Community Benefits Report

Fiscal Year 2023

Beth Israel Lahey Health

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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). NHC consists of multiple entities organized to service the needs of those in its communities. NHC, under a single license, operates Beverly Hospital, Addison Gilbert Hospital, and Bayridge Hospital, as well as an outpatient facility, Beth Israel Lahey Health Care Center Danvers. All are members of 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. BH/AGH's Community Benefits staff are committed to working collaboratively with its communities to address the leading health issues and create a healthy future for individuals, families and communities.

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

Beverly and Addison Gilbert Hospitals' Community Benefits Mission Statement: The Community Benefits Program at BH/AGH partners with community leaders and organizations to assess and meet the health care needs of the community. Strategies used in community benefits health activities include prevention, early detection, early intervention, long-term management, and collaborative efforts with the affiliated

organizations that make up the BILH system. Health issues addressed encompass safety, chronic disease, infectious disease, substance abuse, mental health, maternal and child health, and elder health.

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

More broadly, 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

reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. While BH/AGH is committed to improving the health status and well-being of those living throughout its entire CBSA, per the Commonwealth's updated community benefits guidelines, BH/AGH's FY 2023 - 2025 Implementation Strategy (IS) will focus its Community Benefits resources on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved living in its CBSA.

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

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

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

Key Accomplishments for Reporting Year
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):

- ***Action Inc. "Welcome Home" Program*** – Through support from BH/AGH, permanent housing was secured and maintained for 11 chronically homeless families in FY23.
- ***Beverly Bootstraps*** – Supported Beverly Bootstraps to provide mobile markets at 12 different housing sites, serving more than 5,000 low resourced, older adults.
- ***Breast Cancer Risk Assessment*** – In FY23, BH/AGH provided 3,962 free breast Cancer Risk Assessment (CRA) screenings to identify persons who may have a higher lifetime risk of developing breast cancer, and provided follow-up with all participants' physicians.

- ***Collaborative Care Model*** – BH/AGH integrated behavioral health into ten primary care practices in FY23, reaching 1,288 patients.
- ***Community Home Blood Draw Program*** – BH/AGH staff provided home blood draws for 5,129 patients who were homebound due to illness, injury, or transportation issues.
- ***Compass Moms Do Care Program*** – In FY23 the Moms do Care program provided Case Management support for 89 pregnant or parenting women with a history of substance use.
- ***Massachusetts Coalition for the Homeless "CASA" Program*** – In Fy23 CASA Housing advocates used an upstream homelessness prevention approach to assist 1,981 households experiencing housing instability, and at risk of homelessness.
- ***The Open Door Medically Tailored Groceries Program*** - BH/AGH supported The Open Door to provide the Medically Tailored Groceries Program, which aims to alleviate hunger by ensuring that low-resourced and food-insecure individuals with or at risk of chronic illness have access to healthy foods along with free nutritional counseling and educational workshops. In FY23, more than 1,500 community members participated in the program.
- ***Wellspring House "Accelerating Access to Higher Education" Program*** – BH/AGH supported Wellspring House to provide 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; racially, ethnically and diverse populations.

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

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

- **Social Determinants of Health**
  - The Open Door, Beverly Bootstraps, and Backyard Growers to help alleviate food insecurity and promote healthy eating by providing healthy, low-cost food to communities along with nutrition consults and education sessions.
  - Action Inc.'s Welcome Home Program to help individuals secure and maintain healthy and safe living conditions.
  - Wellspring House Pathways to Jobs program to help low resourced adults find new employment, or employment with higher wages.

- **Mental Health and Substance Use**
  - The Gloucester Police Department Teach to Reach Recovery Coach Training Program to increase access to recovery services and coaches.

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

Hospital Self-Assessment Form

Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), the BH/AGH Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 38. The BH/AGH Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members who participated in BH/AGH's CHNA and asked them to submit the form to the AGO website.

SECTION II: COMMUNITY BENEFITS PROCESS

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

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

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

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

- *Wellbeing - We provide a health-focused workplace and support a healthy work-life balance*
- *Empathy - We do our best to understand others' feelings, needs and perspectives*
- *Collaboration - We work together to achieve extraordinary results*
- *Accountability - We hold ourselves and each other to behaviors necessary to achieve our collective goals*
- *Respect - We value diversity and treat all members of our community with dignity and inclusiveness*
- *Equity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.*

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 serve its patients compassionately and effectively, and to create a healthy future for them, their families, and BIDMC's community. 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, and from corporate and non-profit community organizations.

The BH/AGH CBAC met four times in FY23 on the following dates:
- January 16, 2023
- March 28, 2023
- June 27, 2023
- September 26, 2024 (Annual Public Meeting)

FY23 CBAC Members:
- Nancy Palmer, Board Chair, Northeast Hospital Corporation Board of Trustees
- Tom Sands, President, Beverly & Addison Gilbert Hospitals
- Marylou Hardy, Regional Manager Community Relations/Community Benefits, NHC
- Christine Healey, Director, Community Relations/Community Benefits, BILH
- Jason Andree, Vice President, Addison Gilbert Hospital and Lahey Outpatient Center Danvers
- Maria Fernando Canton, North Shore Community Health
- Andrew DeFranza, Executive Director, Harborlight Community Partners
- Dutrochet Djoko, Chair of Human Rights & Inclusion Committee, Danvers Board of Health
- Mark Gendreau, MD, Chief Medical Officer, Beverly/Addison Gilbert Hospital
- Peggy Hegarty-Steck, Chief Executive Officer, Action, Inc.
- Brian Holmes, Medical Assistant Educator, Beth Israel Lahey Health Primary Care
- Joseph Huang, Chief Operating Officer, Beverly & Addison Gilbert Hospitals
- Robert Irwin, Trustee, Northeast Hospital Corporation Board of Trustees
- Julie LaFontaine, President and CEO, The Open Door
- Chris Lovasco, President, YMCA of the North Shore
- Karen Neva Bell, Trustee, NHC Board of Trustees
- Valerie Parker Callahan, Director, Planning & Development, Greater Lynn Senior Services
- Jonathan Payson, Trustee, NHC Board of Trustees
- Kimberly Perryman, Chief Nursing Officer, Beverly/Addison Gilbert Hospital
- Scott Trenti, Chief Operating Officer, SeniorCare
- Mike Tarmey, Vice President, Bayridge Hospital
- David Thomson, Director, DanversCARES
- Carolina Trujillo, Executive Director, Citizens Inn

Community Partners

BH/AGH recognizes its role as a community hospital in a larger health system and knows that to be successful it needs to collaborate with its community partners and those it serves. BH/AGH's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy were completed in close collaboration with BH/AGH's staff, community residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership and other key collaborators from throughout its CBSA. BH/AGH's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of BH/AGH's mission. BH/AGH currently supports numerous educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA. In this work, BH/AGH collaborates with many of its local community-based organizations, public health departments, municipalities and clinical and social service organizations. The following is a comprehensive listing of the community partners with which BH/AGH 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 (Section VII, page 38).

- 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
- Massachusetts 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 2023 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.

Beth Israel Lahey Health

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 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 (SDoH)

- The SDoH 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.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Equitable Access to Care **Program Name: Home Blood Draw Program** **Health Issue: Additional Needs (Access to Care)**			
Brief Description or Objective	The BH/AGH Laboratory Homebound Phlebotomy Program provides free phlebotomy services in the home for patients who are homebound due to illness or injury, or those with transportation challenges.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	Increase access to phlebotomy services for homebound patients who have difficulty getting to a laboratory/drawing station due to illness or injury.		
Goal Status	In FY23, the Mobile Phlebotomy Team from BH/AGH Laboratory scheduled and performed 5,129 free homebound lab visits. Patients have reported reduced feelings of isolation because the visit with the phlebotomist provided them with a social opportunity, and the ability to comply with necessary testing. Patient population served is primarily the elderly and disabled		
Time Frame Year: Year 1	**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 or emotional/social support. The prenatal component of the CYM program is the Childbirth Preparation Series, designed to prepare expectant mothers and their support people for labor and delivery. The postnatal component is a support group specifically for teens and young women and their children. Until mid-March, the group met in person and child care was provided. From mid-March through the end of the year, the program has been delivering postnatal services remotely. Topics include healthy relationships, challenges of young parenthood, balancing parenting/work/education, child development, and coping with the isolation, stress, job loss, and other challenges. The CYM program also provides extensive resource and referral support to women who do not fully join the program, and those not actively participating.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	Increase the number of referrals into the program.		
Goal Status	There were 77 new referrals in FY23, a 29% increase over FY22. Of those, 50% identified as being part of an ethnic group and 38% were 20 years old or younger.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Equitable Access to Care Program Name: Patient Financial Counseling Health Issue: Additional health Needs / Access to Care			
Brief Description or Objective	Significant segments of the population living in BH/AGH's CBSA, particularly low-income and racial/ethnic minority populations, face significant barriers to care. These groups struggle to access services due to lack of insurance or transportation, cultural/linguistic barriers, and a shortage of providers willing to serve Medicaid-insured or uninsured patients. To address these gaps, BH/AGH employs six MassHealth-certified Application Counselors who screen patients and assist them in applying for state aid. They also estimate for patients their financial responsibility (copay, deductible, coinsurance, self-pay). Financial Counselors spend their time helping patients with issues related to financial assistance and estimates and helping patients understand their insurance benefits.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	To meet with patients who are uninsured to assess their eligibility for and align them with state financial assistance and hospital-based financial assistance programs.		
Goal Status	Financial Counselors dedicated more than 13,000 hours assisting 7,934 residents in FY23. The residents received assistance with applications and enrollments for disability (2501), Medicaid (1352), Masshealth (1,612), and more. The residents served included those over the age of 65 (68%) and those under the age of 65 (32%).		
Time Frame Year: Year 1	**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 Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	To help Medicare beneficiaries and their caregivers navigate their health insurance options. The counselors are also available to review current coverage, compare costs and benefits of available options, and assist those with limited resources in enrolling in helpful programs.		
Goal Status	In FY23, SHINE counselors conducted 3,921 consultations for residents of the North Shore and Cape Ann.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Equitable Access to Care Program Name: Interpreter Services Health Issue: Additional Needs / Access to Care

Brief Description or Objective	BH/AGH offers an extensive interpreter services program that provides interpretation (translation) and assistance in over 60 different languages, including American Sign Language, and hearing augmentation devices for those who are hard of hearing. The interpreter services program also routinely facilitates access to care, helps patients understand their course of treatment, and helps patients adhere to discharge instructions and other medical regimens.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	To provide culturally responsive care through Interpreter Services Department.	
Goal Status	Goal Status: In FY23 NHC interpreters reported a total of 11,480 encounters: 10,719 at Beverly Hospital and 761 at Addison Gilbert Hospital. The top three languages were: Spanish – 1747, Portuguese – 721, Albanian – 172.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcome Goal**

Priority Health Need: Equitable Access to Care **Program Name: BILH Workforce Development** **Health Issue: Social Determinants of Health / Education**	
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 Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. Continue to encourage community referrals and hires. 2. Attend events and give presentations about employment opportunities to community partners. 3. Offer paid trainings for community members across BILH. 4. Offer internships in BILH hospitals to community members over the age of 18. 5. Hire interns hired after internships and place in BILH hospitals 6. Offer English for Speakers of Other Languages (ESOL) classes to BILH employees. 7. Offer citizenship, career development workshops, and financial literacy classes to BILH employees.
Goal Status	In FY23 BILH Workforce Development: 1. Referred 225 job seekers to BILH and hired 70 were across BILH hospitals. 2. Conducted 67 events and presentations with community partners across the BILH service area. 3. Trained 89 community members to Patient Care Technician or Nursing Assistant (30), Pharmacy Tech (16), Perioperative LPN (3), Medical Assistant (21), Behavioral Health roles (4) or into the Associate Degree Nursing Residency program (15).

	4. Placed 54 community members in internships across BILH hospitals to learn valuable skills and hired 22 in BILH hospitals. 5. Enrolled 45 employees across BILH in ESOL classes 6. Offer English for Speakers of Other Languages (ESOL) classes to BILH employees. 7. In FY23, 20 BILH employees attended citizenship classes, 135 BILH employees attended career development workshops and 189 BILH employees attended financial literacy classes.
Time Frame Year: Year 1	**Time Frame Duration: Year 3** — **Goal Type: Outcome Goal**

Priority Health Need: Equitable Access to Care **Program Name: Pharmacy Assistance Program** **Health Issue: Social Determinants of Health / Access to Healthcare**		
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 Intervention	☒ 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 FY23, Beverly Hospital provided $74,500 in financial assistance to low income and/or uninsured patients.	
Time Frame Year: Year 1	**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 (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 Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	The overall goal of the program is to provide chronically homeless people with permanent housing; to help clients maintain that housing; to ensure clients are connected to mainstream health care services; to improve clients' overall health; to improve our clients' mental and behavioral health specifically; and to help clients achieve their self-identified goals for the future. 1. Place 8 chronically homeless individuals in permanent supportive housing by the end of FY23. 2. 95% of formerly homeless clients in the program will retain housing for at least 90 days. 3. 95% of participants will receive care from a primary care physician.	
Goal Status	In FY23, 1. Placed 11chronically homeless individuals in permanent supportive housing in FY23.	

	2. 100% of formerly homeless clients in the program retained housing for at least 90 days. 3. 95% of participants received care from a primary care physician.
Time Frame Year: Year 1	**Time Frame Duration: Year 3** — **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **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 ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	1. Provide at least 30% of each food pantry order as produce. 2. Screen and connect at least 500 clients to TOD Smart Choice meal plans. 3. Provide the Medically Tailored Groceries program to at least 25 people 4. Provide free nutrition counseling for 75 food insecure low-income people at risk of chronic disease. 5. Provide 12 nutrition workshops with at least 10 participants in each session.	
Goal Status	1. Provided 29% of each food pantry order as produce. 2. Screened and connected 500 clients to TOD Smart Choice meal plans. 3. Provide the Medically Tailored Groceries program to 29 people 4. Provide free nutrition counseling for 251 people in FY23, 169 who were food insecure low-income people at risk of chronic disease. 5. Provided 12 nutrition workshops for more than 120 participants.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Beverly Bootstraps Mobile Markets** **Health Issue: Social Determinants of Health / Access to Healthy Food**		
Brief Description or Objective	Through financial support from Beverly/Addison Gilbert Hospital summer mobile markets are offered at housing sites throughout Beverly to bring a free, fresh produce along with nutrition information to residents.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	1. To provide a free fresh traveling farmers market to at least 10 Beverly Housing sites. 2. To ensure at least 50% of participants of the mobile markets increase their intake of fresh fruits and vegetables.	
Goal Status	1. Provided weekly mobile markets to 12 housing sites in Beverly, equaling more than 5,000 resident encounters. 2. 65% of the mobile market participants reported eating more fresh fruits and vegetables.	
Time Frame Year: Year 1	**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 Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	1. By the end of FY23 more than 250 adults will participate in the program and actively work towards achieving their education and/or employment goals. 2. 20% of the participants will transition to new employment with higher wages. 3. 15% of the participants will apply for a degree, certificate, or other training program within 9 months of completing the program.		
Goal Status	1. In FY23 346 adults completed the program and are actively working towards concrete education and/or employment goals. 2. Of the 346 participants 30% transitioned to a new job with higher wages. 3. Of the 346 participants, 20% applied for a degree or certificate. 4. The program served a population that was diverse in age, race, and gender: Gender: 77% women, 22% men, 1% not specified Race: 57% white, 13% black, 3% Asian, 27% multiracial. Age: 18-24, 35%, 25-44 - 46%, 45-64 – 14%, 65+ - 2%		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Social Determinants of Health/ Food Access Program Name: Backyard Growers Health Issue: Additional Needs / Access to Healthy Foods		
Brief Description or Objective	Launched in 2021, agriCulture is a community driven transformation of the garden and adjacent vacant lot in the Gloucester Housing Authority (GHA) Willowood neighborhood. In fall 2022, Backyard Growers installed a communal shade structure designed to provide a food-centric space where residents can prepare food and share knowledge of growing and preparing their own healthy, affordable food. BYG also installed perennial communal garden beds to further increase access to healthy, affordable food. By increasing community engagement with this new community asset, there was an increase in the number of residents who made healthy behavior changes in making healthier food choices.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	1. Increase the number of 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.	

	2. Develop and implement at least 4 workshops 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.
Goal Status	1. Increased the number of garden users from 50 to 90 in FY23, and expect to reach over 100 by 2024. 2. Developed and implement 4 workshops in the agriCulture space. Topics included: 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.
Time Frame Year: Year 1	**Time Frame Duration: Year 3** / **Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: City of Beverly Summer Literacy Program** **Health Issue: Additional Needs**	
Brief Description or Objective	The Summer Literacy Program provided learning opportunities and enrichment experiences to children reading below grade level and at risk of experiencing summer learning loss. Building a Better Beverly, in partnership with Beverly Public Schools and the Greater Beverly YMCA, provided a six-week, free summer learning program to approximately 180 children entering first, second, and third grade. The day camp included three hours of literacy instruction in the morning and a traditional summer camp experience in the afternoon. Children received instruction on spelling, grammar, vocabulary, self-selected reading, and small-group guided reading. Programming at Sterling YMCA also included enrichment activities such as arts & crafts, music, team building activities, swimming, and more.
Program Type	☐ Direct Clinical Services ☐Access/Coverage Supports ☐ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☒ Total Population or Community Wide Intervention
Program Goal(s)	The goals of the program are to help children in grades 1-3 achieve grade-level literacy, and provide a summer camp opportunity to help these children grow healthy and happy.
Goal Status	In FY23 180 students in grades 1-3 participated in the program. Of the 180 students, 100% of maintained or improved their literacy foundational skills, and over 75% of students made ambitious gains in their early literacy skills.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health / Food Access **Program Name: Greater Lynn Senior Services "Food & Thought" Program** **Health Issue: Additional Needs / Access to Healthy Foods**	
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 ☐Access/Coverage Supports ☐ Community Clinical Linkages ☐Infrastructure to Support Community Benefits

	☒ Total Population or Community Wide Intervention
Program Goal(s)	1. Introduce a screening tool that identify individuals living with both food insecurity and behavioral health symptomologies. 2. Serve at least 1,000 residents of underserved populations including those who are racially and ethnically diverse, and those who are low to moderate income.
Goal Status	1. Simple screening tools were created and implemented in FY23 to identify food insecure residents being served at the PFH who are experiencing other behavioral health challenges. Those identified were connected with a Licensed Mental Health counselor for follow up. 2. Served 1,345 residents in FY23. Of the 1,345 residents, 74% identify as Hispanic or minority, 100% experienced low income, 77% were non-English speakers, and 51% were 60 or older.
Time Frame Year: Year 1	**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 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 ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒ Total Population or Community Wide Intervention
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 FY23 CASA will: 1. 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 FY23 999 households received assistance with the following: · 67% assisted in applying for affordable housing, CHAMP, Sec 8, SRO, private developments · 15% assisted in applying for elder/disabled housing · 27% assisted in a market-rate housing search · 34% secured new housing
Time Frame Year: Year 1	**Time Frame Duration: Year 3** / **Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: Infrastructure to Support Community Benefits Collaborations across BILH Hospitals** **Health Issue: Additional Needs / Social Determinants of Health**	
Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital have worked together to plan, implement, and evaluate Community Benefits programs. Community Benefits

	staff continued to understand state and federal regulations, build community engagement and evaluate capacity, and collaborate on implementing similar programs. BILH continues to refine the Community Benefits (CB) database, as part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐Access/Coverage Supports ☒ Infrastructure to Support Community Benefits
Program Goal(s)	1. By September 30, 2023, BILH Community Benefits and Community Relations staff will participate in workshops to build community engagement skills and expertise. 2. By September 30, 2023, continue to refine a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits data to more accurately capture and quantify CB/CR activities and expenditures. 3. By September 30, 2023, all BILH Hospitals will launch a Community Connections newsletter on a quarterly basis to communicate community benefits activities to community partners, residents, and vested parties
Goal Status	1. All 10 BILH Community Benefits hospitals participated in 4 community engagement workshops. 2. All FY23 regulatory reporting data were entered into the Community Benefits Database. The ability for community organizations to apply for grants was added in FY23. 3. BH/AGH launched and sent two newsletters to a mailing list of 150 organizations and people.

Time Frame Year: Year 1	Time Frame Duration: Year 3	Goal Type: Outcome Goal

Priority Health Need: Mental Health & Substance Use **Program Name: Compass Moms do Care** **Health Issue: Substance Use Disorder**	
Brief Description or Objective	The Moms do Care Program provides support for pregnant and parenting women with a history of substance use. The program offers prenatal and postnatal medical care, medication-assisted treatment for addiction, “peer mom” recovery coaches, a team lead social worker (LICSW) for team supervision and complex case management, and two care managers to facilitate support groups and therapy as well as recovery support. The goals are to promote recovery in pregnant and parenting women, improve perinatal care of the mother-baby dyad, support women through the DCF process, and improve dyadic outcomes. These goals are achieved through a multidisciplinary approach focused on improved maternal substance use treatment, trauma-informed and evidence-based maternal and neonatal care, and increased support for substance-exposed newborns and their families. A key element of Compass is its structured support groups made up of other women in the program and “graduates” who continue to work on their sobriety as mothers. There are now several groups a week including pre-natal, parenting, early intervention, and recovery groups. Intensive work is also done with local DCF offices with the goal of a DCF response that is timely, transparent, and trauma-informed.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	For pregnant women, the goals are sufficient prenatal and postnatal care, recovery without substance use, maintain custody of infants, and referral for behavioral health services and hepatitis C treatment (if applicable). The goal is for at least 80% of women participating in the program to

	be discharged with the baby in their custody. For parenting women, the goals are to maintain recovery and retain/regain infant custody. For their infants, the goal(s) are reduced length of stay for treatment of neonatal abstinence, discharge in maternal custody, and early intervention referral.		
Goal Status	In FY23 89 pregnant or parenting moms participated in the program. Of the 89 women, 46% participated in group counseling and 23% participated in individual counseling. Clients enrolled in the program reported they were more likely to initiate prenatal care in the first trimester, attend a postpartum visit, and initiate postpartum contraception. Participants in the program were discharged from the hospital with the baby in their custody 83% of the time. 100% of opioid exposed babies born at Beverly Hospital were referred to early intervention programs, and 15% of opioid exposed babies were admitted for treatment for neonatal abstinence syndrome (NAS). The length of stay for opioid exposed babies not needing treatment was 5 days, compared to the national average of 9 days. For babies needing treatment the average in FY23 was 23 days.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Mental Health & Substance Use **Program Name: High Risk Intervention Team Addiction Consults** **Health Issue: Substance Use Disorder**			
Brief Description or Objective	Beverly/Addison Gilbert Hospital's High Risk Intervention team (HRIT) implemented the Addiction Consult Program to provide assistance to patients with opioid use disorder. The Addiction Consult Service is a team approach where staff from the HRIT work together with medical staff to provide inpatient addiction consults, medication management, and assistance with referrals to outpatient recovery and treatment in the community and/or with recovery coaches on the HRIT. The majority of those served arrive at the hospital from one of the local detox centers or from a local jail or correctional facility.		
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	To provide inpatient addiction consults to at least 200 patients at AGH and BH to better manage withdrawal and/or connect them with recovery support in the community.		
Goal Status	In FY23 the Addiction Consult Service reached over 250 patients.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process 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 Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To provide a safe and convenient way for residents to dispose of unwanted or unused medications.	

Goal Status	In FY23, Beverly Hospital safely collected and disposed of 611.45 pounds of expired or unwanted medications. Although the weight sent back in 2023 was significantly less (611 vs 3808 lbs.) the actual volume and quantity were more in FY23 (FY23 sent back a total of 12 - 38-gallon liners vs 11 38-gallon liners.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health & Substance Use **Program Name: Gloucester Police Department "Teach to Reach" Program** **Health Issue: Substance Use**		
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 Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase job training and workforce development opportunities.	
Goal Status	In FY23 20 participants graduated from the Teach to Reach program and 17 of the graduates earned Recovery Coach certification.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health & Substance Use **Program Name: Pathways for Change Nurturing Fathers 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 Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. Ten fathers will participate in the 13-week Nurturing Fathers program beginning in Middleton. 2. Ten parents and their children will participate in the 15-week program in Beverly. 3. Participants will increase skills in nurturing parenting, positive discipline, and collaborative conflict resolution skills.	
Goal Status	1. 11 fathers completed intakes for Nurturing Fathers at the Middleton pre-release facility; 3 ultimately attended enough sessions to graduate (maximum of 3 absences). Those who needed to leave the program early (primarily due to release from the facility before the program's conclusion) received information for accessing Pathways services in the future. 2. 10 parents and 8 children participated in Nurturing Families in Beverly 3. There was an increase in overall averages for all parenting skills, with final scores all falling in the high average category.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process 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 Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	1. The Technology Navigator will train 6 staff, volunteers and/or community partners in FY23.. 2. The Technology Navigator and trainees will reach 50 people in FY23. 3. The consumer satisfaction survey will reach at least 90% satisfaction result post VR sessions including reported reductions in feeling isolated and lonely with decreased feelings of anxiety and depression.		
Goal Status	1. The Technology Navigator trained 6 staff, volunteers and/or community partners in FY23.. 2. The Technology Navigator and trainees reached 63 people in FY23. 3. 100% of participants completed a post survey and reported the VR Program as being Excellent (69%), Good (31%). In addition, 69% reported they would recommend the program, and 92% reported that the VR group provided them with opportunities to engage and talk with others.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	

Priority Health Need: Mental Health & Substance Use Program Name: Collaborative Care Model Health Issue: Mental Health			
Brief Description or Objective	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 Intervention	☐Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	To increase access to mental health services by incorporating the Collaborative Care Model in Primary Care practices throughout the BILH service area.		
Goal Status	In FY23 the program was implemented in ten practices in the BH/AGH CBSA, serving a total of 1288 patients.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Mental Health & Substance Use Program Name: Behavioral Health Crisis Consultation Health Issue: Mental Health		
Brief Description or Objective	To provide 24/7/365 behavioral health crisis evaluation in the emergency department (ED) and throughout other hospital units for individuals experiencing mental health and substance use related crisis. Services are payer agnostic and provided via in-person or telehealth by a multidisciplinary team of qualified professionals, including Psychiatrists, independently licensed and Master's level clinicians, Nurse Practitioners, Registered Nurses, Certified Peer Specialists, and Family Partners. The services include initial assessments for risks, clinical stabilization, treatment initiation, care coordination, and ongoing evaluation to ensure appropriate level of care placement.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to clinical and non-clinical support services for those with mental health and substance use issues, by providing behavioral health services in the hospital.	
Goal Status	A multidisciplinary team, comprised of qualified behavioral health providers, psychiatry, family partners, and peer specialists, is employed to provide behavioral health crisis consultations in the Emergency Department or medical floors of the hospital. In FY23 the team served a total of 2,339 patients at AGH/BH, a 75% increase over FY22. Patients were served at AGH (316) and Beverly Hospital (2,023).	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Mental Health & Substance Use Program Name: Behavioral Health Community Outreach Health Issue: Mental Health		
Brief Description or Objective	Provides counseling, treatment, and community support services programs for adults and children with mental health issues and/or those recovering from substance use disorder. Services Include outpatient individual or group therapy, psychiatric services and pharmacological care, individual and group counseling, addiction treatment, school based programs, driver alcohol education programs, and court evaluations. In addition, counselors coordinate care and connect patients with community resources to help secure safe and affordable transportation and housing, medical insurance, and financial assistance.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To help adults, children, and families struggling with mental health issues and/or substance use disorder by providing treatment, support, and resources.	
Goal Status	In FY23 a total of 3,656 people were served through the following: · Outpatient Clinics – 14,708 sessions reaching 690 people Beverly 12,337 session serving 542 patients Gloucester 2,371 sessions serving 148 patients Psychopharmacology (Medication) Clinics - 3944 sessions reaching 597 people Beverly, 2534 sessions serving 474 patients Gloucester, 1410 sessions serving 123 patients	

	(Behavioral Health Community Partners – 1,034 sessions reaching 241 people) Danvers – 626 PMPM for 140 patients Beverly – 408 PMPM for 101 patients · Detoxification Services Danvers – 3209 Bed days for 1356 patients Note: Danvers reduced bed capacity due to nursing shortage/recruiting challenges, then closed in mid-April and remained off-line through September. Certain expenses continued for staffing and facility costs · Community Support Services, Danvers - 30,149 sessions reaching 487 patients · Community Services Agency, Beverly - 14,035 days families enrolled, 285 patients
Time Frame Year: Year 1	**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, and sessions run 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 Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. To serve 100 seniors each across its Greater Beverly YMCA, Ipswich Family YMCA, and Cape Ann YMCA, of which 20% each year will be economically disadvantaged. 2. At least 52% of participants will report that they have maintained or increased their general overall health. 3. At least 61% of participants will report that they have improved their physical abilities.
Goal Status	1. Served 100 older adults in FY23, with 20% being economically insecure. 2. 76% of the participants reported that they maintained or increased their feeling of general overall health after participating in the program. 3. 84.5% of the participants reported their physical abilities improved after participating in the program.
Time Frame Year: Year 1	**Time Frame Duration: Year 3** / **Goal Type: Outcome 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 Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	To identify persons who may be at higher lifetime risk of developing breast cancer and to provide screening follow-up to their physicians.	
Goal Status	In FY23, BH/AGH conducted 3962 free screenings in Beverly, Addison Gilbert Hospital, and the Danvers Outpatient Center, an 18% increase over FY22. Of those screened, 1222 women were identified with a high-risk mutation and 740 women were identified with a high lifetime risk of breast cancer. Follow-up consultations were provided after each screening, and results were shared with the participant's physicians so they could discuss the recommended follow-up evaluation and care. Demographic Profile: 20-39: 187 40-59: 2036 60-69:1049 70-79: 603 80 +: 85	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: High Risk Intervention Team** **Health Issue: Chronic Disease**		
Brief Description or Objective	The High Risk Intervention Team (HRIT) is a multidisciplinary team with pharmacists, social workers, and recovery coaches that provides a multitude of services to high-risk clients to support their complex needs, including medication education, home visits, accompaniment to medical appointments, coordinating discharge care, assistance with obtaining insurance, coordinating mental health and recovery services for substance use disorders, housing needs, accessing food, and any and all interventions designed to assist patients to be cared for in their homes or community setting. The HRIT also makes post-acute care and home visits. In addition, a recovery coach on the team is designated to the emergency department to work directly with patients with substance use disorder that present to the ED. The recovery coach is able to provide immediate recovery options.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	The HRIT will serve the community population with the highest risk for readmission to BH/AGH, including those with four or more admissions in the past 12 months, those with readmissions within 30 days, and those with socially complex needs (Medicaid, Medicare, homelessness, and substance use disorder history).	
Goal Status	In FY23 the HRIT served a monthly average of 60 patients at AGH and 400 at BH on an ongoing basis. Of these patients 80% have a public payor (Medicare or Medicaid) and 40% had a mental health diagnosis or substance use disorder	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Skin Cancer Awareness and Prevention Community Campaign**

Health Issue: Chronic Disease / Cancer		
Brief Description or Objective	According to the American Cancer Society, skin cancer is the most common type of cancer in the U.S. More skin cancer cases are diagnosed in the U.S. each year than all other cancers combined, and the number of cases has been on the rise over the past few decades. Education and awareness can help prevent skin cancer from occurring and promote early detection; if detected early, skin cancer can often be treated effectively. Recognizing this, Beverly and Addison Gilbert Hospitals launched a skin cancer prevention campaign to raise awareness of the risk factors associated with skin cancer, provide easy-to-remember sun protection strategies, and promote the importance of sun safety and early detection. In order to maximize the impact, BH/AGH participated in several large community events throughout the year. At each event, sun safety messaging was reinforced using fun and interactive games and displays. In addition, all participants received sun safety tool kits, which included educational information from the American Cancer Society, sunscreen, and lip balm.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Reach at least 1,000 community members to raise awareness of the risk factors associated with skin cancer, provide easy-to-remember sun protection strategies, and promote the importance of sun safety and early detection.	
Goal Status	More than 2,000 people of all ages received sun safety information and skin protection toolkits at 5 different community events in Beverly (1), Danvers (1), and Gloucester (3).	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process 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 ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. Provide high-quality, comprehensive health care to students to support optimal health and academic outcomes.	

	2. Reduce barriers to food access by providing at least 625 food orders reaching at least 67 students via the free food pantry, offered in collaboration with The Open Door 3. Facilitate at least 30 outreach activities reaching 650 students or more.	
Goal Status	1. In FY23 the clinic conducted 1100 nurse practitioner visits (a 12% increase over FY22) and 1083 social worker visits (a 30% 23% increase over FY22). In addition, 490 combined community health worker visits were conducted. 2. Provided 625 food orders serving 67 students and families and made 117 free food deliveries to students and their families. 3. Organized 30 outreach activities reaching 650+ students	
Time Frame Year: Year 1	**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 in the transition from treatment to survivorship.	
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To guide patients through the complexities of the disease, direct them to health care services for timely treatment and into survivorship, and actively identify and help address barriers to care that might prevent them from receiving timely and appropriate treatment.	
Goal Status	In FY23 the Oncology Nurse Navigators at BH and AGH dedicated 7,931 hours to assist more than 900 patients and their families or caregivers, a 10% increase over FY22.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$10,906,536.00	
Community-Clinical Linkages	$ 111,710.00	
Total Population or Community Wide Interventions	$ 561,233.00	$ 246,764.00
Access/Coverage Supports	$ 1,707,558.00	
Infrastructure to Support CB Collaborations	$ 24,824.00	
Total Expenditures by Program Type	$13,311,861.00	
CB Expenditures by Health Need		**$ 246,764.00**
Chronic Disease	$ 1,195,136.00	$ 53,264.00
Mental Health/Mental Illness	$ 3,064,718.50	$ 20,000.00
Substance Use Disorders	$ 1,691,180.00	$ 15,000.00
Housing Stability/Homelessness	$ 52,412.00	$ 40,000.00
Additional Health Needs Identified by the Community	$ 7,308,413.50	$ 118,500.00
Total by Health Need	$13,311,861.00	$ 246,764.00
Leveraged Resources	**$ 5,689,075.00**	
Total CB Programming	$19,000,936.00	
Net Charity Care Expenditures		
HSN Assessment	$ 1,905,648.00	
Free/Discounted Care	$ 283,981.00	
HSN Denied Claims	$ 435,418.00	
Total Net Charity Care	$ 2,625,046.76	
Total CB Expenditures	$21,625,982.76	

Additional Information	
Net Patient Services Revenue	$431,130,193.00
CB Expenditure as % of Net Patient Services Revenue	5.02%
Bad Debt	$2,125,737.00
Bad Debt Certification	

SECTION VI: CONTACT INFORMATION

Marylou Hardy, Regional Community Benefits/Community Relations Manager
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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:

    Vivian Argento, BH/AGH Associate CMO replaced Joseph Huang, CNO in September, 2023. In addition, the following community members joined the CBAC in FY23: David Thomson, DanversCares, Laura DellChiaie, City of Beverly Director of Public Health, Maria Fernando Canton, Chief Human Resource Director for North Shore Community Health, and Andrea Bettencourt, Director of Operations for Northeast Medical Associates.

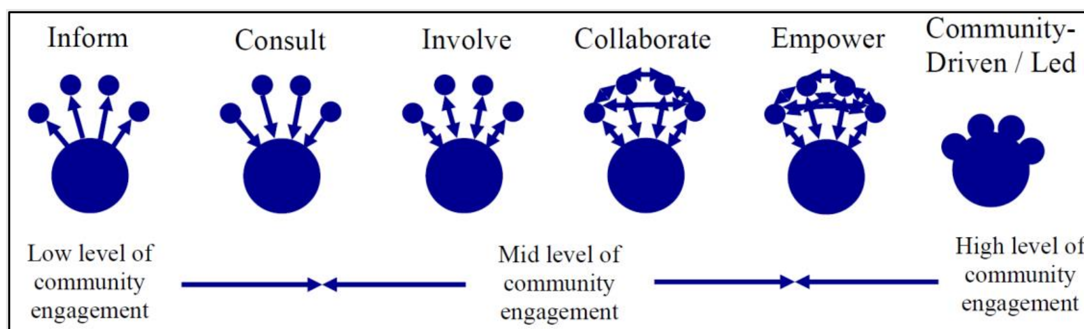
II. Community Engagement

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)
Massachusetts Coalition for the Homeless	Celinet Sanchez, Director of Grants and Communications	Housing organizations	BH/AGH awarded a 3 year grant to support the CASA program. In addition, Celinet Sanchez is a member of the BH/AGH CBAC.

Greater Lynn Senior Services	Eileen Burke, Director of Grants	Social Service Organizations	BH/AGH awarded a 3 year grant to support the Phoenix Food Hub Food for Thought program. In addition, Eileen Burke 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 FY23 a grant was awarded for implementation of a new/pilot program called 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.
Backyard Growers	Alison DiFiore, Executive Director	Social service organizations	BH/AGH awarded a grant to support the AgriCulture program to provide fresh fruits and vegetables to residents living in Gloucester housing locations.

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 FY23 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, identified strategies to be continued, and brought forward	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.

		ideas for new strategies to address the needs.	
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Collaborate	Goal was met. In FY23 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.	Collaborate
Implementing Community Benefits programs	Collaborate	Goal was met. BH/AGH engaged the CBAC in the review process for RFP's for three-year grant funding in alignment with the Implementation Strategy	Collaborate
Evaluating progress in executing Implementation Strategy	Collaborate	Goal was met. BH/AGH engaged grantees in a regular data tracking system to provide mid-year and annual progress on community benefits programs	Collaborate
Updating Implementation Strategy annually	Collaborate	Goal was met. BILH and BH/AGH have worked to update and engage the CBAC in tracking data for community benefits programs on a regular basis	Collaborate

- 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.
   BH/AGH hosted its annual public Community Benefits Meeting on September 25, 2023. The meeting was held in person in Beverly, with more than 50 community members in attendance.

III. Updates on Regional Collaboration

1. If the hospital reported on a collaboration in its **Year 1 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. No updates

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 1 Hospital Self-Assessment Form**.
   No updates