Community Benefits Report

Fiscal Year 2024

Beth Israel Lahey Health
Beverly Hospital

Beth Israel Lahey Health
Addison Gilbert Hospital

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SECTION I: SUMMARY AND MISSION STATEMENT

Northeast Hospital Corporation (NHC), also known as Beverly and Addison Gilbert Hospitals (BH/AGH) is a member of Beth Israel Lahey Health (BILH). The BILH network of affiliates is an integrated health care system committed to expanding access to extraordinary patient care across Eastern Massachusetts and advancing the science and practice of medicine through groundbreaking research and education. The BILH system is comprised of academic and teaching hospitals, a premier orthopedics hospital, primary care and specialty care providers, ambulatory surgery centers, urgent care centers, community hospitals, homecare services, outpatient behavioral health centers, and addiction treatment programs. BILH's community of clinicians, caregivers and staff includes approximately 4,000 physicians and 35,000 employees.

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

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

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

The Community Benefits Program at BH/AGH partners with community leaders and organizations to assess and meet the health care needs of the community. Strategies used in community benefits health activities include prevention, early detection, early intervention, long-term management, and collaborative efforts with the affiliated 3 organizations that make up the BILH system. Health issues addressed encompass safety, chronic disease, infectious disease, substance abuse, mental health, maternal and child health, and elder health.

The following annual report provides specific details on how BH/AGH is honoring its commitment and includes information on the hospitals' Community Benefits Service Area (CBSA), community health priorities, target populations, and community partners as well as detailed descriptions of its Community Benefits programs and their impacts.

More broadly, BH/AGH's Community Benefits mission is fulfilled by:

- **Involving BH/AGH's staff**, including its leadership and dozens of community partners in the Community Health Needs Assessment (CHNA) process as well as in the development, implementation, and oversight of the hospital's three-year Implementation Strategy (IS);

- **Engaging and learning from residents** throughout BH/AGH's Community Benefits Service Area (CBSA) in all aspects of the Community Benefits process, with special attention focused on engaging diverse perspectives, from those, patients and non-patients alike, who are often left out of similar assessment, planning and program implementation processes;

- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to understand unmet health-related needs and identify communities and population segments disproportionately impacted by health issues and other social, economic and systemic factors;

- **Implementing community health programs and services** in BH/AGH's CBSA that address the underlying social determinants of health, barriers to accessing care, as well as promote equity to improve the health status of those who are often disadvantaged, face disparities in health-related outcomes, experience poverty, and have been historically underserved;

- **Promoting health equity** by addressing social and institutional inequities, racism, and bigotry and ensuring that all patients are welcomed and received with respect and have access to culturally responsiveness care; and

- **Facilitating collaboration and partnership within and across sectors** (e.g., state/local public health agencies, health care providers, social service organizations, businesses, academic institutions, community health collaboratives, and other community health organizations) to advocate for, support, and implement effective health policies, community programs, and services.

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

Priority Cohorts

BH/AGH's CBSA includes the towns of Ipswich, Essex, Gloucester, Rockport, Manchester-by-the-Sea, Beverly, Danvers, Middleton, and Lynn. In FY 2022, BH/AGH conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included extensive data collection activities, substantial efforts to engage BH/AGH's partners and community residents, and thoughtful prioritization, planning, and 4 reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. While BH/AGH is committed to improving the health status and wellbeing of those living throughout its entire CBSA, per the Commonwealth's updated community benefits guidelines, BH/AGH's FY 2023 - 2025 Implementation Strategy (IS) will focus its Community Benefits resources on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved living in its CBSA.

Based upon BH/AGH's FY 2022 CHNA, the community characteristics that were thought to have the greatest impact on health status and access to care in its CBSA were issues related to age, race/ethnicity, language, disability status, and immigration status. Residents in the CBSA were predominantly white and born in the United States, but there were non-white, people of color, recent immigrants, non-English speakers, and foreign-born populations in all communities. There was consensus among interviewees and focus group participants

that older adults, people of color, individuals with disabilities, recent immigrants and non-English speakers were more likely to have poor health status and face systemic challenges accessing needed services than young, white, English speakers who were born in the United States. While relatively small, these segments of the population were impacted by language barriers, cultural barriers, and stigma that limited access to appropriate services, posed health literacy challenges, exacerbated isolation, and may have led to discrimination and disparities in access and health outcomes. For its FY 2023 – 2025 IS, BH/AGH will work with its community partners to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, BH/AGH's Community Benefits investments and resources will focus on the improving the health status of the following priority cohorts:

- Youth
- Low-Resourced Populations
- Older Adults
- Racially, Ethnically and Linguistically Diverse Populations

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

Key Accomplishments for Reporting Year
The accomplishments and activities highlighted in this report are based upon priorities identified and programs contained in BH/AGH's FY 2022 Community Health Needs Assessment (CHNA) and FY 2023-2025 Implementation Strategy (IS):

- Beverly Bootstraps provided weekly mobile markets to 12 housing sites in Beverly, reaching more than 5,000 residents. More than 50,000 pounds of food was distributed via the markets.

- Action Inc. Welcome Home Program secured and maintained permanent housing for 12 individuals experiencing chronic homelessness.

- Breast Cancer Risk Assessment – provided 7,552 free breast Cancer Risk Assessment (CRA) screenings, identifying 2,358 women at high risk and 1,340 with a high lifetime risk of developing breast cancer.

- Collaborative Care Model – reached 1,430 patients in eleven primary care practices.

- Compass Moms Do Care Program provided Case Management support for 91 pregnant or parenting women with a history of substance use.

- Massachusetts Coalition for the Homeless "CASA" Program – assisted 1,736 households experiencing housing instability, and at risk of homelessness.

- The Open Door Medically Tailored Groceries Program provided healthy foods along with free nutritional counseling and educational workshops to than 1,200 community members,

- Wellspring House "Accelerating Access to Higher Education" Program – provided education, job training and career advising to 346 adults to help them obtain employment or transition to employment with higher wages.

Plans for Next Reporting Year

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

- Equitable Access to Care
- Social Determinants of Health
- Mental Health and Substance Use
- Complex and Chronic Conditions.

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). BH/AGH's priorities are also aligned with the priorities identified by the Massachusetts Department of Public Health (DPH) to guide the Community-based Health Initiative (CHI) investments funded by the Determination of Need (DoN) process, which underscore the importance of investing in the Social Determinants of Health (i.e., built environment, social environment, housing, violence, education, and employment).

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

Hospital Self-Assessment Form

Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), the BH/AGH Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 56). The BH/AGH Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members and asked them to submit the form to the AGO website.

SECTION II: COMMUNITY BENEFITS PROCESS

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

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

Among BH/AGH's core values is the recognition that the most successful Community Benefits programs are implemented organization wide and integrated into the very fabric of the hospital's culture, policies, and procedures. A commitment to Community Benefits is a focus and value manifested throughout BILH and BH/AGH's structure and reflected in how care is provided at the hospital and in affiliated practices.

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

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The BH/AGH Community Benefits program is spearheaded by the Regional Community Benefits/Community Relations Manager. The Regional Community Benefits/Community Relations Manager has direct access and is accountable to the BH/AGH President and the BILH Vice President of Community Benefits and Community Relations, the latter of whom reports directly to the BILH Chief Diversity, Equity and Inclusion Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of cohorts who have been historically underserved are considered every day in discussions on resource allocation, policies, and program development.

This structure and methodology are employed to ensure that Community Benefits is not the purview of one office alone and to maximize efforts across the organization to fulfill the mission and goals of BILH and BH/AGH's Community Benefits program.

Community Benefits Advisory Committee (CBAC)
The BH/AGH Community Benefits Advisory Committee (CBAC) works in collaboration with BH/AGH's hospital leadership, including the hospital's governing board and senior management to support BH/AGH's Community Benefits mission to work collaboratively with BH/AGH's communities to address the leading health issues and create a healthy future for individuals, families, and communities. The CBAC provides input into the development and implementation of BH/AGH's Community Benefits programs in furtherance of BH/AGH's Community Benefits mission. The membership of BH/AGH's CBAC aspires to be representative of the constituencies and priority cohorts served by BH/AGH's programmatic endeavors, including those from diverse racial and ethnic backgrounds, age, gender, sexual orientation and gender identity, as well as those from corporate and non-profit community organizations.

The BH/AGH CBAC met on the following dates:
January 9, 2024, March 26, 2024, June 24, 2024, September 26, 2024 (Annual Public Meeting)

Community Partners
BH/AGH recognizes its role as a community hospital in a larger health system and to be successful needs to collaborate with its community partners and those it serves. BH/AGH's Community Health Needs Assessment (CHNA) and associated Implementation Strategy (IS) were completed in collaboration with BH/AGH's staff, community residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership and other collaborators from its CBSA. BH/AGH's Community Benefits program exemplifies the spirit of collaboration that is a vital part of BH/AGH's mission.

BH/AGH currently supports numerous educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA. In this work, BH/AGH collaborates with many of its local community-based organizations, public health departments, municipalities and clinical and social service organizations.

The following is a list of the community partners with which BH/AGH joins in assessing community need as well as planning, implementing, and overseeing its Community Benefits Implementation Strategy. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment.

- Action Inc.
- American Cancer Society
- Backyard Growers
- Beverly Bootstraps
- CHNA 13/14
- City of Beverly
- City of Gloucester
- DanversCares
- Gloucester Police Department
- Greater Lynn Senior Services
- MA Coalition for Homeless
- North Shore Community College
- North Shore YMCA
- Pathways4Children
- SeniorCare, Inc.
- The Open Door
- Town of Danvers
- Town of Essex
- Town of Ipswich
- Town of Manchester-by-the-Sea
- Town of Middleton
- Town of Rockport
- Wellspring House

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY 2022 Community Health Needs Assessment (CHNA) along with the associated FY 2023-2025 Implementation Strategy was developed over a twelve-month period from September 2021 to September 2022. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill the BH/AGH's need to conduct a community health needs assessment, engage the community, identify priority health issues, inventory community assets, assess impact, and develop an Implementation Strategy. However, these activities are driven primarily by BH/AGH's dedication to its mission, its covenant to cohorts who have been historically underserved, and its commitment to community health improvement.

As mentioned above, BH/AGH's most recent CHNA was completed during FY 2022. FY 2024 Community Benefits programming was informed by the FY 2022 CHNA and aligns with BH/AGH's FY 2023 – FY 2025 Implementation Strategy. The following is a summary description of the FY 2022 CHNA approach, methods, and key findings.

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

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

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

Between October 2021 and February 2022, BH/AGH conducted 18 one-on-one interviews with key collaborators in the community, facilitated 3 focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 1,341 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 1,400 community residents, clinical and social service providers and other community partners.

The articulation of each specific community's needs (done in partnership between BH/AGH and community partners) is used to inform BH/AGH's decision-making about priorities for its Community Benefits efforts. BH/AGH works in concert with community residents and leaders to design specific actions to be collaboratively undertaken each year. Each component of the plan is developed and eventually woven into the annual goals and agenda for the BH/AGH's Implementation Strategy that is adopted by the BH/AGH's Board of Trustees.

Summary of FY 2022 CHNA Key Health-Related Findings

Equitable Access to Care

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

Social Determinants of Health

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

Mental Health and Substance Use

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

Complex and Chronic Conditions

- Chronic conditions such as cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease contribute to 56% of all mortality in the Commonwealth and over 53% of all health care expenditures ($30.9 billion a year). Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

For more detailed information, see the full FY 2022 BH/AGH Community Health Needs Assessment and Implementation Plan Report on the hospital's website at https://beverlyhospital.org/-/media/files/beverly/bh-agh-2022-community-health-needs-assessment-093022.pdf

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Equitable Access to Care **Program Name: Interpreter Services** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	An extensive body of research illustrates the health disparities and differences in health care access and utilization that exist for diverse individuals/cohorts and foreign-born populations. Language barriers pose significant challenges to providing effective and high-quality health and social services. To address this need, and in recognition that language and cultural barriers are major difficulties to accessing health and social services and navigating the health system, BH/AGH offers free interpreter services for non-English speaking, limited-English speaking, deaf and hard-of-hearing patients. These services are provided in person; by phone using a portable speaker phone to connect patients, their care team and an interpreter; and through video-based remote interpreter service using a computer to connect patients with an interpreter. Professional interpretation services in hundreds of languages are available 24/7.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide access to interpretation and translation services at no cost to BH/AGH patients.	
Goal Status	In FY24, BH/AGH Interpreter Services supported 354,591 patients. The top 3 languages were Spanish, Brazilian, and Portuguese.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Pharmacy Assistance Program** **Health Issue: SDOH (Access to Care)**		
Brief Description or Objective	Northeast Hospital Corporation's utilizes BILH mail-order and specialty pharmacies to offer a Patient Assistance Program for patients with family income at or below 300% of the federal poverty level. The pharmacies are registered as a Health Safety Net (HSN) pharmacies and provides courtesy fills for low-income NHC patients to ensure those without insurance leave with their medication. To support patients in accessing medications through the HSN pharmacy program, NHC contracts with the BILH pharmacies to employ patient assistance staff.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To increase access to care by providing financial assistance for prescriptions for low income or uninsured patients.	
Goal Status	In FY24, Beverly Hospital provided $75,374 in financial assistance to low income and/or uninsured patients.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Connecting Young Moms** **Health Issue: Additional Needs (Access to Care)**		
Brief Description or Objective	The Connecting Young Moms (CYM) program offers comprehensive pre- and postnatal programs to young mothers and their children with limited resources and/or emotional/social support. The prenatal component of the CYM program is the Childbirth Preparation Series, designed to prepare expectant mothers and their support people for labor and delivery. The postnatal component is a support group specifically for teens and young women and their children. The program now operates on a hybrid model wherein we offer both in person and virtual options based on what works best for the patients. Topics include healthy relationships, challenges of young parenthood, balancing parenting/work/education, child development, and coping with isolation, stress, job loss, and other challenges. The CYM program also provides extensive resource and referral support to women who do not fully join the program, and those not actively participating.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. To start and maintain a diaper closet for biweekly diaper distribution for those mothers participating in support groups and to work with other community organizations to offer free material needs for their children. 2. Increase the number of referrals into the program.	
Goal Status	1. Robust diaper closet has been established with the ability to offer biweekly diapers. CYM was selected as 1 of 4 agencies to participate in The Bambino Basket Organization which allows monthly clothing/material needs for children at no cost to the client. 2. There were 55 new referrals in FY24.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Equitable Access to Care **Program Name: Serving the Health Information Needs of Everyone (SHINE)** **Health Issue: Social Determinants of Health (Access to Care)**		
Brief Description or Objective	The Serving the Health Information Needs of Everyone (SHINE) program and financial counselors provide free health insurance counseling services to elderly and disabled adults to help navigate coverage options and benefits of various Medicare/Medicaid plans.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To help Medicare beneficiaries and their caregivers navigate their health insurance options. The counselors are also available to review current coverage, compare costs and benefits of available options, and assist those with limited resources in enrolling in helpful programs.	
Goal Status	In FY24, SHINE counselors conducted 1,929 consultations for residents of the North Shore and Cape Ann. Total hours assisting: 1,187	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Equitable Access to Care **Program Name: BILH Workforce Development** **Health Issue: Additional Health Needs Identified by the Community**		
Brief Description or Objective	BILH is strongly committed to workforce development programs that enhance the skills of its diverse employees and provide career advancement opportunities. BILH offers incumbent employees "pipeline" programs to train for professions such as Patient Care Technician, Central Processing Technician and Associate Degree Nurse Resident. BILH's Employee Career Initiative provides career and academic counseling, academic assessment, and pre-college and college-level science courses to employees at no charge, along with tuition reimbursement, competitive scholarships and English for Speakers of Other Languages (ESOL) classes. BILH is also committed to making employment opportunities available to qualified community residents through training internships conducted in partnership with community agencies and hiring candidates referred by community programs.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	In FY24 Workforce Development will: 1. continue to encourage community referrals and hires. 2. attend events and give presentations about employment opportunities 3. offer employees career development services. 4. offer citizenship, career development, and financial literacy classes to BILH employees. 5. offer English for Speakers of Other Languages (ESOL) classes to BILH employees. 6. offer internships in BILH hospitals to community members over the age of 18. 7. hire interns hired after internships and place in BILH hospitals 8. establish clinical affiliation agreements with vocational technical high schools to hire young people from the community for cooperative education paid and unpaid internships in nursing assistant, medical assistant, and other hospital-specific positions.	
Goal Status	In FY24: 1. 412 job seekers were referred and 111 were hired across BILH hospitals. 2. 33 events and presentations were conducted with community partners across the BILH service area. 3. 1,044 BILH employees received career development services. 4. 14 BILH employees attended citizenship classes, 15 BILH employees attended career development workshops and 207 BILH employees attended financial literacy classes. BH/AGH employees participated in these offerings. 5. 82 employees across BILH were enrolled in ESOL classes. BH/AGH employees participated in these classes. 6. 107 community members placed in internships across BILH hospitals to learn valuable skills. BH/AGH participated in offering these internships. 7. 37 interns were hired permanently in BILH hospitals. BH/AGH participated in hiring. 8. established 10 clinical affiliation agreements with vocational technical high schools, resulting in the hiring of 47 high school students in paid cooperative education placements and 11 into unpaid clinical placements. BH/AGH participated in offering these trainings.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Financial Assistance Counselors** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	Significant segments of the community population living within the hospital's CBSA, particularly low-resourced and BIPOC populations, face significant barriers to care. The hospital's Financial Assistance Program offers emergency and other medically necessary services at low or no cost to qualified patients (when qualifying family income is at or below 400% of the Federal Poverty Level). The hospital's Financial Counseling staff screen people and assist them in applying for all eligible financial assistance programs.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Each year, BH/AGH will screen and enroll eligible patients into entitlement programs.	
Goal Status	In FY24, staff screened 1300 patients for eligibility and enrolled 1053 patients into entitlement programs. Of these patients, 889 were enrolled in MassHealth and 24 uninsured patients utilized Health Safety Net.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Diversity, Equity, and Inclusion** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	BILH Community Benefits sits within the Office of Diversity, Equity and Inclusion (DEI). BILH's Office of Diversity, Equity, and Inclusion develops and advocates for policies, processes and business practices that benefit the communities and our workforce. The DEI vision is to "Transform care delivery by dismantling barriers to equitable health outcomes and become the premier health system to attract, retain and develop diverse talent."	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Across BILH, increase BIPOC representation among new leadership (directors and above) and clinical (physicians and nurses) hires with an aim of at least 25% representation.	
Goal Status	Across BILH, 18% of new hires in leadership (directors and above) and clinical (physicians and nurses) positions identified as BIPOC.	
Program Goal(s)	Increase spend with diverse businesses by 25% over the previous fiscal year across the system.	
Goal Status	More than $70 million was contracted to Women and Minority-owned Business Enterprises (WMBE) in FY24. This is a 28% increase over FY23.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Equitable Access to Care **Program Name: Facilitating Primary and Specialty Care Access** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	Throughout BH/AGH's Community Benefits Service Area, BH/AGH subsidizes primary care services provided by BILH Primary Care or Northeast Medical Practice, Inc.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide access to primary and specialty care for uninsured and underinsured patients	
Goal Status	In FY24, BH/AGH provided primary and specialty care in eight practices in CBSA.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Beverly Bootstraps Mobile Market** **Health Issue: Additional Health Needs (Access to Healthy Foods)**		
Brief Description or Objective	The Mobile Market is a free farmers' market that promotes better health and nutrition and addresses food insecurity by providing low-income Beverly residents with fresh fruits and vegetables in a convenient and socially acceptable way. It provides fresh, nutrient-dense produce to residents of low-income housing complexes throughout Beverly, alleviating the negative impacts of poor nutrition that lead to devastating health consequences. Each week from late June through October the Mobile Market travels to the housing complexes and serves residents directly in their neighborhoods.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. at least 50% of Mobile Market participants utilize other Beverly Bootstraps services between: July 1, 2023 and June 30, 2024; July 1, 2024 and June 30. 2025; and July 1, 2025 and June 30, 2026. 2. By the end of the Mobile Market season (September 2024) and as indicated through client surveys, at least 65% of Mobile Market participants will report that they eat more produce all year long. 3. By the end of the Mobile Market season (September 2024) and as indicated through client surveys, at least 75% of Mobile Market participants will report that they are aware of other Beverly Bootstraps services.	
Goal Status	1. In FY24, 62% of families that participated in our Mobile Market program also utilized other Beverly Bootstraps services. 2. 93% of Mobile Market attendees who were surveyed reported that they were eating more produce as part of their regular diet as a result of attending the Mobile Market. 3. 100% of clients surveyed at the end of the Mobile Market season reported being aware of other Beverly Bootstraps services they were eligible for.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: Backyard Growers agriCulture Program** **Health Issue: Additional Health Needs (Access to Healthy Foods)**		
Brief Description or Objective	Backyard Growers focused on maximizing community engagement with Willowood Commons including its community garden, shared perennial garden, and food-focused infrastructure. Perennial food and herb crops were selected in partnership with families in the community to ensure that the gardens will provide culturally relevant crops. Working alongside residents, BYG staff developed a series of engagement opportunities focused on supporting residents in developing the skills to provide themselves with healthy, low cost food resources.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. Use community input to develop and implement at least 4 workshops by the end of 2023 in the agriCulture space focused on topics including: selecting and planting desired culturally relevant crops, sharing food preparation methods between neighbors of varied cultures, and increasing access to and use of fresh low cost produce. 2. Increase the number of garden users from 50 to 150 by the end of 2024 as measured in attendance and reported garden use (harvesting, planting, cooking with garden-grown produce) through staff-administered surveys. 3. Secure consulting contracts with 2 Housing Authority neighborhoods outside of Gloucester, MA by November 2025 with the shared intent of implementing the consulting model developed in 2024 & 2025.	
Goal Status	1. Survey conducted and 4 workshops planned/conducted: garden closure, garden planning, and two cooking and food preparation workshops. 2. 97 residents used the garden in FY24. 3. Site completed and evaluation of community use started to determine funding.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: Greater Lynn Senior Services "Food & Thought" Program** **Health Issue: Additional Health Need (Access to Healthy Food)**		
Brief Description or Objective	This program addresses nutrition and behavioral health needs via The Phoenix Food Hub (PFH), a "Food Is Medicine" collaboration of the City of Lynn's Food Security Task Force (FSTF). The program focuses on addressing the social determinants of health through a nutrition security gateway serving residents in need throughout Lynn and surrounding areas. The Food and Thought program links nutrition and mental health by ensuring all navigators/Community Health Workers receive training and certification in nutrition and mental health and including a Licensed Mental Health Counselor (LMHC) on the team.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. At least 1,000 individual consumers visit PFH in first year after launch and every year thereafter. Of these, at least 150 consumers with behavioral health needs are supported with integrative nutrition/mental wellness supports and/or connections to traditional behavioral health supports. 2. At least 50% of participants are low-to-moderate income, over 60, Hispanic or a minority, and/or speak a language other than English.	
Goal Status	1. 2052 unique consumers have participated in one or more PFH services since January 1, 2023. This is substantially undercounted because data is not collected on visitors to the Food Pantry or Farmers Markets. Since the program began in May 2023, of the 698 new consumers referred to Phoenix, 216 were deemed eligible for support. Of these, 119 were screened for their interest in Food and Thought; 64 (54%) indicated an interest in participation; and 58 have either received individual Food and Thought services and/or have participated in a Food and Thought workshop. 2. Of the 2052 named consumers supported by PFH since January 2023, 83% of participants who provide data identify as Hispanic or minority, 100% of those for whom data is available experience extremely low or low income, 84% are non-English speakers., and 42% of PFH visitors were 60 or older.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Action Inc. Welcome Home Program** **Health Issue: Additional Health Needs Identified by the Community (Housing)**		
Brief Description or Objective	This program provides permanent housing and supportive services to chronically homeless individuals and families in accordance with the Housing First model. To participate in the program, clients must have long histories of homelessness and at least one disabling condition.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	In FY24: 1. 100% of participants in the Welcome Home program will receive care from a primary care physician (PCP). 2. 90% of participants will attend follow-up appointments or follow through on referrals from a PCP. 3. 95% of participants will maintain their housing for at least 90 days.	
Goal Status	1. 76% of participants received care from a PCP. We believe the goal was not met due to several new clients being reluctant to engage in care via a PCP, although case managers continue to work with clients towards it. Staff have been working on strategies to help reduce the barriers some clients feel in seeking PCP services. 2. 100% of participants have attended a follow-up appointment or followed through on referrals from a PCP. So far, all referrals made by a PCP have been followed through. 3. 100% of participants have maintained their housing for at least 90 days.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health/Housing **Program Name: Massachusetts Coalition for the Homeless CASA Program** **Health Issue: Additional Health Needs/Access to Affordable Housing**		
Brief Description or Objective	The Casa Project is an upstream homelessness prevention model which embeds highly trained advocates inside community health centers and public schools to assist those facing a financial crisis to obtain or retain housing. Annually the Casa Projects assists thousands of families, individuals, and youth. The Casa Project's goal is to ensure everyone has a place to call home. Reaching households that are struggling with housing instability is essential to prevent displacement. Using a health equity lens Casa Project will assist the underserved members of the community in Lynn that are facing housing instability as well as struggling with any other component related to the Social Determinants of Health.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	The Casa Project's overall goal is to ensure everyone has a place to call home. Reaching households that are struggling with housing instability is essential to prevent displacement. In FY24CASA will assist with housing search by applying households to affordable housing including private developments with subsidized units, submitting applications for CHAMP, Section 8, assist with locating and securing Single Room Occupancies and market-rate housing, and assist with relocation, determining affordability, and setting up transportation to view apartments.	
Goal Status	In FY24 1,736 households received assistance with the following: - 85% assisted in applying for affordable housing, CHAMP, Sec 8, SRO, private developments - 15% assisted in applying for elder/disabled housing - 29% assisted in a market-rate housing search	
Time Frame Year: Year 2	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Patient Transportation Voucher Program** **Health Issue: Additional Health Need (Transportation)**		
Brief Description or Objective	Increases access to care by providing financial assistance for transportation to medical appointments for individuals with no means of transportation due to medical or financial issues. Assistance is provided in the form of taxi vouchers and/or scheduled transportation.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to health services by providing rides to individuals with no means of transportation due to medical or financial issues.	
Goal Status	Provided 50 vouchers in FY24.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health

Program Name: Community Benefits Administration and Infrastructure **Health Issue: Chronic Disease, Mental Health/Mental Illness, Housing Stability/Homelessness, Substance Use, Additional Health Needs (Food Insecurity and Access to Care)**		
Brief Description or Objective	Community Benefits and Community Relations staff implement programs and services in our Community Benefits Services Area, encourage collaborative relationships with other providers and government entities to support and enhance community health initiatives, conduct Community Health Needs Assessments and address priority needs and ensure regulatory compliance and reporting. Additionally, Community Benefits and Community Relations staff at BILH hospitals work together and across institutions to plan, implement, and evaluate Community Benefits programs. In FY24, the staff worked collaboratively to begin the Community Health Needs Assessment, sharing community outreach ideas and support, and help to distribute the community survey and identify key community residents for interviews and focus groups.	
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits
Program Goal(s)	Implement effective and efficient programs that support the community health needs of the Community Benefits Service Area.	
Goal Status	BH/AGH supported and implemented more than twenty programs and granted $225,000 to local organizations.	
Program Goal(s)	Offer evaluation capacity workshops to partner organizations and grantees to better understand impact.	
Goal Status	BILH offered two evaluation workshops to 30 organizations and grantees. 100% of organizations and grantees who attended were Satisfied or Very Satisfied with the workshops and 90% stated it was directly relevant to their role at their organization.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Community Support & Engagement** **Health Issue: Additional Health Needs (Access to Care), Food Insecurity, Mental Health/Mental Illness**		
Brief Description or Objective	As a large provider of health care and a major employer in its Community Benefits Service Area (CBSA), it is important for BH/AGH to be engaged in the larger community and support efforts to make the region a healthier, safer, and more vibrant place to live, work and play. To fulfill this objective, the hospital provides financial sponsorships and direct staff engagement to organizations and initiatives which support the goals and strategies identified in BH/AGH's Implementation Strategy.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide community support to organizations that further BH/AGH's community benefits mission	
Goal Status	BH/AGH provided financial support to 20 organizations in its CBSA	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Wellspring House "Accelerating Access to Higher Education"** **Health Issue: Additional Health Needs (Employment)**		
Brief Description or Objective	The Wellspring House "Accelerating Access to Higher Education" program provides intensive education, job training and readiness programs, and career advising to young adults to help them obtain employment or transition to employment with higher wages. The program incorporates three program areas: College Readiness courses, the MediClerk job training program, and Career Readiness program to help students advance in their careers and education by providing mentorship and resources for college, occupational education, or job search.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. At least 50% of participants within each program year who are working towards concrete education or employment outcomes will achieve one or more of the following specific milestones. 2. Across multiple program years, at least 65% of people in the cohorts of program participants in Year One or Year Two will achieve one or more of the following outcomes. - transition from unemployment to new employment, - transition to a promotion or new job with higher wages, - apply to or matriculate into a post-secondary education program (certification, training in the trades or college). - finish a post-secondary education program (certification, trades or college). 3. 90% of program participants who require crisis support for housing while working towards education and employment goals will remain stably housed throughout the year.	
Goal Status .	1. A total of 346 young adult and adult students participated in Wellspring's slate of education, job training and career advising programs. 2. Among students across all program areas, 53% (185) met at least one concrete, measurable milestone showing progress along a career pathway including: A) securing employment from unemployment, B) securing a higher wage job, C) entering or completing a post-secondary education program, and/or D) completing an industry specific training leading directly towards new employment. The remaining 47% of students continue to work towards their longer-term goals over the course of 18-to-24 months. 3. 100% remained stably housed throughout the year.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Addiction Consult Service** **Health Issue: Substance Use Disorder**		
Brief Description or Objective	The goal of the program is to increase access to integrated Hospital-based substance use disorder services, ensure ongoing linkages to care and community-based follow-up, reduce overdose deaths, and promote wellness and long-term recovery. The team is comprised of an Addictions Physician Assistant, and two recovery coaches. The team provides medication and withdrawal management, recovery support, community outreach, support, and connection to patients who are in the Emergency Department as well as Inpatient Units. In addition, the recovery coach runs a recovery support group for community members to attend weekly. The goal is to empower patients to achieve lasting recovery and reintegration into their communities with the support they need to thrive.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To provide inpatient/emergency department addiction services to 250 patients at AGH and BH to better support their recovery journey. Additionally, provide harm reduction kits to at least 12 patients per month.	
Goal Status	Since August 2024 when the program started, the team has seen 160 unique patients with 242 patient encounters.	
Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**Goal Type: Outcome Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Behavioral Health Technicians** **Health Issue: Mental Health/Mental Illness and Additional Health Needs (Access to Care)**		
Brief Description or Objective	Behavioral Health technicians are healthcare professionals who work directly with patients whom present to the ED with psychiatric concerns. They provide skilled, creative, high quality care to patients under the direction of an ED Registered Nurse. They perform a variety of direct and indirect patient care that include, but are not limited to, the use of skilled communication and diversion techniques, activities of daily living supports, and face-to-face interaction with patients and families at the bedside to ensure patient and employee safety.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To provide skilled supportive care to behavioral health patients in the Beverly Hospital Emergency Department.	
Goal Status	There are 22 BHTs in the Beverly Hospital Emergency Department. They rotate to provide two people on site 24/7; so 48 hours a day of behavioral health patient care.	
Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**Goal Type: Outcome Goal**

Priority Health Need: Mental Health & Substance Use **Program Name: Collaborative Care Model (C0CM)**

Health Issue: Mental Health			
Brief Description or Objective	BILH provides a range of behavioral health, substance use, and addiction recovery services and counseling for adults, youth and families including inpatient and outpatient psychiatry services. In order to increase access to mental health services, BH/AGH implemented the CoCM, a nationally recognized primary care "led program that specializes in providing behavioral health services in the primary care setting. The services, provided by a BILH licensed behavioral health clinician, include counseling sessions, phone consultations with a psychiatrist, and coordination and follow-up care. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treat a variety of medical and mental health conditions.		
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	To increase access to mental health services by incorporating the Collaborative Care Model in Primary Care practices throughout the BILH service area.		
Goal Status	In FY24 the program was implemented in eleven practices in the BH/AGH CBSA, serving a total of 1,430 patients		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: BILH Behavioral Health Access Initiative** **Health Issue: Substance Use Disorder, Mental Health/Mental Illness and Additional Health Needs (Access to Care)**		
Brief Description or Objective	To support increased access to mental health and substance use services and supports, BH/AGH participated with other BILH hospitals to pilot Behavioral Health Navigator grant programs, offer Mental Health First Aid (MHFA) trainings, provide behavioral health navigation and digital literacy trainings to BILH physical health navigators and amplify anti-stigma messaging, resources and supports.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. Support Grantees in creating a 3-year logic model and evaluation plan for development and implementation of their Behavioral Health Navigator program. 2. Offer Mental Health First Aid (MHFA) trainings to community residents and BILH staff across the BILH Community Benefits Service Area (CBSA). 3. Increase knowledge and awareness of available behavioral health services and supports among clinical and non-clinical staff who provide patients/clients with physical and/or social determinants of health navigation services.	
Goal Status	1. All four grantees worked with both BILH Director of Evaluation and Data and external evaluator to develop logic model and evaluation plan and are in the process of hiring and onboarding their Behavioral Health Navigator. 2. More than 350 community residents and BILH staff attended one of 21 MHFA trainings provided across the BILH CBSA, of which 75% (274) completed all pre- and post-training requirements to receive Mental Health First Aid certification. 3. 28 BILH, Community Health Center and Community Behavioral Health Center staff were trained. Trainees reported a 35% increase in identifying the essential elements of the behavioral health treatment systems of care; a 49% increase in feeling confident they can navigate patients to the appropriate level of behavioral health care, including outpatient, self -help, hotlines, and helplines; a 26%increase in feeling comfortable using different ways to promote patient engagement and activation; and a 37% increase in explaining the process of referrals to agencies.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Breast Cancer Risk Assessment** **Health Issue: Chronic Disease**		
Brief Description or Objective	Recognizing the risk for breast cancer is not the same for all women, BH/AGH implemented a free risk assessment using a tablet screening tool to help women evaluate their lifetime risk for breast cancer. The assessment includes an evaluation using the tool, and results, which are shared with the person's physician, are reviewed in a follow up consultation to determine if they might benefit from a higher level of screening beyond regular checkups and mammograms.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Screen more than 3,000 women in FY24 in order to identify their risk for developing breast cancer, and to provide screening follow-up to their physicians.	
Goal Status	In FY24, BH/AGH conducted 7,552 free screenings identifying 2,358 participants at high risk and 1,340 participants with a high lifetime risk for breast cancer.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Mental Health & Substance Use **Program Name: Gloucester Police Department "Teach to Reach" Program** **Health Issue: Substance Use Disorder**		
Brief Description or Objective	BH/AGH supported the Gloucester Police Department to continue administering the "Teach to Reach" program designed to increase peer to peer recovery coach services and job training and workforce development opportunities in the community.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. Improve access to substance misuse treatment and support services. 2. Increase job training and workforce development opportunities_	
Goal Status	1. A total of 79 people applied to the program and 25 completed the training. 2. 14 participants in the Teach 2 Reach initiative met the criteria for the Workforce Development portion of the grant. Nine (9) are employed, two (2) are interning as recovery coaches/specialist and or are working in the field of addiction services.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Mental Health & Substance Use

Program Name: Medication Disposal Boxes **Health Issue: Substance Use Disorder**		
Brief Description or Objective	Beverly Hospital provides a medication disposal box to safely dispose of expired or unwanted medication. Medications can be dropped off 24 hours a day, seven days a week in the Emergency Room waiting area and are safely disposed of in accordance with Drug Enforcement Administration regulations.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To provide a safe and convenient way for residents to dispose of unwanted or unused medications.	
Goal Status	In FY24, Beverly Hospital safely collected 10 38-gallon liners and disposed of 435 pounds of expired or unwanted medications.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Mental Health & Substance Use **Program Name: Pathways for Change Nurturing Program** **Health Issue: Mental Health**		
Brief Description or Objective	BH/AGH supported Pathways for Children to facilitate the Nurturing program, a nationally recognized, evidence-based family education program designed to prevent child abuse and neglect by increasing knowledge of parenting skills, child development, and community services and resources. The program was offered in English and Spanish to at-risk families with children ages birth-12.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	1. Conduct outreach and recruitment to families who could benefit from Nurturing Program. 2. Increase parents' nurturing parenting, positive discipline, and collaborative conflict resolution skills. 3. Build self-esteem, increase community resource knowledge (including of mental/behavioral health services where appropriate), and develop peer connections.	
Goal Status	**1**. Eleven fathers enrolled in the January 2024 Nurturing Fathers Program held at the Essex County Correctional Center- Middleton facility. Five fathers completed the full 13-week program. Three participants were moved off unit before they could complete the program, one participant was released to the community, one participant declined to participate after the first week, and one was transferred to a MA DOC prison facility to complete a long-term sentence. 7 parents and 10 children participated in the Spanish language Nurturing Program (Crianza con Carino) in Beverly. We also had child facilitators so that the children were able to engage in activities with age-appropriate themes corresponding to what their parents were learning. 6 out of the 7 parents had custody of their children, and one was working toward reunification. 2. The Crianza con Carino group in Beverly showed increases in each of the five parenting constructs from the pre-test to the post-test, with 4/5 of the final average scores falling into the Above Average category. 3. Parents in both groups came away with resources, social connections, and increased self-esteem. All participants in the ECSD Middleton group received information about Pathways so that they could access the full range of programming and/or receive assistance with finding similar programming in their areas once they returned to their communities and homes. Participants also expressed their appreciation for a safe and supportive environment which allowed them to connect with other inmates and feel less alone in their challenges. All participants in the Crianza con Carino group in Beverly received at least one referral to a community resource in addition to information about other local resources in case needs arise in the future.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Mental Health & Substance Use **Program Name: SeniorCare Rendever Virtual Reality Program** **Health Issue: Mental Health**		
Brief Description or Objective	The Rendever Virtual Program helps older adults reduce feelings of anxiety, chronic stress, depression, and social isolation through the use of virtual reality (VR). VR has a myriad of uses for our population including: reminiscence therapy (visiting their childhood home, wedding location, travel locations); socialization (shared experience, playing games, participating in parties), caregiver applications (sharing personal stories, photos, videos), physical therapy/exercise, addressing dementia/Alzheimer's (sundowning intervention, relaxation exercise, promotes positive emotions, stimulation of memory & cognition, behavioral health applications.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. The Technology Navigator will train a minimum of 3 staff, volunteers and/or community partners to facilitate the Virtual Reality (VR) platform, annually during Year 2 and Year 3 of implementation. 2. The Technology Navigator and Virtual Reality (VR) trainees will reach a minimum of 50 unduplicated individuals, annually during Year 2 and Year 3 of implementation. 3. SeniorCare's Virtual Reality (VR) Program participants will report at least 90% satisfaction with the program and report at least 90% opportunities to connect/engage with others.	
Goal Status	1. In FY24 the Technology Navigator trained 2 community partners in facilitating and co-leading the VR groups. Both partners are Resident Service Coordinators/Social Supports for older adults living in senior housing sites. The Technology Navigator is on target to reach the goal of training 3 staff, volunteers and/or community partners in the VR platform by the end of Year 2. 2. To date the Technology Navigator has reach 30 unduplicated individuals, adults age 60+. Groups have been held at 6 different residential/senior housing settings. The VR Program is on target to reach its goal of over 50 unduplicated individuals this funding year/Year 2. 3. All program participants reported a satisfaction rate of more than 90%.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Oncology Nurse Navigators** **Health Issue: Chronic Disease (Cancer)**		
Brief Description or Objective	The Oncology Nurse Navigator is an RN with oncology-specific clinical knowledge. These Navigators offer individualized support and assistance to patients and their caregivers to help them make informed decisions about their care and to overcome barriers to optimal care. The Navigator contributes to the Hospital's mission by providing cancer patients with coordinated care through a holistic and collaborative approach that includes communication and coordination with the patient's family and/or caregivers along with a multidisciplinary team consisting of physicians, nurse practitioners, oncology nurses, and social workers. The Navigator works in collaboration with the clinical team to develop clinical pathways for appropriate care, and acts as the contact clinical person in resolving all patient-related concerns. The Navigator ensures all medical information has been received by physicians, reviews all medical information prior to a patient visit, and discusses any concerns with the provider prior to the patient visit. The Navigator maintains contact with referring and other collaborating physicians to keep them up to date on the patient's care plan. In addition, the Nurse Navigator connects patients with resources, including support services in their communities, and assists them from treatment to survivorship.	
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To guide patients through the complexities of the disease, direct them to health care services for timely treatment and into survivorship, and actively identify and help address barriers to care that might prevent them from receiving timely and appropriate treatment.	
Goal Status	In FY24 the Oncology Nurse Navigators at BH and AGH dedicated 5,586 hours to assist more than # patients and their families or caregivers.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: North Shore YMCA Enhance Fitness Program** **Health Issue: Chronic Disease**		
Brief Description or Objective	Over the past two decades, obesity rates in the United States have doubled for adults. Overall fitness and physical activity reduce the risk for many chronic diseases, are linked to good emotional health, and help prevent disease. Through a partnership with the North Shore YMCA, Enhance Fitness classes are offered for free at the YMCA and various locations in the community. Enhance Fitness is an evidence-based health intervention offsetting the effects of aging and chronic illness as well as minimizing fall risk. Participants work on cardio and muscular strength, balance, flexibility, and stability, all while engaging in a supportive social community. Classes meet three days per week for eight weeks. Fitness checks are done at the beginning and end of each sixteen-week session.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	The YMCA of the North Shore will serve 100 seniors each year for the next three years across its Greater Beverly YMCA, Ipswich Family YMCA, and Cape Ann YMCA Enhance Fitness programs, of which 20% each year will be economically disadvantaged.	
Goal Status	In FY24 80 seniors were reached, and anticipate reaching 100 seniors by the end of 2024.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Complex and Chronic Conditions

Program Name: School Based Health Center at Gloucester High School **Health Issue: Chronic Disease**	
Brief Description or Objective	This program increases access to healthcare by providing high-quality, comprehensive health care to students on-site at Gloucester High School in order to support optimal health and academic outcomes. The health clinic is a branch of Addison Gilbert Hospital and is supported in part by a grant from the Massachusetts DPH. Services include management of chronic illnesses such as asthma and diabetes, urgent care visits, immunizations, work permits and sports physicals, health education, confidential services, including reproductive health care and behavioral health services, assessing social determinants of health and connecting students to healthcare needs. In addition, the SBHC is a safe place where students are encouraged through a strengths-based approach and motivational interviewing to discuss important personal topics such as stress, exercise, healthy eating, alcohol and drug use, friendship, sexual health, and other personal health issues. The SBHC provides an integrated model of care in its approach, staffed by a Nurse Practitioner, a Licensed Independent Clinical Social Worker, a Program Manager/Sr. Community Health Worker, and a Certified Community Health Worker.
Program Type	☒ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population or Community-Wide Interventions
Program Goals	1. Complete a CQI Project with goal of increasing number of Columbia Suicidality Screenings by 20% over FY2023 = > 92 screenings 2. Complete at least 1 Collaborative and 1 Outreach activities 3. Dedicated effort to serve English Learning Students - goal to serve 50% of EL students Equity Centered component to CQI 4. Establish student-led activities with the Youth Advisory Council for inclusion, equity, climate awareness, gun safety, etc. 5. NP Visits minimum - 935 6. LICSW - Behavioral Health Visit Minimum - 775 7. Serve LGBTQ+ community through individual medical and behavioral health visits and Sexuality and Gender Acceptance Club 8. Through collaboration with The Open Door, reduce barriers to food access by providing a Food Locker, providing free, shelf stable food to > 75 students/families 9. Track Community Health Worker visits connecting GHS students to resources and provide informal counseling
Goal Status .	1. Completed 138 Columbia Suicidality Screenings 2. 21 Outreach Activities completed and 21 Collaborative Activities completed 3. Served 72% of GHS English Learning students, screened Number of GHS SHC EL students were screened 4. Established the following student led activities: - Town Green Leadership Climate Change Training collaboration - Men's Mental Health Project - Gratitude Project for 140 GHS Staff - Valentine Inclusion Project (displayed a heart for each of the 814 GHS student names in atrium - English Learner Family Winter Event welcome table with GHS SHC info - Mean Girls Project in collaboration with GHS Drama Dept. to stop bullying - Community Open House and GHS Clubs Event tabling - GHS SBHC Student Feedback Survey - support through focus groups, translation reviews, school-wide announcements, school newspaper; encourage participation in Home Rooms - Wear Orange Project (to honor survivors and build community with those working to end gun violence. 5. NP conducted 1,084 visits

	6. LICSW conducted 2087 visits for 317 unduplicated students 7. Served LGBTQ+ community through visits and SAGA activities Two outstanding members of the GHS SAGA club were nominated for and received the Youth Recognition Award from the MA Commission on LGBTQ Youth they attended state-wide GAYLA event with stipend for clothing sponsored by Safe Schools Program for LGBTQ Students. 8. Reduced barriers to food access by serving over 110 students/families: - 957 grocery orders - 33 contactless home deliveries - 65 student volunteers -11497 food items delivered to SBHC from The Open Door -6062 pounds of food delivered to SBHC from The Open Door 9. Community Health worker completed 667 visits with 77 unduplicated GHS students

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: The Open Door "Medically Tailored Groceries" Program** **Health Issue: Social Determinants of Health (Access to Healthy Food)**	
Brief Description or Objective	The MTG program is an innovative program to help adults with, or at risk of, chronic illness, and struggling with food insecurity, better manage their health with access to free, diet specific, nutritious food. In addition, the program provides nutrition counseling, educational workshops, and help with meal planning and preparation.
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒ Total Population or Community-Wide Interventions
Program Goal(s)	1. Provide at least 30% of each food pantry order as produce 2. MTG team will screen and connect clients to TOD SmartChoice@TOD and dietary-specific options (Goal: 500+ clients) 3. MTG Team will provide at least 2 sessions of intensive MTG both Track I and Track II with 10-15 people per session 4. RDN will provide 75 Nutritional Counseling sessions (for 10-40 people depending upon need) 5. MTG Team will provide 12 Maridee's Community Nutrition Workshops for up to 10 people/workshop
Goal Status Be consistent with use of bullets or dashes	1. 29% of food distributed in 2023 was produce. (Goal 30%) 2. MTG Team screened and connected 800+ clients to Dietary-specific options (Goal: 500+ clients) 3. MTG Team provided 2 sessions of MTG. Session 4 had 12 participants, 9 completed the entire program (75%); Session 5 had 8 participants, 6 completed the entire program (75%). We launched Session 6 in Oct 2023, with 12 participants enrolled. (Goal: 2 sessions with 10-15 people per session). 4. RDN provided 251 Nutritional Counseling Sessions in 2022, and 169 Nutrition Counseling Sessions Jan – Sept 2023 (Goal: 75) 5. MTG Team provided 14 Nutrition Workshops for clients and individuals (Goal: 12)

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

SECTION V: EXPENDITURES

Item/Description	Amount
CB Expenditures by Program Type	
Direct Clinical Services	$9,829,350
Community-Clinical Linkages	$144,097
Total Population or Community Wide Interventions	$646,460
Access/Coverage Supports	$1,910,363
Infrastructure to Support CB Collaborations	$32,022
Total Expenditures by Program Type	$12,562,292
CB Expenditures by Health Need	
Chronic Disease	$823,000
Mental Health/Mental Illness	$2,168,539
Substance Use Disorders	$1,258,401
Housing Stability/Homelessness	$56,011
Additional Health Needs Identified by the Community	$8,256,341
Total Expenditures by Health Need	$12, 562,292
Leveraged Resources	$5,599,017
Total Leveraged Resources	$5,599,017
Net Charity Care Expenditures	
Total HSN Assessment	$2,170,661
Free/Discounted Care	
HSN Denied Claims	$1,175,120
Total Net Charity Care	$3,345,781
Total CB Expenditures	$21,507,090

Additional Information	
Net Patient Services Revenue	$436,836,927
CB Expenditure as % of Net Patient Services Revenue	4.92%
Approved CB Budget for FY25 (*Excluding expenditures that cannot be projected at the time of the report)	$14,909,865
Bad Debt	$1,876,644
Bad Debt Certification	Yes

SECTION VI: CONTACT INFORMATION

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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

Note: This form is to be completed in the two Fiscal Years following the hospital's completion of its triennial Community Health Needs Assessment

I. Community Benefits Process:

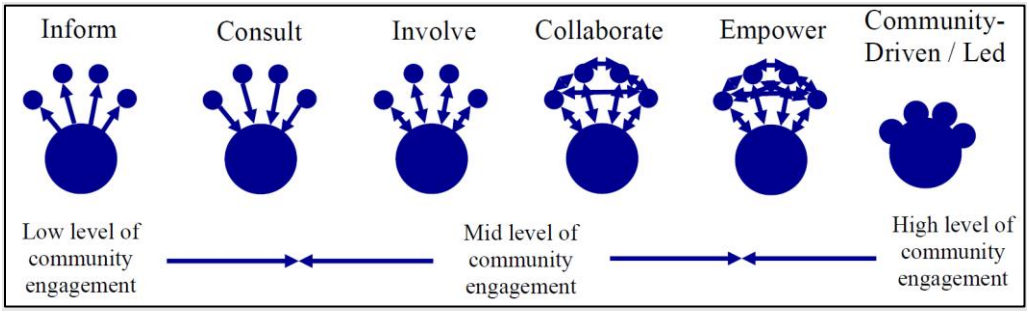
- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? ☐Yes ☒No
    - If so, please list updates:

II. Community Engagement

1. If there have been any updates to the key partners with whom the hospital collaborates, please indicate in the table below. Please feel free to add rows as needed.

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
The Open Door	Julie LaFontaine, CEO	Social service organizations	BH/AGH awarded a three year grant in FY23 to support the Medically Tailored Groceries Program. In addition, Julie is a member of the BH/AGH CBAC.
SeniorCare	Scott Trenti, CEO	Social service organizations	BH/AGH has worked with SeniorCare for several years, in FY24 a grant was awarded for continuation of the Rendever Virtual Reality for Older Adults. In addition, Scott Trenti is a member of the BH/AGH CBAC. Also, BH/AGH Adult Senior Unit social workers work collaboratively with SeniorCare in providing resources and assistance for older adults with social/emotional needs.
MA Coalition for the Homeless	Celinet Sanchez, Director of Grants and Communications	Housing organizations	BH/AGH awarded a 3 year grant in FY23 to support the CASA program. In addition, Celinet Sanchez is a member of the BH/AGH CBAC.
North Shore YMCA	Chris Lovasco, CEO	Other	BHAGH continued support for the Enhance Fitness Program in FY24. In addition, Chris is a member of the BH/AGH CBAC

2. Please use the spectrum below from the Massachusetts Department of Public Health1 to assess the hospital's level of engagement with the community in implementing its plan to address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.



Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Collaborate	Goal was met. In FY24 BH/AGH collaborated with CBAC members to prioritize and allocate grant funding to address health needs identified in the CHNA by participating in discussions and a polling exercise to prioritize the needs. Following the prioritization process, the CBAC evaluated the impact of current strategies,	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Collaborate	Goal was met in FY23 when. In FY24 BH/AGH formed a selection committee comprised of CBAC members to develop an RFP for 3 year grants to grants to community organizations addressing health needs identified in the FY22 BH/AGH CHNA and corresponding Implementation Strategy. The selection committee also reviewed, scored, and determined the awardees. IN FY24 the	Collaborate

[1] "Community Engagement Standards for Community Health Planning Guideline," Massachusetts Department of Public Health, available at: http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf. For a full description of the community engagement spectrum, see page 11 of the Attorney General's Community Benefits Guidelines for Non-profit Hospitals.

		programs that were awarded funding continued as part of a three year grant.	
Implementing Community Benefits programs	Collaborate	Goal was met in FY23 when BH/AGH engaged the CBAC in the review process for RFP's for three-year grant funding in alignment with the Implementation Strategy. FY24 the programs continued as part of a three year grant.	Collaborate
Evaluating progress in executing Implementation Strategy	Consult	Year # 1 Implementation Strategy and evaluation of programs was reviewed and discussed by the BHAGH CBAC.	Consult
Updating Implementation Strategy annually	Consult	The Implementation Strategy was reviewed and discussed with the BHAGH CBAC.	Consult

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

3. Did the hospital hold a meeting open to the public (either independently or in conjunction with its CBAC or a community partner) at least once in the last year to solicit community feedback on its Community Benefits programs? If so, please provide the date and location of the event. If not, please explain why not.
   Yes. A public meeting was held in September, 2024.

4. Maternal Health Focus
   A. How does your organization assess maternal health status in the Community Health Needs Assessment Process? (150-word limit)
   BH/AGH's Community Health Needs Assessment includes comprehensive collection and review of primary and secondary data sources. Secondary data sources include March of Dimes, MDPH, National Center for Health Statistics. Data specific to maternal health are included in the hospital's data table under Reproductive Health" and include low birth weight (6.8%), Mothers with late or no prenatal care (3.7%), Births to adolescent mothers (11%), and mothers receiving publicly funded pre-natal care as well as data on screening for post-partum depression. In addition to secondary data capture and review, throughout the CHNA BH/AGH engages with the community to collect primary data on priorities identified by community residents. This is through a community survey as well as focus groups.

   B. How have you measured the impact of your Community Benefits programs and what challenges have you faced in this measurement? (150-word limit)
   BH/AGH partners with North Shore Community Health and Lynn Community Health Center on maternal health initiative(s) and has done so since 2018. Additionally, BH/AGH is a member of Beth Israel Lahey Health, which, as a system is working to address maternal health equity. Beth Israel Lahey Health

established its Maternal Health Quality and Equity Council (MHQEC) in September of 2023. The Council's objective is to improve maternal health outcomes and eliminate inequities in care, with an overarching aim to reduce the occurrence of maternal morbidity and mortality. The Council is comprised of representatives from all of the BILH hospitals providing maternity services, as well as BILH leadership, including BILH Health Equity system leadership. BILH's Chief Clinical Officer serves as the Executive Sponsor. FY 24 was the Council's inaugural year and MHQEC established initial goals related to Equitable Access to Doulas & Midwifery, Perinatal Mental Health, and Severe Maternal Morbidity. Additionally, BILH established a health equity goal beginning in FY 25 – a year over year improvement in maternal transfusion rate (the goal is to reduce disparities in maternal transfusion rates measured at the system level).

C. Do you need assistance identifying community-based organizations doing maternal health work in your area? No

III. Updates on Regional Collaboration

1. If the hospital reported on a collaboration in its **Year 2 Hospital Self-Assessment**, please briefly describe any updates to that collaboration, including any progress made and/or challenges encountered in achieving the goals of the collaboration.

2. If the hospital entered a regional collaboration in the past year, please provide the information requested of regional collaborations on p. 5 in the **Year 2 Hospital Self-Assessment Form**.