Community Benefits Report

Fiscal Year 2025

Beth Israel Lahey Health
Beverly Hospital

Beth Israel Lahey Health
Addison Gilbert Hospital

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SECTION I: SUMMARY AND MISSION STATEMENT

Northeast Hospital Corporation (BH/AGH), also known as Beverly and Addison Gilbert Hospitals (BH/AGH), is a member of Beth Israel Lahey Health (BILH). The BILH network of affiliates is an integrated health care system committed to expanding access to extraordinary patient care across Eastern Massachusetts and Southern New Hampshire 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 5,900 physicians and 36,000 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 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 Community and Health Impact Officer. This structure makes sure that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WE CARE:*

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

The Community Benefits Program at BH/AGH partners with community leaders and organizations to assess and meet the health care needs of the community. Strategies used in community benefits health activities include prevention, early detection, early

intervention, long-term management, and collaborative efforts with the affiliated 3 organizations that make up BH/AGH. Health issues addressed encompass safety, chronic disease, infectious disease, substance abuse, mental health, maternal and child health, and elder health.

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 inequities and ensuring that all patients are welcomed and received with respect and have access to culturally responsive 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 Amesbury, Beverly, Burlington, Danvers, Essex, Gloucester, Ipswich, Lynn, Manchester-by-the-Sea, Newburyport, and Rockport. In FY 2025, 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 (February 2018). 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 2026 - 2028 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 2025 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, and disability status. There was consensus among interviewees, focus groups, and community listening session participants that people of color, recent immigrants, and non-English speakers were more likely to have poor health status and face systemic challenges accessing needed services than white, English speakers who were born in the United States. These segments of the population are impacted by language and cultural barriers that limit access to appropriate services, pose health literacy challenges, exacerbate isolation, and may lead to discrimination and disparities in access and health outcomes.

For its FY 2026 – 2028 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 improving the health status of the following priority cohorts:

- Youth
- Low-Resourced Populations
- Individuals Living with Disabilities
- Older Adults
- Racially, Ethnically and Linguistically Diverse Populations

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

Key Accomplishments for Reporting Year
BH/AGH's most recent FY 25 CHNA and FY 26-FY 28 IS were approved and adopted, respectively, by the BH/AGH Board of Trustees during the fiscal year ended September 30, 2025. That CHNA and IS will inform the Community Benefits mission and activities of

BH/AGH for the fiscal years ending September 30, 2026; September 30, 2027; and September 30, 2028.

This report covers BH/AGH's fiscal year ending September 30, 2025. The previous FY 22 CHNA and accompanying FY 23-FY 25 IS were approved by the BH/AGH Board before September 30, 2022 and informed the BH/AGH's Community Benefits initiatives for the fiscal years ending September 30, 2023; September 30, 2024; and September 30, 2025. As such, the accomplishments and activities included in this section as well as in Section IV: Community Benefits Programs relate to the CHNA and Implementation Strategy approved as of September 30, 2022.

Program accomplishments include: Over 1,700 unique individuals participated in Phoenix Food Hub services.

- Housing situations were stabilized for more than 1,200 households through the Massachusetts Coalition for the Homeless' Casa Project.
- More than 130 older adults participated monthly in classes that promote physical fitness, cognitive engagement, and social interaction through the Rockport Council on Aging.
- 266 Gloucester High School students visited the School-Based Health Center more than 2,000 times to receive care from nurse practitioners, social workers and/or community health workers.
- Serving the Health Information Needs of Everyone (SHINE) counselors assisted over 800 patients with health insurance enrollment.

Plans for Next Reporting Year

In FY 2025, 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. In response to the FY 2025 CHNA, BH/AGH will focus its FY 2026 - 2028 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 2025 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 2025 CHNA and creating its FY 2026 - 2028 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 identity, sexual orientation, disability status, immigration status, or age. As discussed above, based on the FY 2025 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that for BH/AGH's FY 2026 - 2028 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; and individuals living with disabilities.

BH/AGH will partner with clinical and social service providers, community-based organizations, public health officials, elected/appointed officials, hospital leadership, and other key collaborators throughout its CBSA to execute its FY 2026 – 2028 IS.

- **Equitable Access to Care**
  - BH/AGH will continue the Connecting Young Moms Program, which offers comprehensive pre- and postnatal programs to young mothers and their children with limited resources and/or emotional/social support.

- **Social Determinants of Health**
  - BH/AGH will continue to support Beverly Bootstraps and Backyard Growers Garden Program to increase access to nutritious food and continue to collaborate with Wellspring House on their Pathways to Leading to Living Wage Jobs Programs and Action, Inc's Welcome Home Program.

- **Mental Health and Substance Use**
  - BH/AGH will continue to partner with Greater Lynn Senior Services on behavioral health patient navigation.

- **Complex and Chronic Conditions**

- BH/AGH will partner with the YMCA of the North Shore to offer Enhance Fitness classes, an evidence-based health intervention to support healthy aging and minimize fall risks.

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 48). The BH/AGH Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members and asked them to submit the form to the AGO website.

SECTION II: COMMUNITY BENEFITS PROCESS

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

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

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

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

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- ***E**quity - 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 Community Benefits and Community Relations Manager, who has direct access to 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 Community and Health Impact 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 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 serve its patients compassionately and effectively, and to create a healthy future for them, their families, and BH/AGH'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, as well as those from corporate and non-profit community organizations.

The BH/AGH CBAC met on the following dates:

- December 11, 2024
- March 12, 2025
- June 18, 2025
- September 17, 2025 (Public Meeting)

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 (IS) 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 53).

- Action Inc.
- Backyard Growers
- Beverly Bootstraps
- Beverly Council on Aging
- City of Beverly
- City of Gloucester
- DanversCares
- Gloucester Board of Health
- Gloucester Council on Aging
- Gloucester High School
- Gloucester Police Department
- Greater Lynn Senior Services
- Harborlight Community Partners
- MA Coalition for the Homeless
- North Shore Community College
- Pathways4Children
- SeniorCare
- The Open Door
- Town of Danvers
- Town of Essex
- Town of Ipswich
- Town of Manchester-by-the-Sea
- Town of Middleton
- Town of Rockport
- Unidine
- Wellspring House
- YMCA of the North Shore

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY 2025 Community Health Needs Assessment (CHNA) along with the associated FY 2026-2028 Implementation Strategy was developed over a fifteen-month period from June 2024 to September 2025. 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 2025. FY 2025 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 2025 CHNA approach, methods, and key findings.

Approach and Methods
The FY 2025 assessment and planning process was conducted in three phases between June 2024 and September 2025, 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. 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.

Through the FY 2025 Community Health Needs Assessment process, BH/AGH conducted 18 interviews with key collaborators in the community, facilitated 5 focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 2,000 residents, and organized a community listening session. In total, the assessment process collected information from more than 2,200 community residents, clinical and social service providers and other community partners.

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

Summary of FY 2025 CHNA Key Health-Related Findings

Equitable Access to Care

- Interviewees, focus groups, and listening session participants identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system-level, meaning that the issues stemmed from the ways in which the system did or did not function. System-level issues included full provider panels, which prevented providers from accepting new patients, long wait lists, and an inherently complicated health care system that was 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 forgo or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.

Social Determinants of Health

- The social determinants of health are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." These conditions

influence and define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to housing, food insecurity, economic insecurity, education, access to care/navigation issues, and other important social. There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, surveys, and the listening session reinforced 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, transportation, economic security, and language and cultural barriers to services.

Mental Health and Substance Use

- Anxiety, chronic stress, depression, and social isolation were leading community health concerns. There were specific concerns about the impact of mental health issues for youth and young adults; and social isolation among older adults.
- In addition to the overall burden and prevalence of mental health issues, residents identified a need for assistance navigating a complex behavioral health system, as it can be overwhelming for individuals experiencing mental health challenges. Providing navigation assistance ensures people can access the right services at the right time, improving continuity of care and health outcomes.
- Youth mental health was a concern in the CBSA, including the prevalence of chronic stress, anxiety, and behavioral issues. These conditions were exacerbated throughout the pandemic, because of isolation, uncertainty, remote learning, and family dynamics.

Complex and Chronic Conditions

- Chronic conditions like cancer, heart disease, chronic lower respiratory disease, and stroke account for four of the six leading causes of death statewide, and it is estimated that there are more than $41 billion in annual costs associated with chronic disease. Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

For more detailed information, see the full FY 2025 BH/AGH Community Health Needs Assessment Report and Implementation Strategy on the hospital's website.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Equitable Access to Care **Program Name: Addressing BILH Health Disparities** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	BILH Health Equity division sits within the Office of Community and Health Impact. BILH's Health Equity team's focus is on addressing health disparities to ensure equitable health outcomes across the patient populations served by BILH.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	Meet or exceed goal of 2.65% reduction the occurrence of Severe Maternal Morbidity-Blood Transfusions during the measurement period ending September 30, 2025	
Goal Status	2.91% of BILH patients received Severe Maternal Morbidity-Blood Transfusions	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcome Goal**
Program Goal(s)	Meet or exceed goal of 69.6% of BILH patients 18-85 years of age with a diagnosis of both diabetes and hypertension who meet control targets for both conditions (HbA1c <= 9.0% AND BP < 140/90 mmHg criteria) during the measurement period ending September 30, 2025	
Goal Status	70.4% of the focus population met the control targets for both conditions (HbA1c <= 9.0% AND BP < 140/90 mmHg criteria) during the measurement period through September 2025	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcome Goal**
Program Goal(s)	Meet or exceed goal of 74.8% of BILH patients 18-85 years of age with a diagnosis of hypertension whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period ending September 30, 2025	
Goal Status	75% of the focus population had blood pressure that was adequately controlled (< 140/90 mmHg) during the measurement period	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcome Goal**
Program Goal(s)	Meet or exceed goal of 76.5% of BILH patients 18-85 years of age diagnosed with diabetes (Type 1 and Type 2) who had a hemoglobin A1c (HbA1c) level of <= 9.0% during the measurement period ending September 30, 2025	
Goal Status	The average percentage, of the identified population above, whose hemoglobin A1c (HbA1c) level was <= 9.0% during the measurement period was 78.4% which exceeded the target average goal of 76.5%	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcome Goal**

Priority Health Need: Equitable Access to Care **Program Name: Interpreter Services** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	An extensive body of research illustrates the health disparities and differences in health care access and utilization that exist for diverse individuals/cohorts and foreign-born populations. Language barriers pose significant challenges to providing effective and high-quality health and social services. To address this need, and in recognition that language and cultural barriers are major difficulties to accessing health and social services and navigating the health system, BH/AGH offers free interpreter services for non-English speaking, limited-English speaking, deaf and hard-of-hearing patients. These services are provided in person; by phone using a portable speaker phone to connect patients, their care team and an interpreter; and through video-based remote interpreter service using a computer to connect patients with an interpreter. Professional interpretation services in hundreds of languages are available 24/7.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide access to interpretation and translation services at no cost to BH/AGH patients.	
Goal Status	In FY25, BH/AGH Interpreter Services supported 23,223 requests including Face-to-Face, Telephonic, Video, and ASL.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Pharmacy Assistance Program** **Health Issue: SDOH (Access to Care)**		
Brief Description or Objective	BH/AGH 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 BH/AGH patients to ensure those without insurance leave with their medication. To support patients in accessing medications through the HSN pharmacy program, BH/AGH contracts with the BILH pharmacies to employ patient assistance staff.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To increase access to care by providing financial assistance for prescriptions for low income or uninsured patients.	

Goal Status	In FY25, BH/AGH provided $565,271 in financial assistance for prescriptions to low income and/or uninsured patients.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Connecting Young Moms** **Health Issue: Additional Needs (Access to Care)**		
Brief Description or Objective	The Connecting Young Moms (CYM) program offers comprehensive pre- and postnatal programs to young mothers and their children with limited resources and/or emotional/social support. The prenatal component of the CYM program is the Childbirth Preparation Series, designed to prepare expectant mothers and their support people for labor and delivery. The postnatal component is a support group specifically for teens and young women and their children. The program now operates on a hybrid model wherein we offer both in person and virtual options based on what works best for the patients. The CYM program also provides extensive resource and referral support to women who do not fully join the program, and those not actively participating.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To maintain a diaper closet for biweekly diaper distribution for those mothers participating in support groups and to work with other community organizations to offer free material needs for their children. Increase the number of referrals into the program.	
Goal Status	The robust diaper closet continues to be available for the women participating in CYM. Women receive diapers during every in-person group session. CYM continues to work with The Bambino Basket Organization, which allows seasonal clothing/material needs for children at no cost to the client. There were 62 new referrals in FY25. The program increased volunteer CYM doula staff by adding 3 additional doulas.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process**

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	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

	☐ Total Population or Community-Wide Interventions
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 FY25, the SHINE counselor assisted 809 patients with enrollment.

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

Priority Health Need: Equitable Access to Care **Program Name: BILH Workforce Development** **Health Issue: Additional Health Needs Identified by the Community (Access to Care)**	
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's 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 ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒ Total Population or Community-Wide Interventions
Program Goal(s)	In FY25, Workforce Development will continue to encourage community referrals and hires.
Goal Status	In FY25, 306 job seekers were referred to BILH and 79 were hired across BILH hospitals.

Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Workforce Development will hire interns hired after internships and place in BILH hospitals.	
Goal Status	In FY25, 36 interns were hired permanently in BILH hospitals.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Workforce Development will offer English for Speakers of Other Languages (ESOL) classes to BILH employees.	

Goal Status	In FY25, 126 employees across BILH were enrolled in ESOL classes.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Workforce Development will offer internships in BILH hospitals to community members over the age of 18	
Goal Status	In FY25, 131 community members were placed in internships across BILH hospitals to learn valuable skills.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Workforce Development will offer paid trainings for community members across BILH.	
Goal Status	In FY25, BILH trained a total of 97 community members to pipeline programs, including Patient Care Technician/ Nursing Assistant, Pharmacy Tech, Medical Assistant, CPT, Surg Tech, Research Admin, Endoscopy Tech, and the Associate Degree Nursing Residency program.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Workforce Development will attend events and give presentations about employment opportunities to community partners.	
Goal Status	In FY25, 42 events and presentations were conducted with community partners across the BILH service area.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Workforce Development will establish clinical affiliation agreements with vocational technical high schools to hire young people from the community for cooperative education paid and unpaid internships in nursing assistant, medical assistant, and other hospital-specific positions.	
Goal Status	In FY25, Workforce Development established/maintained 11 clinical affiliation agreements with vocational technical high schools, which resulted in the hiring of 55 high school students in paid cooperative education placements and 20 into unpaid clinical placements. Beverly and Addison Gilbert Hospital participated in offering these trainings.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees.	
Goal Status	In FY25, 12 BILH employees attended citizenship classes, 102 BILH employees attended career development workshops and 138 BILH employees attended financial literacy classes.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Workforce Development will offer employees career development services.	
Goal Status	In FY25, 831 BILH employees received career development services.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Financial Assistance Counselors** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	Significant segments of the community population living within the hospital's CBSA, particularly low-resourced populations, face significant barriers to care. The hospital's Financial Assistance Program offers emergency and other medically necessary services at low or no cost to qualified patients (when qualifying family income is at or below 400% of the Federal Poverty Level). The hospital's Financial Counseling staff screen people and assist them in applying for all eligible financial assistance programs.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Each year, BH/AGH will screen and enroll eligible patients into entitlement programs.	
Goal Status	In FY25, the number of patients screened for assistance was 6,220 patients and 9,260 encounters. The number of MassHealth applications processed were 1,749 applications, of which 1,374 were approved Of which 537 applied for Charity Assistance, total 351 were approved and The number of uninsured patients that utilized the Health Safety Net were 3,950. BH/AGH also assisted 809 patients in Medicare Part D enrollment.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Facilitating Primary and Specialty Care Access** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	Throughout BH/AGH's Community Benefits Service Area, BH/AGH subsidizes primary care services provided by BILH Primary Care affiliated practices and women's health services.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide access to primary and specialty care for uninsured and underinsured patients.	
Goal Status	In FY25, BH/AGH provided primary and specialty care in eight practices in the CBSA including women's health services	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Beverly Bootstraps Mobile Market** **Health Issue: Additional Health Needs (Access to Healthy Foods)**		
Brief Description or Objective	The Mobile Market is a free farmers' market that promotes better health and nutrition and addresses food insecurity by providing low-income Beverly residents with fresh fruits and vegetables in a convenient and socially acceptable way. It provides fresh, nutrient-dense produce to residents of low-income housing complexes throughout Beverly, alleviating the negative impacts of poor nutrition that lead to devastating health consequences. Each week from late June through October the Mobile Market travels to the housing complexes and serves residents directly in their neighborhoods.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	To promote better health and nutrition and address food insecurity.	
Goal Status	Operated six mobile market sites. Over the 16 weeks of the program, had over 2,500 client visits total, serving 905 unique individuals/448 families. Distributed 21,754 pounds of fresh, mostly local produce.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	At least 50% of Mobile Market participants utilize other Beverly Bootstraps services.	
Goal Status	There has been a steady increase in Mobile Market participants' service integrations, with nearly 75% of Mobile Market participants utilizing additional Beverly Bootstraps services. By consistently informing participants at the Mobile Market sites about the food pantry, thrift shop, education, and case management services, the gap has been successfully bridged for many families. The program's re-education efforts ensure that even long-term participants are aware of new or updated programming.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	By September 2025, at least 65% of participants report eating more produce all year long.	
Goal Status	Survey results indicate this threshold has been exceeded, reaching close to 75%. The program attributes this increase to educational "point-of-distribution" talks, where they provide nutritional information and recipes. This continuous reinforcement has empowered clients to prioritize fresh produce in their daily diets well beyond the summer months.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	At least 75% of participants report awareness of other services by September 2025.	

Goal Status	The program has reached a high-water mark for service awareness. Through the strategic use of printed materials and one-on-one conversations at every mobile market stop, their focus on re-educating the community has ensured that over 75% of their clients now view the Mobile Market as a gateway to a full suite of supportive services.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: Backyard Growers agriCulture Program** **Health Issue: Additional Health Needs (Access to Healthy Foods)**		
Brief Description or Objective	Backyard Growers focused on maximizing community engagement with Willowood Commons including its community garden, shared perennial garden, and food-focused infrastructure. Perennial food and herb crops were selected in partnership with families in the community to ensure that the gardens will provide culturally relevant crops. Working alongside residents, BYG staff developed a series of engagement opportunities focused on supporting residents in developing the skills to provide themselves with healthy, low cost food resources.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	To increase the number of garden users at Willowood Gardens from 50 to 150 by spring 2025, measured through attendance and reported garden engagement via staff-administered surveys.	
Goal Status	This goal has been successfully achieved, thanks to increased programming, site improvements, and deeper community involvement throughout the 2023 and 2024 growing seasons.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	Secure consulting contracts with 2 Housing Authority neighborhoods outside of Gloucester, MA by November 2025 with the shared intent of implementing the consulting model developed in 2024 & 2025.	
Goal Status	The consulting model is becoming stronger through active implementation within Gloucester neighborhoods. Current pilot projects at Pondview and McPhearson Park, as well as the active programming at Willowood, have informed materials development and best practices for space layout, multilingual engagement, shared beds, culturally meaningful crops, and low-barrier participation. These efforts are building self-sufficient, inclusive, and resilient community spaces that can be replicated in future consulting work.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Greater Lynn Senior Services "Food & Thought" Program** **Health Issue: Additional Health Need (Access to Healthy 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 ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	At least 1,000 individual consumers visit PFH in first year after launch and every year thereafter. Of these, at least 150 consumers with behavioral health needs are supported with integrative nutrition/mental wellness supports and/or connections to traditional behavioral health supports.	
Goal Status	The total visitors to PFH have far exceeded the goal. Over 1,773 unique consumers took advantage of one or more PFH services during this reporting period. This is substantially undercounted because data is not collected on visitors to the Food Pantry or Farmers Markets. During this reporting period, of the 719 consumers referred to Phoenix, 247 were considered eligible for support. Of these, 130 were screened for their interest in Food and Thought; 60 (53%) expressed an interest. For the F&T program, which now includes hydroponics gardening, 78 individuals received services during this period.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	At least 50% of participants are low-to-moderate income	
Goal Status	Of the 1773 named consumers supported by PFH in this reporting period, almost all experience low or extremely low income.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Action Inc. Welcome Home Program** **Health Issue: Additional Health Needs Identified by the Community (Housing)**		
Brief Description or Objective	This program provides permanent housing and supportive services to chronically homeless individuals and families in accordance with the Housing First model. To participate in the program, clients must have long histories of homelessness and at least one disabling condition.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	100% of participants in the Welcome Home program will receive care from a primary care physician (PCP).	
Goal Status	Goal partially met; as of the end of October, 82% of participants received care from a PCP. Goal was not fully met due to several new clients being reluctant to engage in care via a PCP, although case managers continue to work with clients towards it.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	90% of participants will attend follow-up appointments or follow through on referrals from a PCP.	
Goal Status	100% of participants have attended a follow-up appointment or followed through on referrals from a PCP. So far, all referrals made by a PCP have been followed through.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	95% of participants will maintain their housing for at least 90 days.	
Goal Status	100% of participants have maintained their housing for at least 90 days.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health/Housing **Program Name: Massachusetts Coalition for the Homeless CASA Program** **Health Issue: Additional Health Needs/Access to Affordable Housing**		
Brief Description or Objective	The Casa Project is an upstream homelessness prevention model which embeds highly trained advocates inside community health centers and public schools to assist those facing a financial crisis to obtain or retain housing. The Casa Project's goal is to ensure everyone has a place to call home. Reaching households that are struggling with housing instability is essential to prevent displacement. Using a health equity lens Casa Project will assist the underserved members of the community in Lynn that are facing housing instability as well as struggling with any other component related to the Social Determinants of Health.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Assisting with housing search by: • Applying households to affordable housing including private developments with subsidized units • Submitting applications for CHAMP, Section 8 • Assistance locating and securing Single Room Occupancies and market-rate housing. • Searching and assisting with relocation, determining affordability, and setting up transportation to view apartments.	
Goal Status	864 households received support in their housing search, including applications for affordable and market-rate housing: - 71% assisted in applying for affordable housing, CHAMP, Sec 8, SRO or private developments. - 53% assisted in securing new housing - 36% assisted in a market-rate housing search - 17% assisted in applying for elder/disabled housing	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	Creating a long-term housing stabilization plan by: • Educate households on creating a livable budget • Assist in repairing and increasing credit scores • Providing help for households to enroll in credit repair programs. • Assisting with signing leases and educating tenants on their rights and responsibilities to maintaining a good tenancy.	
Goal Status	1,738 households developed long-term housing stabilization plans, including budgeting, credit repair, and tenant education: - 59% assisted with signing leases and educating tenants on their rights and responsibilities to maintain a good tenancy - 87% assisted in creating a livable household budget - 19% assisted in enrolling in a credit repair program - 51% assisted with startup needs for new housing	

Time Frame Year: Year 3	Time Frame Duration: Year 3	Goal Type: Process Goal
Program Goal(s)	Maximizing household incomes by: Applying for cash benefit programs Helping to apply and obtain supplemental benefits such as TAFDC, EAEDC, and SNAP Assist with unemployment benefits, SSI, and Social Security Disability	
Goal Status	622 households were assisted in maximizing their incomes through benefit applications and financial planning. - 44% assisted in applying for benefit programs, SNAP, TAFDC, EAEDC, among others -21% enrolled in the Arrearage Management Program (AMP) -35% assisted in applying for fuel assistance, energy discount programs, and any other utility discount programs they were eligible for but not receiving.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	Stabilizing Housing: Advocates are applying the household for Residential Assistance for Families in Transition (RAFT) for first month's rent, security deposits, and rent and utility arrearages. Communicating with their landlord on lease agreements, pest management, negotiating with landlords for manageable repayment plans to maintain housing. Working to resolve evictions prior to and during the eviction process. Assisting households with health and safety issues to be resolved by landlords, management companies and housing authorities (e.g., leaking pipes, mold, heating issues, dirty carpets, peeling paint, broken windows, and any other health-related and/or safety issues.) Resolving utility arrearages and any shut-off notices by working to negotiate a manageable payment plan with utility companies.	
Goal Status	1,271 households had their housing situations stabilized: - 38% assisted in resolving utility arrearages and any shut-off notices - 51% assisted in securing financial assistance for the first month's rent, security deposits, and rent and utility arrearages as well as securing assistance through RAFT. -22% communicating with their landlords and management companies to resolve health and safety issues such as leaking pipes, broken windows, pest management, mold, heating issues, and peeling paint. -43% assisted in stopping eviction and with eviction defense, communicating with landlords and management companies for recertification on subsidized housing, recalculation of rent on subsidized housing, and lease agreements.	

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

Priority Health Need: Social Determinants of Health **Program Name: Patient Transportation Voucher Program** **Health Issue: Additional Health Need (Transportation)**		
Brief Description or Objective	Increase access to care by providing financial assistance for transportation to medical appointments for individuals with no means of transportation due to medical or financial issues. Assistance is provided in the form of taxi vouchers and/or scheduled transportation.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to health services by providing rides to individuals with no means of transportation due to medical or financial issues.	
Goal Status	Provided 50 vouchers in FY25.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Community Benefits Administration and Infrastructure** **Health Issue: Chronic Disease, Mental Health/Mental Illness, Housing Stability/Homelessness, Substance Use, Additional Health Needs (Food Insecurity and Access to Care)**		
Brief Description or Objective	Community Benefits and Community Relations staff implement programs and services in our Community Benefits Services Area, encourage collaborative relationships with other providers and government entities to support and enhance community health initiatives, conduct Community Health Needs Assessments and address priority needs and ensure regulatory compliance and reporting. Additionally, Community Benefits and Community Relations staff at BILH hospitals work together and across institutions to plan, implement, and evaluate Community Benefits programs. In FY24, the staff worked collaboratively to begin the Community Health Needs Assessment, sharing community outreach ideas and support, and helped to distribute the community survey and identified key community residents for interviews and focus groups.	
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits
Program Goal(s)	Implement effective and efficient programs that support the community health needs of the Community Benefits Service Area.	

Goal Status	BH/AGH supported and implemented more than 15 programs through grants to local organizations.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	Offer evaluation capacity workshops to partner organizations and grantees to better understand impact.	
Goal Status	BILH offered five (5) evaluation workshops in FY25 focusing on data collection, analysis, interpretation, reporting and storytelling, with 96% of attendees reporting increased knowledge.	
Time Frame Year: Year 3	**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 Program** **Health Issue: Additional Health Needs (Employment)**			
Brief Description or Objective	The Wellspring House "Accelerating Access to Higher Education" program provides intensive education, job training and readiness programs, and career advising to young adults to help them obtain employment or transition to employment with higher wages. The program incorporates three program areas: College Readiness courses, the MediClerk job training program, and Career Readiness program to help students advance in their careers and education by providing mentorship and resources for college, occupational education, or job search.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	At least 50% of participants within each program year who are working towards concrete education or employment outcomes will achieve one or more of the following specific milestones: • transition from unemployment to new employment • transition to a promotion or new job with higher wages • apply to or matriculate into a post-secondary education program (certification, training in the trades or 2-or-4 year college). • finish a post-secondary education program (certification, training in the trades or 2-or-4 year college).		
Goal Status	50% of program participants achieved measurable education and employment milestones within 12 months.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	
Program Goal(s)	At least 65% of people, in the cohorts of program participants in Year One or Year Two, will achieve one or more of the following outcomes. • transition from unemployment to new employment • transition to a promotion or new job with higher wages • apply to or matriculate into a post-secondary education program (certification, training in the trades or 2-or-4 year college). Finish a post-secondary education program (certification, training in the trades or 2-or-4 year college).		
Goal Status	60% of program participants achieved measurable education and employment milestones within 24 months.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	
Program Goal(s)	90% of program participants who require crisis support for housing while working towards education and employment goals will remain stably housed throughout the year.		

Goal Status	An average of 97% of students pursuing careers and employment, who required housing crisis support, remained stably housed throughout the year.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Rockport COA Fitness Classes** **Health Issue: Additional Health Needs**		
Brief Description or Objective	BH/AGH supports the Rockport Council on Aging (COA) year-round schedule of wellness sessions designed specifically for seniors. Funding supports a variety of evidence-informed activities, including strength and balance classes, yoga, exercise and dance, and brain games.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Improve physical health and functional mobility among older adults through regular strength, balance, flexibility, and movement-based activities. Decrease social isolation by providing consistent opportunities for seniors to connect with peers and build supportive relationships	
Goal Status .	Year to date, the program has served an average of 137 seniors each month, with many participants attending classes multiple times per week. In addition to improving physical and mental well-being, the program fosters meaningful connections among participants, strengthening social support and overall quality of life.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Addiction Consult Service** **Health Issue: Substance Use Disorder**		
Brief Description or Objective	Beverly/Addison Gilbert Hospitals were awarded a grant by BSAS to fund the Addiction Consult Service to provide assistance to patients with Substance Use Disorder. The goal of the program is to increase access to integrated Hospital-based substance use disorder services, ensure ongoing linkages to care and community-based follow-up, reduce overdose deaths, and promote wellness and long-term recovery. The team is comprised of an Addictions Physician Assistant, and two recovery coaches. The team provides medication and withdrawal management, recovery support, community outreach, support, and connection to patients who are in the Emergency Department as well as inpatient units. In addition, our recovery coach runs a recovery support group for community members to attend weekly. Our goal is to empower patients to achieve lasting recovery and reintegration into their communities with the support they need to thrive.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To provide inpatient/emergency department addiction services to 250 patients at BH/AGH to better support their recovery journey. Additionally, provide harm reduction kits to at least 12 patients per month.	
Goal Status	The Addiction Consult Service saw an increase in the number of consults placed from roughly 65 to 100 consults per month. These consults can be placed by any care team members (hospitalist, ED provider, Social Work, or nursing). The team also saw an increase in the number of unique patients they saw (regardless if consult was placed) from 63 to 120. The team also had an increase in number of patient contacts from 84 to 174 . In total, the team has distributed roughly 21 harm reduction kits since January 2025.	
Time Frame Year: Year 2	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Behavioral Health Crisis Consultation** **Health Issue: Mental Health/Mental Illness, Substance Use Disorder**		
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	☐ Access/Coverage Supports

	☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population or Community-Wide Interventions
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 providing a total of 720 screens.
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and 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, and "peer mom" recovery coaches. It also includes a program manager (LICSW) for team supervision, as well as three social workers/mental health specialists who facilitate support groups and therapy, provide recovery support, and deliver case management.	
Program Type	☒ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population or Community-Wide Interventions	
Program Goal(s)	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	100% of opioid exposed babies born at Beverly Hospital were referred to early intervention programs, and 50% 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 NAS treatment, the average stay for babies in the SCN during FY24 was 22.6 days, and in FY25 dropped to an average of 19.1 days.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	For pregnant people, 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 patients 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.	

Goal Status	In FY25, 83 pregnant or parenting moms participated in the program. Of the 83 women, 45% participated in group counseling, and 40% participated in individual counseling, 33% working individually with a perinatal recovery coach, and 70% engaged with case management and advocacy. 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. Out of 19 births that occurred this fiscal year, 17 or 89% were discharged home or to residential facilities with their birth mothers.
Time Frame Year: Year 3	**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	BILH provides a range of behavioral health, substance use, and addiction recovery services and counseling for adults, youth and families including inpatient and outpatient psychiatry services. In order to increase access to mental health services, BH/AGH implemented the CoCM, a nationally recognized primary care led program that specializes in providing behavioral health services in the primary care setting. The services, provided by a BILH licensed behavioral health clinician, include counseling sessions, phone consultations with a psychiatrist, and coordination and follow-up care. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treat a variety of medical and mental health conditions.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To increase access to mental health services by incorporating the Collaborative Care Model in primary care practices throughout the BILH service area.	
Goal Status	Provided the service at nine primary care practices across the CBSA serving 1,185 patients.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: BILH Behavioral Health Access Initiative** **Health Issue: Substance Use Disorder, Mental Health/Mental Illness and Additional Health Needs (Access to Care)**	
Brief Description or Objective	To support increased access to mental health and substance use services and supports, BH/AGH participated with other BILH hospitals to pilot Behavioral Health Navigator grant programs, offer Mental Health First Aid (MHFA) trainings,

	provide behavioral health navigation and digital literacy trainings to BILH physical health navigators and amplify anti-stigma messaging, resources and supports.
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒ Total Population or Community-Wide Interventions
Program Goal(s)	Offer Mental Health First Aid (MHFA) trainings to community residents and BILH staff across the BILH Community Benefits Service Area (CBSA).
Goal Status	More than 146 community residents and BILH staff attended one of 11 MHFA trainings (9 Adult and 2 Youth, with 1 of the Adult trainings conducted in Spanish) provided across the BILH CBSA, of which 53% (78) completed all pre- and post-training requirements to receive Mental Health First Aid certification.
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	Increase knowledge and awareness of available behavioral health services and supports among clinical and non-clinical staff who provide patients/clients with physical and/or social determinants of health navigation services.
Goal Status	Two (2) Behavioral Health Navigation and Digital Literacy workshops were conducted in FY25 with 13 participants, including RNs, CHWs/Navigators, Social Workers and a Housing Case Manager. In the program evaluation, 82% of participants felt confident to help navigate patients to appropriate behavioral health care and 70% felt confident to guide patients to web-based apps to help them meet their behavioral health needs.
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Behavioral Health Navigation – Greater Lynn Senior Services** **Health Issue: Mental Illness and Mental Health, Substance Use Disorders**	
Brief Description or Objective	To support increased access to mental health and substance use services and supports, BH/AGH participated with other BILH hospitals to pilot community-based Behavioral Health Navigator (BHN) grant programs, including one with the Greater Lynn Senior Services (GLSS). A BH Navigator serving the community of Lynn identifies, understands and effectively connects residents experiencing mental health and substance use issues to appropriate support and assistance. GLSS also conducts educational activities in the communities focused on increasing awareness of available mental health and substance use resources.
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒ Total Population or Community-Wide Interventions
Program Goal(s)	By June 2027, recipients of community educational activities will demonstrate increased knowledge and awareness of available behavioral health services and support
Goal Status	47 unnamed consumers met with BH Navigator during outreach events.

	In addition, to promote awareness of behavioral health issues from multiple perspectives, the GLSS Conversations for Caring program offered multiple mental/behavioral health training sessions to professionals, stakeholders, and consumers in the community. In FY25, five sessions engaged 541 attendees.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	By June 2027, the community-based Behavioral Health Navigator model will demonstrate success in connecting individuals experiencing mental health and/or substance use issues from the selected priority cohort(s) to appropriate behavioral health referral, screening, assessment and treatment services and supports.	
Goal Status	The BHN program connected with 43 unduplicated people; 31 are currently active with BHN Navigator.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Breast Cancer Risk Assessment** **Health Issue: Chronic Disease**		
Brief Description or Objective	Recognizing the risk for breast cancer is not the same for all women, BH/AGH implemented a free risk assessment using a tablet screening tool to help women evaluate their lifetime risk for breast cancer. The assessment includes an evaluation using the tool, and results, which are shared with the person's physician, are reviewed in a follow up consultation to determine if they might benefit from a higher level of screening beyond regular checkups and mammograms.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Screen more than 3,000 women in FY25 in order to identify their risk for developing breast cancer, and to provide screening follow-up to their physicians.	
Goal Status	In FY25, BH/AGH conducted 3,152 free screenings, identifying 1,068 participants with a high-risk mutation and 758 participants with a high lifetime risk for breast cancer.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Mental Health & Substance Use **Program Name: Gloucester Police Department Teach to Reach Program** **Health Issue: Substance Use Disorder**

Brief Description or Objective	BH/AGH supported the Gloucester Police Department to continue administering the "Teach to Reach" program designed to increase peer-to-peer recovery coach services and job training and workforce development opportunities in the community.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	Improve access to substance misuse treatment and support services. Increase job training and workforce development opportunities.	
Goal Status	For the most recent class, 29 individuals applied, and 21 were accepted. Of those participants, 13 graduates are currently gainfully employed as recovery coaches or recovery specialists and/or are working in the addiction services field.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Mental Health & Substance Use **Program Name: Medication Disposal Boxes** **Health Issue: Substance Use Disorder**		
Brief Description or Objective	BH/AGH provides a medication disposal box to safely dispose of expired or unwanted medication. Medications can be dropped off 24 hours a day, seven days a week in the Emergency Room waiting area and are safely disposed of in accordance with Drug Enforcement Administration regulations.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	To provide a safe and convenient way for residents to dispose of unwanted or unused medications.	
Goal Status	In FY25, BH/AGH safely collected 14 x 38-gallon liners and disposed of 532 pounds of expired or unwanted medications.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process**

Priority Health Need: Mental Health & Substance Use **Program Name: Pathways for Children Nurturing Program** **Health Issue: Mental Health**		
Brief Description or Objective	BH/AGH supported Pathways for Children to facilitate the Nurturing program, a nationally recognized, evidence-based family education program designed to prevent child abuse and neglect by increasing knowledge of parenting skills, child development, and community services and resources. The program was offered in English and Spanish to at-risk families with children ages birth-12.	
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports	

	☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒ Total Population or Community-Wide Interventions		
Program Goal(s)	Up to 10 fathers will participate in the 13-week Nurturing Fathers program beginning in January 2025 in Middleton.		
Goal Status	12 fathers participated in the 13-week Nurturing Fathers group that ran January - April 2025 at the Essex County Sheriff's Dept. pre-release correctional facility in Middleton.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: ProcessGoal**	
Program Goal(s)	Up to 10 parents and their children will participate in the 15-week Nurturing Families program beginning in March 2025 in Gloucester.		
Goal Status	11 parents and their children participated in the 15-week Crianza con Carino program (Spanish-language Nurturing Program) that ran March - June 2025 at Pathways' Gloucester center.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal(s)	Average pre-/post-test results will indicate improvement in at least two nurturing parenting constructs.		
Goal Status	Average scores on AAPI pre/post-tests showed improvement in at least two parenting constructs, most commonly Developmentally Appropriate Expectations and Appropriate Family Roles.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	
Program Goal(s)	Facilitators will make at least 1 referral per family to a community resource.		
Goal Status	Facilitators made at least 1 referral per family (typically more) to a community resource.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	

Priority Health Need: Mental Health & Substance Use **Program Name: SeniorCare Rendever Virtual Reality Program** **Health Issue: Mental Health**		
Brief Description or Objective	The Rendever Virtual Program helps older adults reduce feelings of anxiety, chronic stress, depression, and social isolation through the use of virtual reality (VR). VR has a myriad of uses for older adults including: reminiscence therapy (visiting their childhood home, wedding location, travel locations); socialization, caregiver applications physical therapy/exercised and addressing dementia/Alzheimer's	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	The Technology Navigator will train a minimum of 3 staff, volunteers and/or community partners to facilitate the Virtual Reality (VR) platform, annually during Year 2 and Year 3 of implementation.	
Goal Status	Two new employees were trained in virtual reality during Year 2 and 3.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	The Technology Navigator and Virtual Reality (VR) trainees will reach a minimum of 50 unduplicated individuals, annually during Year 2 and Year 3 of implementation.	
Goal Status	From July through December 2025, the Technology Navigator held 8 separate VR sessions serving 30 unduplicated individual adults age 60+ for a total of 63 unduplicated individuals served during the year 2025. The sessions were offered at various Senior Centers and residential house settings. -66% of attendees rated the program as "excellent" with the remaining 33% rating the program as "good." -97% of the attendees would recommend the VR program to friends and family.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	SeniorCare's Virtual Reality (VR) Program participants will report at least 90% satisfaction with the program and report at least 90% opportunities to connect/engage with others.	
Goal Status	Participants completing the post-survey reported-31% reported that they met new people as part of participating in the VR Program. 66% reported the VR group provided opportunities for them to engage/talk with others in the group.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Oncology Nurse Navigators** **Health Issue: Chronic Disease (Cancer)**		
Brief Description or Objective	The Oncology Nurse Navigator is an RN with oncology-specific clinical knowledge. These Navigators offer individualized support and assistance to patients and their caregivers to help them make informed decisions about their care and to overcome barriers to optimal care. The Navigator contributes to the Hospital's mission by providing cancer patients with coordinated care through a holistic and collaborative approach that includes communication and coordination with the patient's family and/or caregivers along with a multidisciplinary team consisting of physicians, nurse practitioners, oncology nurses, and social workers. The Navigator works in collaboration with the clinical team to develop clinical pathways for appropriate care, and acts as the contact clinical person in resolving all patient-related concerns. The Navigator ensures all medical information has been received by physicians, reviews all medical information prior to a patient visit, and discusses any concerns with the provider prior to the patient visit. The Navigator maintains contact with referring and other collaborating physicians to keep them up to date on the patient's care plan. In addition, the Nurse Navigator connects patients with resources, including support services in their communities, and assists them from treatment to survivorship.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To guide patients through the complexities of the disease, direct them to health care services for timely treatment and into survivorship, and actively identify and help address barriers to care that might prevent them from receiving timely and appropriate treatment.	
Goal Status	In FY25 the Oncology Nurse Navigators at BH and AGH assisted 1,369 patients and their families or caregivers.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: North Shore YMCA Enhance Fitness Program** **Health Issue: Chronic Disease**		
Brief Description or Objective	Through a partnership with the North Shore YMCA, Enhance Fitness classes are offered for free at the YMCA and various locations in the community. Enhance Fitness is an evidence-based health intervention offsetting the effects of aging and chronic illness as well as minimizing fall risk. Participants work on cardio and muscular strength, balance, flexibility, and stability, all while engaging in a supportive social community. Classes meet three days per week for eight weeks. Fitness checks are done at the beginning and end of each sixteen-week session.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

	☒ Total Population or Community-Wide Interventions	
Program Goal(s)	The YMCA of the North Shore will serve 100 seniors each year for the next three years across its Greater Beverly YMCA, Ipswich Family YMCA, and Cape Ann YMCA Enhance Fitness programs, of which 20% each year will be economically disadvantaged.	
Goal Status	The program has served 39 unique seniors.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	At least 52% of participants each year for the next three years will report that they have maintained or improved their overall sense of health thanks to the EnhanceFitness program.	
Goal Status	59% of participants reported that they have maintained or improved their overall sense of health after completing the Enhance Fitness program.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	At least 61% of participants each year for the next three years will report that the EnhanceFitness program has improved their physical abilities.	
Goal Status	82% of participants reported that their physical abilities had improved with the Enhance Fitness program.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: School Based Health Center at Gloucester High School** **Health Issue: Chronic Disease**		
Brief Description or Objective	This program increases access to healthcare by providing high-quality, comprehensive health care to students on-site at Gloucester High School in order to support optimal health and academic outcomes. 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. 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 Interventions	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goals	Administer iDecide Substance Use Harm Reduction Program and counseling to GHS students caught with substances at GHS.	
Goal Status .	The nurse practitioner administered the iDecide Program and counseling to 19 GHS students	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goals	Complete a CQI Project with goal to complete HEADSS, CRAFFT screenings for 75% of GHS Student Health Center population.	

Goal Status	Goal exceeded:- 86% of SBHC students received a HEADSS screening- 84.5% of SBHC students received CRAFFT 2.1+n screening- Equity Lens: 75% of the GHS ML student population received a HEADSS screening	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goals	Increase the number of Columbia Suicidality Screenings by 20% over FY2024 = > 165 screenings.	
Goal Status	Exceeded goal: Completed 229 Columbia Suicidality Screenings = 86% of SBHC students screened.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goals	Establish student-led activities with the Youth Advisory Council for inclusion, equity, climate awareness, gun safety, etc.	
Goal Status	The SBHC supported approximately 10 student-led activities including a climate change training, cannabis harm reduction project, English Learner parent event, community open house, wear orange project, among others.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goals	Provide health services through a minimum of 935 Nurse Practitioner visits and 775 LICSW behavioral health visits. Track Community Health Worker visits connecting GHS students to resources and provide informal counseling	
Goal Status	Goal exceeded: The SBHC had a total of 2,012 visits with 266 unduplicated students, including- 1,064 Nurse practitioner visits- 948 LICSW visits. Goal accomplished: Community Health workers completed 855 visits with 77 unduplicated GHS students.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goals	Through collaboration with The Open Door, reduce barriers to food access by providing a Food Locker, providing free, shelf stable food to more than 75 students/families.	
Goal Status	Reduced barriers to food access by providing SBHC shelf pantry food items to over 75 students/families.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: The Open Door Medically Tailored Groceries Program** **Health Issue: Social Determinants of Health (Access to Healthy Food)**	
Brief Description or Objective	The MTG program is an innovative program to help adults with, or at risk of, chronic illness, and struggling with food insecurity, better manage their health with access to free, diet specific, nutritious food. In addition, the program provides nutrition counseling, educational workshops, and help with meal planning and preparation.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide at least 30% of each pantry order as produce.
Goal Status	29% of food distributed was produce.

Time Frame Year: Year 3	Time Frame Duration: Year 3	Goal Type: Outcome Goal
Program Goal(s)	The MTG team will screen and connect clients to our online ordering system and dietary-specific options;	
Goal Status	MTG team is screening and connecting clients to online ordering and dietary-specific food options;	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	The MTG team will provide at least two sessions of intensive MTG, both Track I and Track II, with 10-15 people per session	
Goal Status	MTG sessions I and II are in progress	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	The Registered Dietary Nutritionist (RDN) will provide 75 Nutritional Counseling sessions (for 10-40 people, depending on need)	
Goal Status	RDN is providing Nutritional Counseling sessions, ongoing	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	The MTG team will provide 12 Maridee's Community Nutrition Workshops for up to 10 people per workshop.	
Goal Status	MTG team is providing Nutrition Workshops for clients and individuals	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

SECTION V: EXPENDITURES

Item/Description	Amount
CB Expenditures by Program Type	
Direct Clinical Services	$11,139,786
Community-Clinical Linkages	$537,242
Total Population or Community Wide Interventions	$895,108
Access/Coverage Supports	$2,011,538
Infrastructure to Support CB Collaborations	$29,565
Total Expenditures by Program Type	$14,613,239
CB Expenditures by Health Need	
Chronic Disease	$860,718
Mental Health/Mental Illness	$2,521,643
Substance Use Disorders	$1,639,215
Housing Stability/Homelessness	$54,783
Additional Health Needs Identified by the Community	$9,536,881
Total Expenditures by Health Need	$14,613,239
Leveraged Resources	
Total Leveraged Resources	$5,449,928
Net Charity Care Expenditures	
HSN Assessment	$3,199,976
Free/Discounted Care	N/A
HSN Denied Claims	$2,617,972
Total Net Charity Care	$5,817,948
Total CB Expenditures	$25,881,115

Additional Information	
Net Patient Services Revenue	$459,160,231
CB Expenditure as % of Net Patient Services Revenue	5.64%

Approved CB Budget for FY26 (*Excluding expenditures that cannot be projected at the time of the report)	**$16,518,887**
Bad Debt	**$3,602,811**
Bad Debt Certification	**Yes**
Optional Supplement	
Comments	

SECTION VI: CONTACT INFORMATION

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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Year 1

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

I. Community Benefits Process:

1. Community Benefits in the Context of the Organization's Overall Mission:

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

While BH/AGH oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Community and Health Impact 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:

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 mission of BH/AGH is to provide high-quality, compassionate medical care in partnership with its medical staff to improve the health of its communities

2. Community Benefits Advisory Committee (CBAC):

Members (and titles):

- Jason Andree, Vice President, Beverly and Addison Gilbert Hospitals

- Vivian Argento, Associate Chief Medical Officer, Beverly and Addison Gilbert Hospitals
- Karen Neva Bell, Board of Trustees, Northeast Hospital Corporation
- Andrea Bettencourt, Director of Operations, Northeast Medical Associates
- Valerie Parker Callahan, Executive Director, Greater Lynn Senior Services
- Andrew DeFranza, Executive Director, Harborlight Community Partners
- Laura DellaChiaie, Director of Public Health, City of Beverly
- Dr. Mark Gendreau, Chief Medical Officer, Northeast Hospital Corporation
- Marylou Hardy, Community Benefits Community Relations, Beverly and Addison Gilbert Hospitals
- Christine Healey, Director of Community Benefits Community Relations, Beth Israel Lahey Health
- Peggy Heggarty-Steck, President and Executive Director, Action, Inc.
- Dominique Hurley, Director of Public Health, Gloucester Health Department
- Robert Irwin, Board of Trustees, Northeast Hospital Corporation
- Julie LaFontaine, President and CEO, The Open Door
- Chris Lovasco, President, YMCA of the North Shore
- Denise Mason, Director, BH/AGH Bayridge Mental Health
- Laura Mayer, Director, DanversCares
- Nancy Palmer, Resident
- Jonathan Payson, Board of Trustees, Northeast Hospital Corporation
- Kim Perryman, Chief Nursing Officer, Beverly and Addison Gilbert Hospitals
- Ryan Robeiro-Rodriguez, Chief Operating Officer, North Shore Community Health
- Tom Sands, North Market President, Beth Israel Lahey Health
- Scott Trenti, Chief Executive Officer, SeniorCare, Inc.
- Carolina Trujillo, Chair, Northeast Hospital Corporation Community Benefits Advisory Committee; Board of Trustees

Leadership:

- Gregory Beaumier, Chief Financial Officer
- Dr. Mark Gendreau, Chief Medical Officer
- Joseph Hwang, Chief Operating Officer
- Kim Perryman, Chief Nursing Officer
- Timothy Reilly, Vice President of Human Resources
- Tom Sands, Market President – North Shore
- Lisa Zopatti, Vice President of Philanthropy

Frequency of meetings: Quarterly

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

Place a checkmark next to each leadership group if it is involved in the specified aspect of your Community Benefits process:

	Review Community Health Needs Assessment	Review Implementation Strategy	Review Community Benefits Report
Senior leadership	☒	☒	☒
Hospital board	☒	☒	☒
Staff-level managers	☒	☒	☒
Community representatives on CBAC	☒	☒	☒

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

Hospital Board:
BH/AGH's Board of Trustees – reviewed and approved its CHNA and adopted its Implementation Strategy.

Community Benefits Advisory Committee - oversaw CHNA and Implementation Strategy process.

Senior Leadership:
• Tom Sands, President: Designated a member of the senior leadership team to the CBAC and participated in the approval process.

- Jason Andree, Vice President, Beverly and Addison Gilbert Hospitals
- Vivian Argento, Associate Chief Medical Officer, Beverly and Addison Gilbert Hospitals
- Dr. Mark Gendreau, Chief Medical Officer, Northeast Hospital Corporation
- Kim Perryman, Chief Nursing Officer, Beverly and Addison Gilbert Hospitals
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• Nancy Kasen, Vice President of Community Benefits and Community Relations, and Community Benefits team: designed, directed and oversaw the CHNA and IS, managed prioritization process, drafted Implementation Strategy
•Marylou Hardy, Manager of Community Benefits and Community Relations: led BH/AGH community engagement efforts
• BILH Board of Trustees Community Benefits Committee (CBC): guided the process for the system

4. Hospital Approach to Assessing and Addressing Social Determinants of Health

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

BH/AGH undertook a robust, collaborative and transparent assessment and planning process. The approach involved extensive quantitative and qualitative data collection and substantial efforts to engage community residents, with special emphasis on population segments often left out of similar efforts. The assessment was supported by BH/AGH's Community Benefits Advisory Committee (CBAC). The CBAC is comprised of community members, service providers, and other stakeholders who live and/or work in BH/AGH's CBSA. BH/AGH's Implementation Strategy (IS) reflects the hospital and the CBAC's prioritization of the following social determinants of health: career mobility, education, food security and nutrition, housing, and transportation .

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

BH/AGH and BILH are committed to health equity, the attainment of the highest level of health for all people. Throughout the assessment process, BH/AGH worked to understand the needs of all populations in the Community Benefits Service Area, including those who have been historically underserved. Health equity is an overarching lens applied to all four pillars within the BH/AGH's Implementation Strategy. The Implementation Strategy is designed to address the underlying social determinants of health and barriers to accessing care

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

BH/AGH's Implementation Strategy includes a range of programs and resources to address the prioritized needs within the hospital's Community Benefits Service Area. The majority of BH/AGH's community benefits initiatives are focused on cohorts and geographies based on identified needs. Additionally, BH/AGH collaborates with many community partners to own, catalyze and/or support total population and community-wide interventions.

5. Maternal Health Focus

- How does your organization assess maternal health status in the Community Needs Assessment Process? (150-word limit)

BH/AGH's Community Health Needs Assessment (CHNA) process includes comprehensive collection and review of primary and secondary data sources.

Secondary data sources include the Center for Health Information Analysis (CHIA), Community Health Equity Survey (CHES), County Health Rankings, MA DPH, National Center for Health Statistics and U.S. Census Bureau. The hospital's data table has a section for Maternal and Child Health/Reproductive Health which includes infant mortality rate (%) and low birth weight (%). In addition to secondary data capture and review, throughout the CHNA BH/AGH engages with the community to collect primary data via a survey, focus groups and listening sessions to directly enable community residents to identify priorities.

- How have you measured the impact of your Community Benefits programs and what challenges have you faced in this measurement?

BH/AGH partners with North Shore Community Health and Lynn Community Health Center on maternal health initiative(s) and has done so since 2018. Additionally, BH/AGH is a member of Beth Israel Lahey Health, which, as a system is working to address maternal health equity. Beth Israel Lahey Health established its Maternal Health Quality and Equity Council (MHQEC) in September of 2023. The Council's objective is to improve maternal health outcomes and eliminate inequities in care, with an overarching aim to reduce the occurrence of maternal morbidity and mortality. The Council is comprised of representatives from all of the BILH hospitals providing maternity services, as well as BILH leadership, including BILH Health Equity system leadership. BILH's Vice President of Health Equity serves as the Executive Sponsor. Additionally, BILH established a health equity goal beginning in FY 25 – a year over year improvement in maternal transfusion rate (the goal is to reduce disparities in maternal transfusion rates measured at the system level).

- Do you need assistance identifying community-based organizations doing maternal health work in your area?

BH/AGH currently works with North Shore Community Health and Lynn Community Health Center. No additional assistance is needed, BH/AGH's maternal health work will continue to be guided by the BILH MHQEC and BH/AGH looks forward to spreading this work and collaborating with its myriad of long-standing community partners in pursuit of maternal health equity.

II. Community Engagement

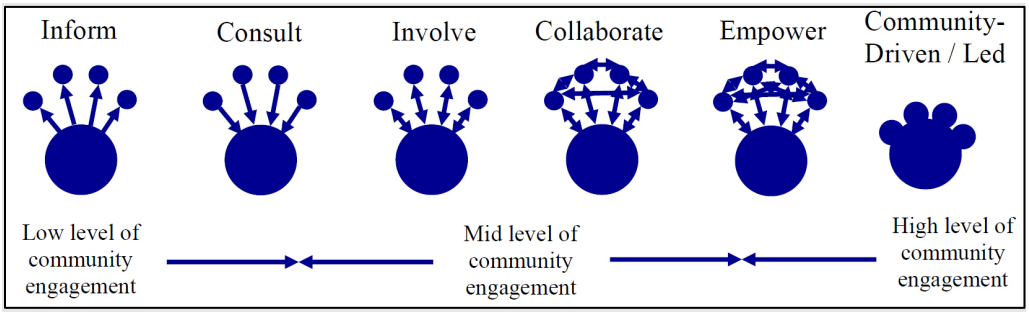
1. Organizations Engaged in CHNA and/or Implementation Strategy

   Use the table below to list the key partners with whom the hospital collaborated in assessing community health needs and/or implementing its plan to address those needs and provide a brief description of collaborative activities with each partner. Note that the hospital is not obligated to list every group involved in its Community Benefits

process, but rather should focus on groups that have been significantly involved. Please feel free to add rows as needed.

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
Action, Inc.	Peggy Hegarty-Steck, Chief Executive Officer	Social service organizations	Action, Inc. is a partner of BH/AGH. During the FY25 CHNA, Action hosted two focus groups to assist in elevating voices from hard-to-reach populations: unhoused/recently housed and English Language Learners. In addition, Peggy Hegarty-Steck is an active member of BH/AGH's CBAC, which informed prioritization and strategies related to the FY26-FY28 Implementation Strategy.
SeniorCare	Scott Trenti, CEO	Social service organizations	Scott Trenti is a member of BH/AGH CBAC, which helped to inform the FY25 CHNA and FY26-FY28 Implementation Strategy, especially in regards to needs of the older adult population. In addition, BH/AGH has worked with SeniorCare for several years, in FY25 a grant was awarded for continuation of the Rendever Virtual Reality for Older Adults.
Pathways for Children	Eric Mitchell, CEO	Social Service Organization	Pathways for Children partnered with BH/AGH for the FY25 CHNA by hosting a focus group for low-resourced fathers. In addition, BH/AGH has supported Pathways' Children Nurturing Program for several years, which strives to prevent child abuse and neglect through evidence-based education.

2. Level of Engagement Across CHNA and Implementation Strategy
   Please use the spectrum below from the Massachusetts Department of Public Health[1] to assess the hospital's level of engagement with the community in implementing its plan to address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.



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

A. Community Health Needs Assessment: Please assess the hospital's level of engagement in developing its CHNA and the effectiveness of its community engagement process.

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in assessing community health needs	Involve	Goal was met	Involve
Collecting data	Involve	Goal was met	Involve
Defining the community to be served	Collaborate	Goal was met	Collaborate
Establishing priorities	Collaborate	Goal was met	Collaborate

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

[1] "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.

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

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Collaborate	Goal was met	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Collaborate	Goal was met	Collaborate
Implementing Community Benefits programs	Collaborate	Goal was met	Collaborate
Evaluating progress in executing Implementation Strategy	Collaborate	Goal was met	Collaborate
Updating Implementation Strategy annually	Consult	Goal was met	Consult

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

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

   In FY25, BH/AGH held four CBAC meetings, a community listening session and an annual meeting that were broadly advertised to the public. Additionally, four newsletters were distributed to inform the community about the Community Health Needs Assessment and Implementation Strategy process, including opportunities for input, and other Community Benefits updates.

The BH/AGH CBAC met on the following dates:

- December 11, 2024

- March 12, 2025
- June 18, 2025
- September 17, 2025 (Public Meeting)

BH/AGH Community Listening: February 12, 2025

4. Best Practices/Lessons Learned: The AGO seeks to continually improve the quality of community engagement.

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

   BH/AGH is most proud of its committed CBAC and the long-standing relationships it has with many community-based organizations, the public health department, and other government partners. BH/AGH is proud of its collaboration with these and other organizations that allow for meaningful community engagement. Increased focus was placed on reaching communities typically not engaged in assessments, as such, BH/AGH saw a significant increase in community surveys from the following populations: Hispanic/Latino, Asian and people who speak languages other than English.

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

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

III. Regional Collaboration

1. Are Community Benefits planning and investments part of your hospital's strategic plan? ☒Yes ☐No

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

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

- Brief description of goals of collaboration
- Key communities engaged through collaboration. If you did not participate in a collaboration, please explain why not:

For its FY 2025 CHNA, Beth Israel Lahey Health (BILH) took the unique approach of designing and implementing a system-wide, highly coordinated CHNA and prioritization process across each of the system's 11 licensed hospitals, including BH/AGH. While BH/AGH focuses its Community Benefits resources on improving the health status of those in its CBSA experiencing significant barriers to care, this system-wide approach enhances opportunities for collaboration and alignment with respect to addressing unmet need and maximizing impact on community health priorities. Together, BILH hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact.