older adult populations who are most likely to be isolated and struggle to make ends meet financially.

There are a number of risk factors that have a major impact on chronic disease and the general level of health for individuals and communities. The risk factors with the greatest health effects are overweight/obesity, physical exercise, poor nutrition and smoking. These factors can lead to a variety of conditions such as diabetes, heart disease, hypertension, COPD, asthma, cancer and arthritis. Obesity is a particular and increasing problem at a national and state-level, as well as at regional level. Conversely healthy habits and behaviors with respect to nutrition and physical exercise can be protective and improve heart and lung function, diabetes control, and hypertension and reduce the risk of cancer, fall-related injuries and other conditions.
Chronic diseases such as diabetes, heart disease, stroke, hypertension, respiratory disease and cancer are the major causes of morbidity, disability and mortality, both in the region and the state. These conditions are, in fact, among the leading causes of death across the nation. Caused by a mixture of factors including genetic, environmental and lifestyle factors, chronic diseases are pervasive, difficult to treat and occur in an increasing proportion of our society. The regional prevalence, hospitalization and death rates for chronic diseases are comparable to the rates at the state, in almost all cases, but there are some important exceptions—particularly with respect to diabetes and hypertension. There are also indications that some residents in the region are not properly engaged or receiving appropriate preventive, acute, or chronic disease management services in primary care. This is evidenced by higher rates of emergency department and hospital inpatient utilization for some conditions.

Depression, anxiety and stress are major health issues throughout the nation and place significant burdens on individuals, families and communities. Numerous national studies have shown that many of the leading chronic illnesses, such as diabetes and heart disease, are linked to mental illness and the rates of co-occurring physical and mental illness are extremely high. Mental illness also plays a significant role in increasing healthcare expenditures and is responsible for a large proportion of total hospital emergency department visits and inpatient stays. Numerous data elements from the survey and the state’s quantitative morbidity and mortality data highlight the burden that it places on the region, especially among low-income populations.

Like mental health, substance abuse is evident across all income and geographic groups and causes significant burdens and loss of productivity upon individuals, families and communities. Substance abuse increases healthcare expenditures as well as community expenditures on law enforcement and incarceration. One of the more dramatic findings in the assessment was the extent to which many segments of the region’s population abuse alcohol and prescription drugs. Regionally, those who responded to our survey were much more likely to identify as “heavy” alcohol drinkers (more than seven drinks a week for women and more than 14 drinks a week for men) or binge drinkers (more than four drinks at any one sitting for women and more than five drinks at any one sitting for men) than those in the state overall. Regionally, high proportions of the population also abused prescription drugs.

**Conclusion**

Northeast Hospital Corporation and the staff at Addison Gilbert and Beverly Hospitals are committed to developing hospital services and other community-based programs that are tailored to meet the needs of the communities they serve. Both hospitals have a recognized track record of working collaboratively with community partners to develop programs and services that are providing health education, expanding access to service, addressing barriers to care and improving overall health status.

We are proud of this record and look forward to using the findings from this assessment to refine our current services and develop new community programs and partnerships. Community health workgroups that correspond to the health priorities identified by the assessment have already been convened and these workgroups are in the process of developing detailed strategic plans. The staff at Addison Gilbert and Beverly Hospitals looks forward to working with all of the area’s health and social service providers and the community at-large to improve the overall health status of the North Shore and Cape Ann communities.
Summary of Highlighted Programs for Fiscal Year 2013

Beverly Bootstraps Mobile Market

**Brief Objective or Description:** Beverly Hospital provided the funding to allow Beverly Bootstraps to offer 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 about basic nutrition and recipes from clinical nutrition managers at Northeast Hospital Corporation. During the year, 428 households were served, 770 total individuals were served and 37,513 pounds of produce was distributed.

**Status:** The immediate goal was to provide access to fresh produce, while providing basic information as it relates to nutrition in a community setting. Knowing transportation is a barrier to access, the mobile market was able to bring food to the housing authority location and its residents on a weekly basis. We achieved this goal in the first year of this pilot program. The breakdown of individuals were 28 seniors, 22 disabled, 53 single-parent households, 83 unemployed and 79 female heads of household.

**Partners:** Beverly Bootstraps and Beverly Housing Authority

**Detailed Description:** There are a number of risk factors that have a major impact on chronic disease and the general level of health for individuals and communities. The risk factors with the greatest health effects are overweight/obesity, physical exercise, poor nutrition and smoking. These factors can lead to a variety of conditions such as diabetes, heart disease, hypertension, COPD, asthma, cancer and arthritis. Obesity is a particular and increasing problem at a national and state-level, as well as at a regional level. Conversely healthy habits and behaviors with respect to nutrition and lack of physical exercise can be protective and improve heart and lung function, diabetes control, and hypertension and reduce the risk of cancer, fall-related injuries and other conditions. *(Overweight/Obesity: The prevalence of obesity and overweight—according to body mass index—for the region was comparable to state but nonetheless extremely high with approximately 50 percent of the population reporting as either overweight or obese. Source: 2012 Community Health Needs Assessment)*

Walk-In Blood Pressure Clinic(s)

**Brief Objective or Description:** Addison Gilbert Hospital offers a free weekly walk-in blood pressure clinic every Monday (minus holidays) from 1 to 3 pm in the Women’s Health Conference Room.

**Status:** In fiscal year 2013, we saw 1,202 individuals, 45 presented with high blood pressure. The goal of the program is to educate patients and offer information related to additional resources for patients. Retired nursing staff members see patients, take blood pressure, review results, review medications and counsel if necessary. We also ask the patient if they would like us to share results with their primary care physician or nurse practitioner for follow-up care.

**Partners:** Organizational Initiative

**Detailed Description:** Chronic diseases such as diabetes, heart disease, stroke, hypertension, respiratory
disease and cancer are the major causes of morbidity, disability and mortality, both in the region and the state. These conditions are, in fact, among the leading causes of death across the nation. Caused by a mixture of factors including genetic, environmental and lifestyle, chronic diseases are pervasive, difficult to treat and occur in an increasing proportion of our society. The regional prevalence, hospitalization and death rates for chronic diseases are comparable to the rates at the state level in almost all cases but there are some important exceptions, particularly with respect to diabetes and hypertension.

There is also indication that some residents in the region are not properly engaged or receiving appropriate preventive, acute or chronic disease management service in primary care. This is evidenced by higher rates of emergency department and hospital inpatient utilization for some conditions. Regionally, the proportion of the population with hypertension is slightly higher than the state but there are segments of the population, including the low-income population, that have much higher rates than region and state. *(Overall survey sample: 27 percent; low income: 30 percent; state: 26 percent)* Source: 2012 Community Health Needs Assessment

### Beverly Hospital Senior Dine and Learn Program

**Brief Objective or Description:** Beverly Hospital in partnership with Unidine and the Beverly Council on Aging launched a senior meals program to provide healthy and nutritious foods as well as educational seminars.

**Status:** In Fiscal Year 2013, Beverly Hospital conducted nine sessions. We served 310 senior citizens in our inaugural year. Topics that were highlighted include: basic nutrition, what is a stroke?, stress management and coping skills, spring fitness tips and ideas, memory loss, how to read a nutrition label, balance as we age, what is assisted living?, staying safe and healthy during the fall and winter. Each presentation was accompanied by a healthy and nutritious meal, prepared by the dining services team from Unidine at the Beverly Hospital cafeteria. The program and registration was promoted and scheduled with the help of the activities office at the Beverly Council on Aging.

**Partners:** Unidine Corporation and the Beverly Council on Aging

**Detailed Description:** Chronic diseases such as diabetes, heart disease, stroke, hypertension, respiratory disease and cancer are the major causes of morbidity, disability and mortality, both in the region and the state. These conditions are, in fact, among the leading causes of death across the nation. Caused by a mixture of factors including genetic, environmental and lifestyle, chronic diseases are pervasive, difficult to treat and occur in an increasing proportion of our society. The regional prevalence, hospitalization and death rates for chronic diseases are comparable to the rates at the state level in almost all cases, but there are some important exceptions, particularly with respect to diabetes and hypertension.

There is also indication that some residents in the region are not properly engaged or receiving appropriate preventive, acute or chronic disease management service in primary care. This is evidenced by higher rates of emergency department and hospital inpatient utilization for some conditions. Regionally, the proportion of the population with hypertension is slightly higher than the state but there are segments of the population, including the low-income population, that have much higher rates than region and state. *(Overall survey sample: 27 percent; low income: 30 percent; state: 26 percent)* Source: 2012 Community Health Needs Assessment
There are a number of risk factors that have a major impact on chronic disease and the general level of health for individuals and communities. The risk factors with the greatest health effects are overweight/obesity, physical exercise, poor nutrition and smoking. These factors can lead to a variety of conditions such as diabetes, heart disease, hypertension, COPD, asthma, cancer and arthritis. Obesity is a particular and increasing problem at a national and state level, as well as at regional level. Conversely healthy habits and behaviors with respect to nutrition and physical exercise can be protective and improve heart and lung function, diabetes control, and hypertension and reduce the risk of cancer, fall-related injuries and other conditions.

**Overweight/Obesity:** The prevalence of obesity and overweight individuals (according to body mass index) for the region was comparable to state but nonetheless extremely high with approximately 50 percent of the population reporting as either overweight or obese.

Obesity/overweight was perceived to be the first or second most significant health problem across all of the groups in the survey.

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**Addison Gilbert Hospital ED-SBIRT Program**

**Brief Objective or Description:** The goal of this project is to increase prevention by reinforcing healthy patient behaviors and reducing dependent and high-risk substance use behaviors and the co-occurring underlying issues as indicated for all Addison Gilbert Hospital (AGH) emergency department patients beginning at 12 years of age. With expansion of the ED-SBIRT program from one to two part-time Health Promotion Advocates, all youth entering the Addison Gilbert Hospital Emergency Department, who have parent approval and are not physically incapacitated, will have the opportunity to talk with a Health Promotion Advocate to receive high-quality, preventive patient-centered care, increased education and service referrals for substance use and related behavioral health or other underlying issues.

The ED-SBIRT model has proven its effectiveness—and exceeded expectations—over the year-long pilot at AGH at both the patient level and at the systemic level to improve communication and outcomes among high-risk alcohol and drug users. ED-SBIRT is designed to meet the unique challenges of high-volume and fast-pace Emergency Departments. Integral to the model is a substance abuse liaison, called a *Health Promotion Advocate* (HPA), who, in the “teachable moment” during the ED experience, provides both preventive care and immediate support for those with high-risk substance use, their families and peers.

**Status:** We have successfully grown the ED-SBIRT program by hiring a second HPA. In addition, we are also in the very early stages of implementing the pediatric ED-SBIRT program. As it relates to sustainability, we have identified a billing model that will allow for sustainability when the grant funding has been fully allocated.

**Partners:** Lahey Health Behavioral Services, Boston University School of Public Health BNI ART Institute.

**Detailed Description:** Mental Health: Depression, anxiety and stress are major health issues throughout the nation, and these conditions place significant burdens on individuals, families and communities. Numerous national studies have shown that many of the leading chronic illnesses, such as diabetes and heart disease, are linked to mental illness and the rates of co-occurring physical and mental illness are extremely high. Mental illness also plays a significant role in increasing healthcare expenditures.
and is responsible for a large proportion of total hospital emergency department visits and inpatient stays. Numerous data elements from the survey and the state quantitative morbidity and mortality data highlight the burden that it places on the region, especially among low-income populations.

**Poor Mental Health:** Regionally, the proportion of survey respondents who reported being in poor mental health more than 15 days in a given month was comparable to the state. However, among low-income populations overall and cities/towns with higher proportions of low-income populations, the proportion of people reporting this level of illness was higher. *(Poor Mental Health > 15/month: Overall survey sample: 9 percent; low income: 18 percent; state: 9 percent)* Source: 2012 Community Health Needs Assessment

**Depression and Anxiety:** The proportion of people in the overall survey sample who reported being sad/blue more than 15 days in a given month was significantly smaller than the proportion of those who reported this level of illness in low-income brackets. Similarly, the proportion of people in the overall survey sample who reported being tense or anxious more than 15 days in a given month was also smaller than the proportion of people who reported this level of illness in the low-income population. *(Sad/Blue > 15/month: Overall survey sample: 8 percent; low income: 18 percent) (Tense/Anxious > 15/month: Overall survey sample: 12 percent, low income: 26 percent)* Source: 2012 Community Health Needs Assessment

**Substance Abuse:** Like mental health, substance abuse is evident across all income and geographic groups, and it causes significant burdens and loss of productivity upon individuals, families and communities. Substance abuse increases healthcare expenditures as well as community expenditures on law enforcement and incarceration. The extent to which many segments of the region’s population abuse alcohol and prescription drugs were one of the more dramatic findings in the assessment. Regionally, those who responded to our survey were much more likely to report as “heavy” alcohol drinkers (more than seven drinks a week for women and more than 14 drinks a week for men) or binge drinkers (more than four drinks at any one sitting for women and more than five drinks at any one sitting for men) than those in the state overall. Regionally, high proportions of the population also abused prescription drugs.

**Heavy and Binge Drinking:** The proportion of survey respondents who reported as heavy drinkers was significantly higher than the proportions for the state, particularly in the more affluent areas of the region.


**Prescription Drug Abuse:** A large proportion of people who responded to the survey reported abusing prescription drugs, particularly in the low-income brackets. *(Prescription Drug Abuse: Overall survey sample: 9 percent; low income: 16 percent)* Source: 2012 Community Health Needs Assessment Random Sample Survey
Addison Gilbert Hospital / Gloucester Public Schools
Diabetes Program

**Brief Objective or Description:** The most recent Community Health Needs Assessment demonstrated the alarmingly high rate of diabetes in the Gloucester community. Upon the public release of the Community Health Needs Assessment Executive Summary, Cindy Junker, RN Lead Nurse for the Gloucester Public School System approached hospital staff members regarding her concern about the elevated number of students in Gloucester Public Schools that have a diabetes diagnosis. Immediately, planning began to implement a support and education group for students to participate in after the school day.

**Status:** In Fiscal Year 2013, we were able to conduct a monthly session for students. The following is a summary of the types of programs that were facilitated.

Lisa Watson, LICSW, Medical Psychology Center of Beverly provided a therapist for the first session to discuss how it feels to be different from other students, how to cope and resolve these issues.

Dietitian Lynn Larsen, Clinical Nutrition Manager provided information on good nutrition, staying on track and recipe ideas.

Mike Muldoon, Rehabilitation Services, provided information on exercises to stay fit.

Karen Pischke, BSN, RN, CCRN, Certified Hypnotherapist, Reiki Master Teacher, Tobacco Treatment Specialist; Dreamtime Wellness: Promoting Optimal Wellness for Body, Mind & Spirit provided a Reiki session and stress management.

David Gauvin, Food & Nutrition Services, Addison Gilbert Hospital, provided recipes for healthy shakes.

Lisa Watson, LICSW, Medical Psychology Center of Beverly, spoke at the end of the program regarding stress management and staying on track.

**Partners:** Gloucester Public School System, Unidine and Medical Psychology Center of Beverly

**Detailed Description:** Chronic diseases such as diabetes, heart disease, stroke, hypertension, respiratory disease and cancer are the major causes of morbidity, disability and mortality, both in the region and the state. These conditions are, in fact, among the leading causes of death across the nation. Caused by a mixture of factors including genetic, environmental and lifestyle, chronic diseases are pervasive, difficult to treat and occur in an increasing proportion of our society. The regional prevalence, hospitalization, and death rates for chronic diseases are comparable to the rates at the state level in almost all cases but there are some important exceptions, particularly with respect to diabetes and hypertension. There is also some indication that some residents in the region are not properly engaged or receiving appropriate preventive, acute, or chronic disease management service in primary care, as evidenced by higher rates of hospital emergency department and hospital inpatient utilization for some conditions.

**Diabetes:** Relative to the state, residents of the North Shore and Cape Ann region are more likely to have diabetes, particularly those in low-income categories. *(Overall survey sample: 13 percent; low income: 15 percent; state: 7 percent)* Source: 2012 Community Health Needs Assessment
First Parish Church Community Supper Program

**Brief Objective or Description:** Northeast Hospital Corporation funded a weekly supper program, which drew more than 2,200 patrons in Fiscal Year 2013. NHC funding allowed the First Parish Church to provide a hot and nutritious meal every Tuesday night. Often, this meal was the only meal of the day for patrons.

**Status:** To provide funding to allow the First Parish Church in Beverly to continue their Tuesday supper program, while being able to provide meals for the ever growing number of attendees.

**Partners:** First Parish Church in Beverly, MA

**Detailed Description:** Given persistent unemployment and homelessness, the need to feed people in Beverly has never been greater. Beverly Bootstraps experienced a record amount of requests for assistance in 2013. In the past 12 months, we saw a 10 percent increase in the average attendance in the weekly supper program. The parish feeds people from all walks of life including families and children.

NHC Community collaborative grant program

**Brief Objective or Description:** In Fiscal Year 2013 NHC funded four community collaborative projects. The grant funding is focused on mental health/substance abuse, chronic disease management and wellness, and access to health and education.

Each year, about 33 percent of Americans experience some type of mental health or substance abuse problem. Through this grant, NHC hopes to develop new community partnerships and raise awareness of the risk factors and available resources to help tackle mental health and substance abuse issues.

Heart disease, cancer, stroke and diabetes are leading causes of death on the North Shore, and the region’s residents also have higher smoking rates and participate less in regular exercise compared to the state as a whole. Through this grant, NHC hopes to increase access to preventative screenings, diagnosis and treatment services so that patients can better manage their diseases, and also increase access to educational resources relating to chronic disease prevention and management.

Inequitable access to health education, services and resources is an ongoing issue in our communities. Through this grant, NHC hopes to increase collaboration among public health partners and agencies, schools, advocacy groups, nonprofits and other social service providers to reach at-risk and underserved populations.

**Status:** Northeast Hospital Corporation launched a new Community Collaborative Grant to address significant health issues in our North Shore communities. The grant program is a key aspect of the NHC community benefit program and is a direct result of our most recent Community Health Needs Assessment. Through the grant, NHC awarded four $10,000 grants for innovative, community-based initiatives in one of three key areas: 1) promotion of mental and behavioral health education, prevention and early intervention; 2) promotion of healthy lifestyles, and 3) improving chronic disease prevention (including diabetes, stroke, cancer and heart disease); and those that improve access to health services and resources in the community.
Partners: Organizational initiative

Detailed Description: In Fiscal Year 2013, Addison Gilbert and Beverly Hospitals funded four community-based projects. The first was to the Sterling Center YMCA/Be Healthy Beverly to implement a raised-bed garden program with curriculum at each of the five Beverly public elementary schools. The second was to the Grace Center in Gloucester to expand their current case management offerings to clientele who suffer from mental health and substance abuse related healthcare issues. The third funded proposal was the Beverly Public Schools Integrated Comprehensive Resources in Schools program, which calls for expanded mental health coverage in the school nurse's office for students. The fourth funded project was from Express Yourself, Inc. in Beverly. The grant dollars were used to expand upon their creative outreach program for children who are coping with behavioral health issues through art and music.

Pioneering Healthier Communities Grant (Be Healthy Beverly)

Brief Objective or Description: The Greater Beverly YMCA, with a grant funded by the Centers for Disease Control and in partnership with Beverly Hospital, Beverly Public Schools and other community organizations, is launching a new healthy-living movement known as Be Healthy Beverly. The group's first area of focus over the past year has been to join the national effort to combat childhood obesity and support the new nutrition standards in the National School Lunch Program.

Status: Be Healthy Beverly expanded upon the highly successful fruit and vegetable bars in all five Beverly public elementary school cafeterias by incorporating raised-bed gardens in each school as well. Green City Growers was contracted by Be Healthy Beverly to implement a science and math curriculum utilizing the raised-bed gardens. Research has demonstrated that food consumed by children during the school day has a significant impact on both health and education outcomes. This program and garden maintenance is funded by Beverly Hospital.

Partners: Greater Beverly YMCA, Beverly Public Schools, City of Beverly, Beverly Bootstraps, North Shore United Way, Boston Children’s Hospital, Beverly Recreation Department, Beverly Public Health Department, Beverly School Committee, and the Food Project.

Detailed Description: There are a number of risk factors that have a major impact on chronic disease and the general level of health for individuals and communities. The risk factors with the greatest health effects are overweight/obesity, lack of physical exercise, poor nutrition and smoking. These factors can lead to a variety of conditions such as diabetes, heart disease, hypertension, COPD, asthma, cancer and arthritis. Obesity is a particular and increasing problem at a national and state level, as well as at a regional level. Conversely, healthy habits and behaviors with respect to nutrition and physical exercise can be protective and improve heart and lung function, diabetes control and hypertension, and reduce the risk of cancer, fall-related injuries and other conditions.

Overweight/Obesity: The prevalence of obesity and overweight individuals (according to body mass index) for the region was comparable to the state, but nonetheless extremely high with approximately 50 percent of the population reporting as either overweight or obese. Obesity/overweight was perceived to be the number one or two most significant health problem.
ImPACT Baseline Concussion Testing

Brief Objective or Description: The Beverly Hospital Concussion Management Program adopted the use of ImPACT in March 2013. ImPACT (Immediate Post-Concussion Assessment and Cognitive Testing) is the most-widely used and most scientifically validated computerized concussion evaluation system. ImPACT provides trained clinicians with neurocognitive assessment tools and services that have been medically accepted as state-of-the-art best practices as part of determining safe return to play decisions.

Through tools such as the ImPACT Concussion Management Model, ImPACT addresses the need for an accurate, medically accepted assessment system that is used as part of an overall concussion management protocol. This model builds partnerships with healthcare professionals and athletic trainers to offer training and resources for affordable concussion management. ImPACT benefits athletes at all levels of play, from professional sports teams to students and their parents.

ImPACT has received numerous accolades and endorsements from many of the world’s leading sports authorities, governing bodies, teams and athletes. Currently, more than 10,000 medical professionals have been trained by ImPACT on concussion management and the ImPACT Program. ImPACT is in use by many teams in Major League Baseball, National Hockey League, National Football League and World Wrestling Entertainment. More than 7,400 high schools, 1,000 colleges and universities, 900 clinical centers, 430 credentialed ImPACT consultants, 200 professional teams and select military units use ImPACT.

Status: Addison Gilbert and Beverly Hospitals donated $500 per high school, allowing the schools to purchase baseline testing packages from ImPACT. In Fiscal Year 2013, more than 300 baseline tests were completed at Beverly and Ipswich high schools. At Beverly High School, we baseline tested freshman, sophomore, junior and senior classes both male and female in the following sports: soccer, football, cheering, field hockey and volleyball. At Ipswich High School, we were able to baseline test all of the aforementioned sports at Beverly High School, in addition to the lacrosse teams. The plan for Fiscal Year 2014 will call for expansion to Gloucester High School and one additional school with baseline testing for all student-athletes occurring for the 2014/2015 school year in May 2014.

Partners: Beverly High School and Ipswich High School

Detailed Description: The ImPACT test is:

- One important piece of the overall concussion evaluation and management process;
- A sophisticated test of cognitive abilities;
- The most scientifically researched concussion management tool;
- A tool that can help healthcare professionals track recovery of cognitive processes following concussion;
- A tool to help communicate post-concussion status to athletes, coaches, parents and clinicians; and
- A tool that helps healthcare professionals and educators make decisions about academic needs following concussion.

The ImPACT test is not:
• A “panacea” or cure-all for concussion, as there is no such thing. As long as contact to the head occurs, concussion will continue to happen.

• A tool to diagnose concussion, which should always be diagnosed by a qualified healthcare provider.

• A substitute for medical evaluation and treatment.

(Source: Impacttest.com)

Serving the Health Insurance Needs of Everyone (SHINE)

Brief Objective or Description: The SHINE (Serving the Health Insurance Needs of Everyone) Program provides health insurance counseling services to Massachusetts residents. SHINE counselors are trained to handle complex questions about Medicare, Medicare supplements, Medicare Health Maintenance Organizations, public benefits with healthcare components, Medicaid, free hospital care, prescription drug assistance programs, drug discount cards and long-term health insurance.

Status: In Fiscal Year 2013, SHINE counselors managed 1,803 client contact forms.

Partners: Rose Baker Senior Center, Gloucester; Beverly Council on Aging; Rockport Council on Aging and the Cape Ann Farmer’s Market

Detailed Description: With the passage of the Massachusetts healthcare reform law in 2006, Massachusetts became the first state in the nation to adopt measures that would lead to nearly universal health coverage. As a result, almost everyone in the state has comprehensive health insurance. The North Shore area also has a comprehensive array of health and social service organizations that are able to provide nearly all of the enabling, supportive, preventive, acute, chronic disease management, specialty care, hospital-based and other community-based services needed.

The most significant issues with respect to access to care were related to dental services, particularly for adults and mental health and substance abuse services for low-income and middle-income brackets. In addition, a significant proportion of the population in the region struggled to access prescription drugs, due primarily to the cost of co-pays and deductibles. Access to care was also affected by transportation and cost barriers, which were by far the two most significant barriers to care for those in the region. These issues have a particularly strong impact on low-income and older adult populations that are most likely to be isolated and struggle financially.

Health Insurance Status: Health insurance rates in the region were high and comparable to state rates. (Health Insurance: Overall survey sample: 95 percent; state: 96 percent) Source: 2012 Community Health Needs Assessment

Usual Source of Care: Nearly everyone had access to a primary care provider or doctor. (Regular PCP or Doctor: Overall survey sample: 96 percent; state: 91 percent) Source: 2012 Community Health Needs Assessment

Dental Insurance: Significant proportions of the population in the region lack dental insurance. (Dental Insurance: Overall survey sample: 40 percent; low income: 58 percent) Source: 2012 Community Health Needs Assessment
No Dental Care: Significant proportions of the population in the region had no dental care in the past 12 months. *(No Dental Care in Past Year: Overall survey sample: 27 percent; low income: 45 percent; state: 19 percent)*. Source: 2012 Community Health Needs Assessment

No Prescription Drugs: Significant proportions of the population in the region were unable to obtain prescription drugs due to cost. *(No prescription drug: Overall survey sample: 12 percent; low income: 23 percent)*. Source: 2012 Community Health Needs Assessment

**Skin Cancer Clinic**

**Brief Objective or Description:** Addison Gilbert and Beverley Hospitals work collaboratively in partnership with the American Cancer Society and the Melanoma Foundation of New England on a free community skin cancer clinic. Patients call to schedule an appointment with one of our oncologists. At the clinic, patients are provided with a thorough examination and information on skin cancer prevention. If they were in need of further evaluation and treatment, the findings could be shared with their primary care physician.

The goal of the program is to educate patients and offer them preventative services. NHC oncologists and oncology nurses partner to help intervene with early detection of skin cancer.

**Status:** In Fiscal Year 2013, a total of 79 patients participated in two community skin cancer clinics. Out of the 37 patients, 20 needed further treatment and or evaluation. Residents from 19 communities attended.

**Partners:** American Cancer Society, Melanoma Foundation of New England

**Detailed Description:** A great amount of the communities we serve at NHC are coastal communities with many public and private beaches, increasing exposure and risk to our residents seriousness of all cancers. Hospitalization and death rates for cancer (all-types) is comparable or lower than the state rate for all cities/towns in the region, but there are a number of notable exceptions where certain cities/towns have higher rates for certain cancers. *(Cancer death rate per 100,000 – all types: Essex County: 182; state: 183)*. Source: 2012 Community Health Needs Assessment

**Speakers Bureau**

**Brief Objective or Description:** The Beverly and Addison Gilbert Hospitals Speakers Bureau is a free service designed to bring timely information on a variety of health-related topics. Speakers include physicians, registered nurses, dietitians, physical therapists, pharmacists and other healthcare professionals. Speakers provide information about healthy living and illness prevention.

**Status:** Provide information about healthy living and illness prevention for the following health-related topics: neurological health, cardiac health, cancer, senior health, infectious disease, child development, parenting, diabetes, fitness/exercise, memory loss/dementia/Alzheimer's disease, arthritis and joint pain, ophthalmology, behavioral health, nutrition, women's health, nervous system, nephrology, men's health,
respiratory, hypertension and chronic pain management.

**Partners:** Town of Ipswich; Hamilton Wenham Regional School District; Beverly High School; North Shore YMCA; North Andover Council on Aging; Middleton Men’s Club; Manchester Men’s Club; Rowley Public Library; Babies"R"US in Danvers; Gorton’s of Gloucester; Tannery Apartments, Peabody; Peabody Council on Aging; Herrick House; Turtle Creek; Spectrum Adult Day Health, Beverly; Spectrum Adult Day Health, Andover; Faith Christian School, Gloucester; Cape Ann TV; Gloucester High School; Gloucester Health Department; Shaws, Eastern Avenue, Gloucester; The Open Door Food Pantry; Willowood Gardens, Gloucester; Rockport Council on Aging; Gloucester Council on Aging; Greater Lynn Senior Services; Cruiseport Gloucester; TRU Corporation, Peabody; North Shore Community College; Salem State University; Rockport High School and Endicott College

**Detailed Description:** In Fiscal Year 2013, the Speakers Bureau program conducted 50 free community presentations accounting for a total of 55 hours. Presentations occurred in Gloucester, Danvers, Beverly, North Andover, Andover, Manchester, Hamilton, Wenham, Rockport, Rowley, Peabody and Salem.

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**Massachusetts Opioid Abuse Prevention and Collaborative (MOAPC) Program**

**Brief Objective or Description:** The MOAPC grant is meant to address the issue of opioid misuse and abuse, unintentional deaths and non-fatal hospital events associated with opioid poisonings on a regional scale. Partnership in this grant includes the City of Gloucester, City of Beverly and Town of Danvers. The partnership will use grant funding to accomplish the following: 1) Assessment. The inclusive and comprehensive assessment process will seek to expand and leverage the existing strengths of each community and the success of the Healthy Gloucester Collaborative, implementing sustained policy and practice systems changes. 2) Capacity Building. The partnership will convene leaders and stakeholders in each community, train community stakeholders and service providers, leverage existing resources and engage community members to sustain activities. 3) Planning. The partnership will work together to implement a common planning process based upon the agreed template of the lead community, prepare a written community strategic plan and collaborate to maximize resource efficiencies and progress against identified priorities at both the partnership and community level.

**Status:** The partnership is currently in the capacity-building phase at the time this report is published.

**Partners:** Gloucester Public Health Department, City of Gloucester, Healthy Gloucester Collaborative, DanversCARES, Town of Danvers, Be Healthy Beverly, Beverly Public Health Department and City of Beverly

**Detailed Description:** Substance abuse is evident across all income and geographic groups, and it causes significant burdens and loss of productivity for individuals, families and communities. Substance abuse increases healthcare expenditures as well as community expenditures on law enforcement and incarceration. The extent to which many segments of the region’s population abuse alcohol and prescription drugs were one of the more dramatic findings in the assessment. Regionally, high proportions of the population also abused prescription drugs.
Support Groups

**Brief Objective or Description:** In Fiscal Year 2013, Addison Gilbert and Beverly Hospitals hosted 201 support group sessions. We offered 18 different types of support groups, totaling 305 hours. We hosted support groups at Beverly Hospital, Lahey Outpatient Center, Danvers and Addison Gilbert Hospital.

**Status:** Based on the findings of our most recent Community Health Needs Assessment, we will 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 help to inform, console and lift the spirit—all part of the healing process.

**Partners:** Organizational initiative

**Detailed Description:** Support groups include: Breast Cancer, General Cancer, Melanoma, Prostate Cancer, Connecting Young Moms, Mother Time, Alzheimer’s Disease, Early State of Memory Loss, Post-Partum, Infant Loss, Stroke, Widowed Persons, Military Family, Polycythemia Vera, Epilepsy, Nicotine Anonymous, Stroke, Ostomy, Diabetes and Child Loss. All support group programs are free to the community.

Community Outreach Overview Fiscal Year 2013

In addition to our well-established Community Benefits Program, Addison Gilbert and Beverly Hospitals also has a diverse and far-reaching community outreach program that provides support to local communities in a variety of ways which include, but are not limited to, food and clothing drives, employee volunteerism, health fairs, sponsorships, leadership on local nonprofit and community boards and a state-approved model for medication and sharps disposal.

In Fiscal Year 2013, Addison Gilbert & Beverly hospitals also conducted the following community benefit programming:

- Weekly podiatry clinic at Lahey Outpatient Center, Danvers
- Pediatric language assessment open house(s)
- Hearing clinics
- Five American Red Cross blood drives
- Weekly glucose screenings
## Fiscal Year 2013 Required Financials (Draft)

### Community Benefits Programs

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### Community Services Programs

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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 or HMO 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 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 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 healthcare or social needs of Massachusetts communities, but is not related to the priorities or target population identified in the hospital 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 non-contractual 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 healthcare or public health services volunteered.
by healthcare providers employed by the hospital or HMO should be calculated using either (a) the rate of the employee’s pay, or (b) the average hourly rate for Massachusetts healthcare workers as calculated by the Centers for Medicare and Medicaid Services for purpose of the Medicare Area Wage Index during the reported fiscal year ($25 in 2001). The value of non-healthcare services volunteered by any employee should be calculated using the standard hourly rate set by the Independent Sector, a Washington, D.C.-based coalition of voluntary organizations, foundations and corporate giving programs, during the reported fiscal year ($15.39 in 2001).

**Other Leveraged Resources:** Funds and services contributed by third parties for the express purpose of supporting a hospital or HMO’s Community Benefits or Community Service Programs. These include: 1) services provided by non-salaried 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 fundraising 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, which 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 of time occurring during the reported fiscal year.

**Target Population:** The specific community or communities that are the focus of the hospital 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 healthcare).

**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.