COMMUNITY BENEFITS REPORT

FISCAL YEAR 2018

Beth Israel Lahey Health
Beverly Hospital

Beth Israel Lahey Health
Addison Gilbert Hospital

Massachusetts Attorney General's Community Benefits Guidelines

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

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

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

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

Source: Excerpt taken from the Official Website of the Attorney General of Massachusetts. For full guidelines, please go to http://www.mass.gov/ago/docs/healthcare/hospital-guidelines.pdf.

Northeast Hospital Corporation's Community Benefits Mission Statement

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

Northeast Hospital Corporation's Community Benefit Plan

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

Community Benefit Advisory Board — 2018

Nancy Palmer – Chairwoman, Northeast Hospital Corporation Board of Trustees
Phil Cormier – CEO, Addison Gilbert and Beverly Hospitals
Charles Favazzo – Trustee, Northeast Hospital Corporation
Robert Irwin – Trustee, Northeast Hospital Corporation
Mark Gendreau, MD – Chief Medical Officer, Addison Gilbert and Beverly Hospitals
Peter Short, MD – Associate Chief Medical Officer, Addison Gilbert and Beverly Hospitals
David DiChiara, MD – Associate Chief Medical Officer, Addison Gilbert and Beverly Hospitals
Kimberly Perryman – Chief Nursing Officer, Addison Gilbert and Beverly Hospitals
Cynthia Donaldson – Vice President, Addison Gilbert Hospital and Lahey Outpatient Center Danvers
Lisa Neveling – Vice President, Business Development, Lahey Health
Christine Healey – Director, Community Relations, Lahey Health
Grace Numerosi – Regional Manager, Community Relations
Christopher Lovasco – President and CEO, North Shore YMCA
Julie LaFontaine – Executive Director, The Open Door Food Pantry
Scott Trenti – Executive Director, SeniorCare

Key Accomplishments for Fiscal Year 2018

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

- Hosted a total of 16 Senior Dine and Learn sessions (Senior Suppers), which ran at both Addison Gilbert Hospital and Beverly Hospital, reaching over 880 seniors.

- Came together with Addison Gilbert and Beverly Hospitals and our community partners, The Open Door in Gloucester and Beverly Bootstraps in Beverly, to continue the Emergency Food Bag Program for both communities, as well as mobile markets throughout the summer.

- Over 340 seniors took part in the classes provided in partnership with the North Shore YMCA, including Osteo Exercise, Enhance Fitness, LIVESTRONG and Aqua Aerobics.

- Gave Speakers Bureau presentations to numerous community partners, including the Rockport and Gloucester Councils on Aging, and Danvers, Beverly, Rockport and Gloucester high schools.

- Provided $65,000 in grant funding to local community organizations whose programs address our community priorities.

- Partnered with Gloucester High School and coordinated a school-based Health Fair & Resource Information Day, providing health screenings and information to over 700 attendees.

- Participated in health fairs and several screening activities throughout the communities of Gloucester, Rockport, Essex, Manchester, Beverly and Danvers.

- Partnered with the American Cancer Society (ACS) and the North Shore YMCA to provide skin cancer prevention kits to over 1,000 campers in Beverly, Gloucester, Rockport and Ipswich for the ACS “Slip, Slop, Slap … and Wrap” program.

- Sponsored a fall-prevention program at the Peabody Council on Aging, with over 100 seniors and multiple departments participating.

- Provided 46 free Weekly Blood Pressure Clinics, screening over 700 people.

- Sponsored a free Dermatology Cancer Screening at Beverly Hospital that screened over 40 people.

Fiscal Year 2018 Community Partners

Action Inc., Gloucester
American Cancer Society
American Red Cross
Backyard Growers
Be Healthy Beverly
Beverly Bootstraps
Beverly Community Council
Beverly Fire Department
Beverly Health Department
Beverly High School
Beverly Main Streets
Beverly Police Department
Beverly Rotary
Beverly Senior Center
Cape Ann Chamber of Commerce
Cape Ann Farmers Market, Gloucester
Cape Ann YMCA
Care Dimensions
Community Health Network Area 13/14
Danvers Community Access Television
Danvers Farmers Market
Danvers High School
Danvers Kiwanis Club
Danvers Police Department
Danvers Rotary
Danvers Senior Center
Danvers YMCA
DanversCARES
First Baptist Church of Beverly
Gloucester Board of Health
Gloucester Fire Department
Gloucester High Risk Task Force
Gloucester Police Department
Gloucester Public Schools
Gloucester Rotary
Greater Beverly Chamber of Commerce
Healthy Gloucester Collaborative
Ipswich High School
Ipswich YMCA
Manchester Essex Rotary
North Shore Chamber of Commerce
North Shore Health Project
North Shore Mall
North Shore United Way
Northeast Arc
PAARI
Pathways for Children
Peabody Area Chamber of Commerce
Rockport Public Schools
Rockport Senior Center
Rose Baker Senior Center, Gloucester
Salem State University
SeniorCare
Shaw's, Eastern Avenue, Gloucester
Sterling Center YMCA, Beverly
The Open Door
Wellspring House, Gloucester

Plans for Reporting — Fiscal Year 2019

In FY19, Beverly and Addison Gilbert Hospitals (BH & AGH) will continue to work with community partners and hospital leaders to address the needs identified in the 2019 Community Health Needs Assessment (currently in development) while taking into consideration the Statewide Priority Needs identified by the Executive Office of Health and Human Services and the Department of Public Health Priorities, which include an increased focus on the social determinants of health.

Statewide Focus Areas:
Chronic Disease (Cancer, Heart Disease, Diabetes)
Housing Stability/Homelessness
Mental Illness and Mental Health
Substance Use Disorders

DPH Priorities: Social Determinants of Health
Built Environment
Education
Employment
Housing
Violence
Social Environment

Community Health Needs Assessment Overview

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

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

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

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

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

Quantitative Data Sources:

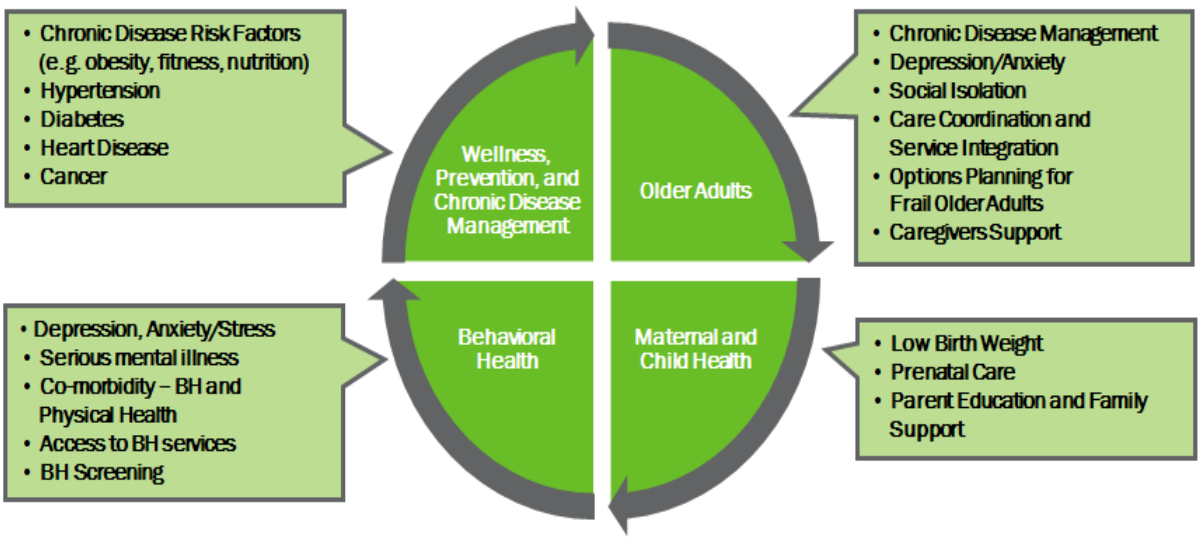
- Massachusetts Community Health Information Profile (MassCHIP)
- U.S. Census Bureau, American Community Survey 5-Year Estimates (2009-2013)
- Behavioral Risk Factor Surveillance System (BRFSS) (2012-2013 aggregate)
- CHIA Inpatient Discharges
- Massachusetts Health Data Consortium (MHDC) ED Visits
-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

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

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

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

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



Fiscal Year 2018 Community Benefit Programs

Health Priority Area #1-Wellness, Prevention and Chronic Disease

School-Based Health Center at Gloucester High School

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

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

Outcome: The SBHC is staffed by a Nurse Practitioner, a Licensed Independent Clinical Social Worker and a Certified Community Health Worker. The SBHC provides an integrated model of care in its approach. Services offered include management of chronic illnesses such as asthma and diabetes, urgent care visits, immunizations, routine and sports physicals, health education, and confidential services, including reproductive health care and behavioral health services. As evidenced by its staffing structure, behavioral health care is a significant focus of the clinic, with individual therapy and group counseling services provided for issues such as depression, anxiety, stress management and substance use. In partnership with the school, the team offers everything from routine evaluations for illness and injury to mental health screenings. Students needing further health or mental health services are referred to providers in the community. Some providers will go to the school to see students, if the teens are unable to travel to another location for appointments.

The clinic had 1,100 nurse practitioner visits, 750 social worker visits and 5,200 total assessments. Staff organized almost 30 outreach activities, including social skills workgroups and reproductive health classes. In addition to facilitating the Walking Club, they facilitate and mentor the GHS-SBHC Youth Advisory Council (YAC). YAC is a peer-to-peer leadership group open to all GHS students committed to work to promote inclusively and teen health issue. The SBHC staff also supports the Gay-Straight-Alliance group, and the annual health resources fair.

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

Homebound Lab Program — Mobile Phlebotomy

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

Goal: The goal of the Home Blood Draw Program is to increase access to phlebotomy services for homebound patients who have difficulty getting to a laboratory/drawing station due to illness or injury. The Homebound Lab program aims to provide timely and convenient lab services to patients who might not otherwise be able to comply with routine lab monitoring.

Outcome: Our Mobile Phlebotomy team provided homebound lab services to over 5,000 patients. In addition to appreciating the convenience of the home blood draw, patients have reported reduced feelings of isolation, as the visit with the phlebotomist provides them with a social opportunity. There is no charge to the patient for this service. Our service area includes the following towns: Beverly, Boxford, Danvers, Essex, Georgetown, Gloucester, Hamilton, Ipswich, Lynn, Lynnfield, Manchester-by-the-Sea, Marblehead, Middleton, Peabody, Rockport, Rowley, Salem, Saugus, Swampscott, Topsfield and Wenham.

Results: The program operates Monday-Friday, year round. In FY18, specimens were collected from 5,100 patients.

Community Partners: Lahey Health at Home and Primary Care

Be Healthy Beverly

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

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

Outcome: The gardens were harvested during the summer months, and the fresh produce were made available to Beverly Bootstraps.

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

Nutrition Circle of Care

Description: Recognizing that there is no one solution to hunger, and that children, families, mothers and seniors have different nutritional needs, The Open Door's Nutrition Circle of Care provides wraparound nutrition services through three priority areas — Congregate Meals, Increased Food Access and Nutrition Education — to improve the health of vulnerable families and elders. They use practical strategies to connect people to good food, to advocate on behalf of those in need and to engage others in the work of building food security

Goal: To increase participation in Congregate Meals, Increased Food Access and Nutrition Education of residents in Gloucester, Rockport, Essex, Ipswich and Rowley.

- Gloucester Food Pantry provided more than 1.265 million pounds of food to 5,464 unduplicated people representing 2,294 households through 30,802 visits.
- Ipswich Community Food Pantry provided 179,907 pounds of food to 746 unduplicated people representing 377 households through 6,895 visits.
- In addition, the Gloucester food pantry distributed 2,974 packages of diapers (113,012 diapers) to 203 households with 228 diaper-aged children, and 1,715 women and girls accessed 6,516 packages of menstrual products (195,480 tampons or pads).
- Provided robust Senior Soup and Salad luncheon (salad bar, soup, dessert) three days a week at Rose Baker Senior Center, dinner at Rockport Council on Aging (quarterly) and lunch at Essex Council on Aging (quarterly).
- Provided Family Supper for families of Pathways (our local Head Start program) and the Gloucester Public Integrated Preschool. Along with a nutritious entrée that follows the Farm to School curriculum, nutrition education and fun family activities encouraged families to have a fun, healthy meal together.
- Increased our Food Rescue program by 15% year to date, on top of a 123% increase in 2017.
- A registered dietitian provided nutrition counseling for 24 clients during 70 counseling sessions.

Outcome:

Food Access: Total number of pantry visits: 37,697.

- 80.2% choose healthier options when they are offered.
- 34% of each distribution was fresh produce.
- 79.9% of those surveyed agreed that shopping at the food pantry helps them eat family meals at home.
- 76.4% agreed that they eat more fruits and vegetables.
- 39.5% agreed that they try recipes at home that they get from The Open Door.

Congregate Meals: Total number includes Family Supper and Senior Soup and Salad: 10,187.

Senior Soup and Salad (SSS) participants:

- 73% agreed that because of SSS they make healthy food choices.
- 81% agreed that because of SSS they eat more fruits and vegetables.
- 74% agreed that because of SSS they learned about nutrition or cooking.
- 66% agreed that because of SSS they are trying new foods or new recipes at home.
- 95% agreed that because of SSS they socialize with people more.
- 78% agreed that because of SSS they feel less lonely.

- 76% agreed that because of SSS they live more independently.
- 60% agreed that because of SSS their grocery bill is lower, or their finances have improved.

If unable to participate in SSS:

- 58% agreed that they would have less variety in their diet.
- 47% agreed that they would eat less food overall.
- 60% agreed that they would consume a less healthy diet.

Family Supper

- 100% of parents agreed that their children tried fruits and vegetables at home.
- 94% of parents agreed that their children love fruits and vegetables.

Because of Family Supper:

- 94% of parents made healthy food choices.
- 82.3% of parents stated they eat more fruits or vegetables.
- 82.2% of parents have learned about nutrition or cooking.
- 76.4% of parents are trying new foods or recipes at home.
- 88.2% of parents agreed that their children eat more fruits and vegetables.
- 82.3% of parents agreed that they eat more meals together as a family.
- 82% of parents agreed that their grocery bill is lower or their finances have improved.

If unable to participate in Family Supper:

- 68.7% of parents agreed that they would have less variety in their diet.
- 50% of parents agreed that they would eat less food overall.
- 49.9% of parents agreed that they would consume a less healthy diet.

Family Supper Children Surveys:

- 70% of the children rated Family Supper as Very Good.
- 80% of the children said they tried new fruits and vegetables.
- 100% of the children said they thought Family Supper was healthy.
- 81.3% of the children said they like to try new foods.
- 100% of the children said they loved fruits and vegetables.

Community Partners: Senior Centers, SeniorCare, Pathways for Children, Wellspring House, Gloucester Schools, Action Inc., Backyard Growers, Food Rescue, Greater Boston Food Bank

Beverly Bootstraps Mobile Market

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

Goal: To provide access to fresh produce while providing basic information about nutrition in a community setting. Knowing transportation is a barrier to access, the Mobile Market brings food to the housing authority location and its residents on a weekly basis. Additionally, participants can

access SNAP information and other resources through Beverly Bootstraps, such as Back to School Backpacks, heating assistance and education programs.

Outcome: During the summer and fall of 2018, 2,798 visits were made to the mobile market, 455 households were served and 35,983 pounds of fresh produce were distributed.

Community Partners: Beverly Bootstraps, Beverly Housing Authority, Fairweather Housing

Emergency Department Prescription Food Bag Program

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

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

Outcome: Addison Gilbert Hospital distributed 90 Prescription Food Bags (20 of which were for diabetics); 28 people received gift cards from The Open Door. Once people went to use The Open Door Food Pantry, they became regular clients, and they made appointments with their client advocates for SNAP application assistance and recertification. Beverly Hospital distributed 80 Prescription Food Bags; 10 people were eligible to receive the gift card from Beverly Bootstraps.

Community Partners: Beverly Bootstraps, The Open Door Food Pantry

LIVESTRONG at the YMCA

Description: Beverly and Addison Gilbert Hospitals partnered with the Cape Ann, Ipswich and Greater Beverly YMCAs for the LIVESTRONG program for cancer survivors. LIVESTRONG is a small-group, evidence-based class that helps cancer survivors and those in the midst of their treatment, believe in and achieve a healthier tomorrow and envision life after cancer. Classes are tailored for all cancer survivors, regardless of stage of diagnosis or treatment, and adapted for all fitness levels. Each class meets for 90 minutes each week for 12 weeks. Staff members are trained on the unique physical and emotional needs of cancer survivors, and on the curriculum and best practices. These staff members work with each participant to create an individual exercise program from pre-program assessment results and to teach and demonstrate exercise technique and safety.

Goal: The program creates communities among cancer survivors and guides them through safe physical activity, helping them build supportive relationships leading to an improved quality of life. LIVESTRONG at the YMCA has an established research-based evaluation plan that uses pre- and post-assessment tests, including a detailed assessment of arm function, range of motion and lymph node prognosis; shoulder flexion, extension and abduction; and a thorough postural assessment.

Body composition is also measured, which includes height, weight, body mass index, waist girth and hip girth.

Outcome: Thirty-three participants over four classes. Program participants are asked to rate overall quality of life, ability to perform daily tasks, mobility, eating habits, fitness level, perceived body image, current energy levels and overall happiness. Research has demonstrated that LIVESTRONG at the YMCA significantly increases cancer survivors' cardiovascular endurance and quality of life while reducing cancer-related fatigue.
Participants demonstrated the following improvements in these selected measures:

- 11% improvement in endurance.
- 20% improvement in physical function.
- 26% improvement in depression symptoms.
- 23% improvement in cancer-related fatigue.

Community Partner: YMCA of the North Shore

Walk-in Blood Pressure Screening Program

Description: Addison Gilbert Hospital offers a free, weekly walk-in blood pressure clinic every Monday (minus holidays) from 1 to 3 p.m. in the Babson Wing of Addison Gilbert Hospital. In FY18, 100 clients made 719 visits to the clinic which is an increase of over 50 visits from FY17.

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

Outcome: The guidelines for the clinic are from the Joint National Committee on the Prevention, Evaluation and Treatment of High Blood Pressure. The DASH diet is recommended.
Number of client visits: 719
Number of new clients: 37
Female clients: 66%; male: 34%
Average number of clients seen weekly: 16
Active clients: 100
Age range of clients: 40-90
Number of clients advised to seek physician care: 19
Number of client visits per year:
1 to 9 times: 75%
10 to 30 times: 20%
30 to 40 times: 5%

Community Partners: Internal initiative

Skin Cancer Awareness and Prevention Community Outreach Campaign

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

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

Outcome: Over 2,000 people of all ages were reached at 12 different community events between April and August 2018 in the towns of Beverly, Danvers, Gloucester, Ipswich and Rockport.

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

Free Breast Cancer Risk Assessment

Description: In the BH & AGH service area, eight of the 13 towns that are part of our primary service area reported statistically higher incidence rates of cancer (all cancer types) than in the commonwealth. The highest cancer incidence rate per 100,000 population was in Middleton (647), followed by Boxford (600), Manchester-by-the-Sea (595), Hamilton (594), Peabody (575), Danvers (575), Ipswich (572) and Gloucester (564). These rates compare to 509 for the commonwealth and 531 for Essex County. Specifically, breast cancer hospitalization rates for women were statistically higher than the commonwealth's across nearly all the primary service area's cities/towns.

Moreover, according to the BH & AGH Community Health Survey, rates of mammography screening for women 40+ were slightly higher within the past two years than they had been prior to that: 88.4% in BH & AGH primary service area, compared with 85% in the commonwealth. The risk for breast cancer is not the same for all women, some women need more advanced screening beyond the standard recommendations.

In response to this identified community need, Lahey Health has implemented an assessment screening tool to help community residents determine whether they may be at risk for breast cancer. Using an electronic tablet, people are able to confidentially answer questions that help determine whether they may be at a higher risk for breast cancer. The assessment, evaluation and follow-up are all provided at no cost to the participant. Results are given to their physician, who can help them

determine whether they might benefit from a higher level of screening, beyond regular checkups and mammograms.

Goal: Identify persons who may be at a higher risk for breast cancer and provide screening follow-up to their physician.

Outcome: In FY18, BH & AGH screened 11,694 people and identified 399 patients who had a high-risk mutation, and 1,138 who had a high lifetime risk of breast cancer.

"Stop the Bleed" Campaign

Description: As a Level III Trauma Center, Beverly Hospital is committed to trauma prevention and to educating our service area on preventable causes of death. According to the World Health Organization, uncontrolled post-traumatic bleeding is the leading cause of potentially preventable death among trauma patients and an important issue for us to address in our primary service area and beyond. In response, Beverly Hospital joined the American College of Surgeons and the Committee on Trauma's evidence-based Stop the Bleed campaign and started educating local high schools, teachers, counselors, school nurses and first-responder students on how to apply tourniquets. Instructors provide a hands-on and didactic program on bleeding control techniques to health care and non-health care workers and students. Participants learn about the various ways to control bleeding, whether they have only their two hands to use or a full trauma first-aid kit available.

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

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

Outcome: The trauma department provided 100 of the CAT tourniquets recommended by the American College of Surgeons to area schools.

Healthy State

Program Website: https://www.myhealthystate.org/

Description: More people are turning to web-based resources for health information. By providing expert health information, personal stories and connections to resources, Healthy State provides health information to educate and influence people to change their unhealthy behaviors and encourage interventions capable of improving health status.

Healthy State is a health news website that highlights the expertise of our practitioners across Lahey Health. We collaborate with practitioners (doctors, advanced practitioners, staff, etc.) on stories across various service lines to share information relevant to our audience. Stories range from health and wellness to patient and colleague stories to community programs.

The site offers free, easy-to-read articles for the community. The site strategically addresses health issues that are most pressing to the community, including:

- Cancer awareness, with articles on the benefits of cancer screenings including information on breast, skin, colon, cervical, prostate and lung cancers.
- Sports and exercise safety, healthful eating, high blood pressure and heart health.
- Seasonal wellness tips, including educating residents about the difference between the cold and flu and how to avoid heat stroke in extreme heat.
- Emerging health concerns, such as new forms of smoking and understanding Juul and other vaping/e cigarette products health risks. Articles also address the increase in suicide rates and how to speak to a child about suicide.

Goal: Healthy State seeks to influence personal health choices, to inform people about ways to enhance health or to avoid specific health risks by:

- Increasing knowledge and awareness of a health issue.
- Influencing behaviors and attitudes toward a health issue.
- Dispelling misconceptions about health.

Outcome:

- Number of page views for FY18: 81,511
- Number of return users for FY18: 6,098
- Average session duration for FY18: 53 seconds
- Pages per session: 1.42

Patient Financial Counselors

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

Despite the overall success of the commonwealth's health reform efforts, information captured for the CHNA shows that while the vast majority of the area's residents have access to care, large segments of the population, particularly low-income and racial/ethnic minority populations, face significant

barriers to care. These groups struggle to access services due to lack of insurance, cost, lack of transportation, cultural/linguistic barriers and a shortage of providers willing to serve Medicaid-insured or uninsured patients.

In response, Beverly and Addison Gilbert Hospitals employ Certified Application Counselors with MassHealth and the Health Connector who can screen patients and help them apply for state aid. Patient access billing reps provide estimates to patients for their financial responsibility (copay, deductible, coinsurance, self-pay).

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

Outcome: The financial counselors serve approximately 35-40 patients per day, or about 12,000 patients per year.

Support Groups

Description: In FY18, NHC hosted 26 different monthly support groups at Addison Gilbert Hospital, Beverly Hospital and Lahey Outpatient Center, Danvers. These support groups are directly responsive to a number of identified community health needs in the BH & AGH service area and serve a diverse population of individuals. Based on the findings of the most recent CHNA, we will continue to offer a variety of support groups to help educate, support and assist individuals and families who are going through difficult times. Support groups can help inform, console and lift the spirit, which are all part of the healing process.

Goal: To provide free support group services to help educate, support and assist individuals and families who are going through difficult times.

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

Community Partners: Internal initiative

Increasing Access to Care: Transportation Programs

Description: While social determinants of health affect all populations, community and organizational experts expressed concern that seniors may feel these effects more acutely. Many older adults live on fixed incomes with limited funds for medical expenses, leaving them less able to afford the high costs associated with negative health outcomes. Transportation was also consistently mentioned as a major barrier to senior well-being, as many elders no longer drive and find themselves with fewer transportation options.

In response, Beverly and Addison Gilbert Hospitals provide a variety of ways that we help to bridge the gaps that can be caused by lack of transportation. In FY18, we provided close to 100 taxi vouchers for patients without access to transportation.

Additionally, Bay Ridge Hospital Bay Ridge Hospital provides a part-time shuttle driver to assist patients with transportation services. Many of these patients are receiving intensive outpatient services designed to provide an alternative to acute inpatient treatment. Specific services can include daily treatment meetings, individual, family, group and psychopharmacological intervention.

Goal: The goal of the Transportation Program is to increase access to health services by providing transportation to individuals with no means of transportation due to medical or financial issues.
Partners: Tri-City Services, Tom's Taxi, TG's Taxi and Gloucester Taxi and Livery Services.

Health Priority Area #2 — Elder Health

Senior Dine and Learn Program

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

Goal: In FY18, Beverly and Addison Gilbert Hospitals conducted eight monthly sessions each, serving over 880 elder adults. Highlighted topics included basic nutrition, medication review, fall prevention, stress management and coping skills, fitness tips, memory loss, reading nutrition labels, and winter safety tips. Each presentation was accompanied by a healthy and nutritious meal, prepared by the dining services team from Unidine at the Beverly and Addison Gilbert Hospitals cafeterias and served by hospital employees.

Community Partners: Unidine; Beverly, Gloucester and Rockport Councils on Aging; Gloucester Police Department

Danvers Senior Nutrition Program

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

Goal: To increase access for senior residents of Danvers to local, farm-fresh produce, meats, fish, eggs and honey. The program allows for community engagement, social interaction and healthy food alternatives.

Outcome: The program was designed to reach 19.3% of the Danvers population over 65 years of age. In 2018, we saw 400 certificates distributed and 90% of the vouchers were redeemed at participating farm vendors for fresh items.

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

The Aging Mastery Program

Description: The Aging Mastery Program is an education and behavior change program designed to support seniors in "aging well." The program philosophy is built on the belief that modest changes in lifestyle can result in big changes, thus empowering individuals to develop sustainable behaviors in multiple dimensions of well-being. Over 12 weekly sessions, the program incorporates evidence-based materials, guest speakers, group discussion, peer support and incentives/rewards.
The core curriculum covers 10 dimensions:

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

Community Partners: Beverly Council on Aging

Enhance Fitness

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

Goal: For older adults to build strength and endurance for independence while enjoying a sense of community and social-connectedness. Participants are encouraged to attend three classes per week. Sixteen-week sessions are offered continuously throughout the year.

Outcome: Across the three locations (Beverly, Gloucester and Ipswich), 273 unique participants completed a total of 7,880 sessions. Participants were able to "achieve or maintain at average or above," compared with age/gender-matched norms.

Community Partners: Greater Beverly YMCA, Ipswich and Cape Ann YMCA, Beverly Council on Aging

Water Aerobics Classes

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

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

Outcome: The Aqua Adventure class held once a week had 25 participants. The Aqua Fit class, also held once a week, had 42 participants.

Community Partner: Cape Ann YMCA

Osteoporosis Prevention Exercise Class

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

Goal: A group class uses strength and body weight exercise to maintain bone density and prevent or slow the development of osteoporosis.

Outcome: In FY18, Addison Gilbert Hospital hosted free one-hour classes every Tuesday and Thursday. There were 34 registered participants and the average class size was 20.

Community Partners: Cape Ann YMCA

Serving the Health Information Needs of Everyone Program

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

Goal: A trained SHINE liaison is available daily at the Beverly and Addison Gilbert Hospitals, as well as weekly at Councils on Aging in Beverly, Gloucester and Rockport 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 help those with limited resources enroll in programs. The SHINE program is open to everyone and not limited to NHC patients.

Outcome: In FY18, SHINE counselors conducted 1,300 visits throughout the North Shore and Cape Ann.

Health Priority Area #3 — Behavioral Health (Mental Health and Substance Abuse)

Mental Health First Aid Training

Description: The project trained 120 paraprofessionals and support staff in the Danvers Public School district in the national Youth Mental Health First Aid certificate training sponsored by the National Association of Mental Illness (NAMI).

Goal: The goal is to give frontline staff who work directly with youth the skills to identify and respond to a mental health crisis in an appropriate and compassionate manner.

Outcome: The Danvers School District contracted with facilitators trained to deliver the NAMI Youth Mental Health First Aid Model. Per NAMI certification requirements, a maximum of 30 participants were allowed per group, with a primary and secondary facilitator. Therefore, to ensure training capacity, four groups were offered. The training was offered on August 29 and 30, two contracted professional development days designated by the Danvers Public Schools. The eight-hour training was offered over two half-day sessions, from 8 a.m. to 12:30 p.m. Certificates were awarded only to staff that completed the full eight hours of training time. The DanversCARES Director worked with the Director of Student Services and the Director of Curriculum to organize and communicate training logistics. Staff were notified through regular professional development communications, including online pre-registration. The school provided four classrooms that accommodated 120 people.

Community Partners: DanversCARES, Danvers Public Schools, Lahey Behavioral Health, North Shore Education Consortium

Medication Disposal Box Program

Description: As part of our CHIP commitment to helping address prescription drug misuse, Beverly Hospital is now providing a medication disposal kiosk to safely dispose of expired or unwanted medication. Medications can be dropped off 24 hours a day, 7 days a week in the Emergency Room Waiting Area and are safely disposed of in accordance with DEA regulations. According to the National Institute on Drug Abuse (NIDA), an estimated 54 million people have used medications for nonmedical reasons at least once in their lifetime. Opioids are among the most misused prescriptions, with 75% of those who abuse reporting their first opioid was a prescription. The NIDA reports that unintentional opioid pain reliever deaths have quadrupled since 1999, and that nearly 80% of heroin users reported using prescription opioids prior to heroin.

Goal: To provide a safe and convenient way for residents to dispose of unwanted or unused medications.

Outcome: In FY18, Beverly Hospital collected and disposed of 400 pounds of medications.

Opioid Awareness Training and Outreach to the Fishing Community

Description: Awareness programs and training initiatives to reach fishermen and their families. Training fishermen to administer Naloxone/Narcan and providing overdose-prevention education.

Goal: Fishing Partnership (FP) Support Services was able to expand their capacity to serve the mental/behavioral health needs of fishing households in Gloucester and the North Shore; increase life-saving knowledge, awareness and skills in the fishing community about opioids and how to intervene in cases of overdose by embedding learning within existing structures that fishermen value (such as safety and CPR trainings); scale their mental/behavioral health work related to opioids to a new region; and coordinate efforts with community partners, contributing new learning to help us continue to innovate and share findings.

Outcome: FP was able to expand their capacity to provide assistance to members in the fishing community who have overdosed or are interested in recovery by training a Navigator as a Recovery Coach through the Peer Recovery Coach Academy. FP was able to increase knowledge, awareness and skills among members of the fishing community in a new region by conducting Opioid Awareness and Narcan trainings as part of three FP-hosted trainings (one safety and survival training and two CPR/first-aid trainings in Gloucester).

Community Partners: Fishing Partnership, Learn to Cope, PAARI (Police Assisted Addiction and Recovery Initiative), Gloucester Police Department

Healing to Housing Program

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

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

Outcome:

- Fifty-three Emergency Homeless Shelter guests moved into affordable housing. These clients received clinical counseling from the Shelter Counselor and/or supportive case management from shelter staff. This team approach to care included working closely together to create moving-on plans, which contain housing, employment and health goals.

- All formerly homeless clients (now in housing) were able to retain their housing. Shelter Counselors provided these clients with critical aftercare services. After years of homelessness, some individuals struggle with the transition, and the counselors can provide continuity of care and additional support.

- Twenty-five homeless individuals overcame behavioral health barriers in order to obtain housing. All 25 were diagnosed with mental health and/or substance use disorder. These individuals received one-on-one clinical counseling from the Shelter Counselor as they worked toward permanent housing. The Shelter Counselor also helped many access psychiatric and psychopharmacological care.

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

Recovery Coaches in the Emergency Room

Description: The role of the Recovery Coach is to provide supportive services described below to individuals who present in an ED for an opiate overdose, as well as individuals seeking services for substance use disorders, regardless of insurance status. Recovery Coaches work closely with hospital ED staff.

Goal: Recovery Coaches are to provide non-judgmental, non-clinical recovery support and shall meet the following minimum requirements:

- Be a member(s) of the ESP team that provides non-clinical support and shall not be used in a clinical capacity;
- Be supervised by a licensed ESP Director or clinician with substance use disorder training and experience, LADC preferred;
- Be a peer(s), preferably with lived addiction experience;
- Complete the Bureau of Substance Abuse Services (BSAS) Recovery Coach Academy or the Connecticut Community Addiction Recovery (CCAR) training prior to working with individuals in the ED and within one month of hire;
- Meet with the individuals who present in an ED post-overdose if the individual agrees;
- Serve as a recovery guide and role model in the management of recovery and assist the individual to identify and overcome barriers to recovery, connect the individual with recovery support services and encourage hope, optimism, and health;
- Provide support with problem solving and advocacy to assist individuals to meet their recovery goals;
- Obtain necessary releases of information signed by the individual in order to provide short-term follow-up support;
- Provide education on overdose prevention and the use of naloxone to the individual and offer the individual an overdose prevention kit;
- Provide short-term telephonic (or text) follow-up support, coaching, and assistance to help the individual access treatment or recovery support services if agreed upon by the individual;
- Be knowledgeable about the substance use disorder (SUD) service system and link the individual to treatment and recovery resources including but not limited to AcuteTreatment Services (ATS), sober housing, benefits, and Narcan education;
- Conduct a warm handoff of the individual to appropriate treatment or recovery services including a Community Support Program (CSP) to encourage continued treatment and recovery support in the community;

- Provide education to individuals and family members on the recovery process; and act as a resource for any individual who presents to the ED seeking services for a substance use disorder.

Outcome: We have one full time Recovery Coach that serves approximately 500 clients per year.

Team Fourteen

Description: Team Fourteen is a group of clinicians and case managers who serve adolescents and their families with emerging substance use concerns in Essex County. We offer group and individual counseling as well as training and consultations for schools and other community providers.

Goal: This project will serve more than 295 youth and families who will be served through this multi-year project and will benefit from enhanced treatment outcomes. Service delivery will take place in the community, primarily in family homes but also in public spaces like schools, libraries, cafes.

Outcome:

Stated Outcome	Progress Toward Outcome
Total of 64 individuals served by the program in year one	**Outcome exceeded.** Total **91 individuals** served.(37 families)
Total of 102 individuals served by the program in year two	**Outcome exceeded.** Total **131 individuals** served (73 families)
Total 128 individuals served in year three, with 588 individuals served over three years.	On track to goal.
60% youth enrolled will complete model to completion	**Outcome met.** **60% of 110 youth served** since program launch have either graduated or on track to graduate in April 2018 **19%** dropped out **20%** referred out

Community Partners: Project Adventure, Beverly High School, Cape Ann Community Service Agency, Children's Friend and Family Services (outpatient therapy) ,DCF (Department of Children and Families),DYS (Department of Youth Services),Gloucester High School, North Shore Medical Center, Peabody High School, Salem Juvenile District Court, Lahey Behavioral Services

Student Assistance Program (SAP)

Description: SAP is a core program of Lahey Health Behavioral Services and advances our organization's mission by partnering with local middle and high schools in Essex County to offer free school-based interventions that encourage and enable academic and behavioral success. The program leverages the school environment to provide proactive in-school mental health support and counseling for issues that at-risk youth – particularly those struggling with mental health concerns and problems related to drug and alcohol use –regularly face, with the ultimate goal of minimizing obstacles to achieving academic and behavioral success. SAP counselors – all of whom are Master's level clinicians and many of whom are independently licensed – are embedded into the fabric of each partner school, carry an average caseload of 30 students, and provide a range of complementary services including group counseling, consultation services for parents and school staff, and unique programming on topics such as bullying, substance use, and suicide prevention that reduce stigma and raise awareness around common behavioral health concerns for young people.

Goal: In the past year, SAP served 115 students with individualized services and engaged over 1,000 unique individuals (students, parents, teachers, and other community members) through presentations, community engagement, and professional trainings at four schools in Essex County.

Outcome: 100% of students surveyed reported "likely" or "very likely" to recommend services to a peer, average increase of 13 points on happiness scale as a result of services (tool is a 16-160 scale with 16 indicated least life satisfaction and 160 indicating most)

Community Partners: Ipswich High School, Beverly High School, O'Maley Middle School (Gloucester) and Holten Richmond Middle School (Danvers).

Transportation Voucher Program.

Description: Lahey Health Behavioral Services lead a program awarded funds by the Legislature for maximizing resources, increasing access and removing barriers for substance use treatment. Specifically, the funds will be used to provide transportation for people who need acute substance use treatment programs but do not have transportation to facilities. The Gloucester High Risk Task Force which received the funding has partnered with LHBS and Beauport Ambulance and Sunshine Taxi to decrease the transportation barrier for people seeking services at detox facilities in the North Shore and Boston proper areas. LHBS staff, primarily the Salem Emergency Services Program, will identify and screen candidates for acute substance use treatment services.

Goal: The program is expected to eliminate barriers for treatment for 3-6 individuals per week. This would help reduce overdose and provide substance use treatment for individuals that will directly affect the community as a whole.

Outcome: The program provided transportation to and from substance use facilities throughout Massachusetts for 111 individuals that would otherwise not have received treatment.

Community Partners: Gloucester, Beverly, Salem, Danvers, Middleton, Ipswich, Hamilton, Marblehead, Peabody, Rockport, Topsfield, Wenham, Essex, Manchester-by-the-sea.

High Risk Intervention Program

Description: The High Risk Intervention team provides additional resources to supplement existing case management and social work services and works with existing care providers to bridge gaps for these high risk patients. In addition, pharmacists will provide medication therapy management and education.

The High Risk Intervention team will also make post-acute and home visits. Health Promotion Advocates will provide ED-SBIRT education and prevention by reinforcing healthy patient behaviors and reducing high risk substance use behaviors for all patients in the Emergency Department. In FY18 the High Risk Team saw 4000 patients.

Youth at Risk Conference

Description: The Youth at Risk (YAR) conference is the region's only annual all-day conference for professionals who work with at-risk youth. The event features 38 breakout sessions as well as keynote speakers, program exhibitions and networking opportunities. We provided clinical expertise during breakout sessions and community resources in order to build the capacity of service providers. This event attracted 792 participants and volunteers. The YAR attendees represented over 400 organizations and 106 communities across the commonwealth. The YAR network is made up of over 4,000 professionals in Essex County who dedicate their lives to working with at-risk youth.

Health Priority Area #4 — Maternal and Child Health

Connecting Young Moms Programs

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

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

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

Goal: This free program is to be attended in the first or second trimester and focuses on healthy pregnancy. Topics include nutrition, body image and preterm labor. Through a team approach, staff are committed to bringing health and parenting education, community resources and peer support to help young mothers develop healthy and positive parenting skills.

Outcome: Connecting Young Moms offered five prenatal sessions throughout the year to 65 young mothers plus their children, fathers of the babies and support people.

The Nurturing Program for Parents

Description: The Nurturing Program® for Parents of School Aged Children or the Nurturing Program® for Parents of Infants, Toddlers and Preschoolers ran concurrently in order to accommodate the increased participant interest from the community. Parents learned about nurturing parenting, with particular attention paid to nurturing/attachment, knowledge of parenting/child development, parental resilience, social connections, concrete services and social-emotional competence of children. Children learned comparable skills at age-appropriate levels through puppets, role-play, music, art activities and leader-led discussions.

Each week, parents and their children came together for dinner at the midpoint of the evening's session. We found that dinner was a powerful opportunity to share strategies with families, as the children were eager to show what they had learned and made in their classrooms as well as discuss what they had enjoyed about their day and what they had not. From there, families used the skills they had been learning in a group to brainstorm ideas on ways to help children have more successful days in the future.

Goal: Sixty-three participants initially enrolled in the Nurturing Program, and 42 participants met the attendance requirement to graduate (a maximum of three absences). While retention of participants represents an ongoing challenge, we find that the Nurturing Program serves as a conduit to providing these families with the emotional support and the concrete services that they need during times of transition. For example, the parent who relocated due to domestic violence actually disclosed her situation during group, and the facilitator was able to work with her to obtain immediate safe shelter. Several of our participants begin the program while in temporary shelter, meaning that they are completely at the whim of the availability of more permanent housing. While families typically feel relieved when they are notified of a permanent public housing placement, the good news often carries an element of trepidation regarding the unknown. We are able to ease some of the anxiety families may feel through group support and facilitation of any necessary referrals to programs in their new communities.

Outcome: Parent participants completed the Adult Adolescent Parenting Inventory (AAPI) risk assessment tool before starting the program and again upon graduation from the program. The AAPI measures improvement in the following constructs: Inappropriate Expectations, Lack of Empathy, Physical Punishment, Role Reversal, and Power and Independence. Upon program completion, the scores of all 42 graduating participants had increased, indicating that they had increased their knowledge of parenting skills.

To determine progress of the program from week to week, facilitators monitored parents' participation during role plays and group activities, and parents were asked to self-report on their homework activities for the previous week. Parents also reported to the group about which strategies worked during the week and what helped them be successful. Every five weeks throughout the program, parents completed a survey to share whether they felt the material was being presented in a constructive manner. Through the final evaluations, parents provided concrete examples of how the Nurturing Program helped them improve their family functioning through enhanced communication strategies, effective discipline approaches and a greater understanding of empathy.

Community Partners: Children's Friend and Family Services, Early Intervention, Department of Children and Families, Probate Court, Head Start, Wellspring House, The Open Door, Family Dinner Project

Neonatal Abstinence Program

Program Description: With its expertise, experience, and mission to address behavioral health and the health of mothers and newborns, Beverly Hospital has identified substance use disorder (SUD) in pregnant and parenting women and neonatal abstinence syndrome (NAS), defined as withdrawal symptoms that present in substance exposed newborns (SENs), as urgent needs to be addressed in Essex County.

Goal: The overall program goals are to promote recovery in pregnant and parenting women, improve perinatal care of the mother-baby dyad, and improve dyadic outcomes. We aim to achieve these goals through a multidisciplinary approach focused on improved maternal substance use treatment, trauma-informed and evidence-based maternal and neonatal care, and increased support for SENs and their families.

The Integrative Care Program provides a thorough and effective support system for women during pregnancy and for 1 year postpartum. Specifically, we provide:

- Trauma-informed, gender-specific individual and group counseling
- Medication assisted treatment for opioid use disorder
- Case management
- Psychiatric assessment and referral
- Peer Recovery Counselors
- Integration of holistic approaches and mindfulness exercises to help maintain recovery
- Opportunities for women to meet with representatives from Early Intervention, community social service agencies, and the Special Care Nursery for care planning
- One-site, one-day model to facilitate access to care

Community Partners: MA Division of Children and Families, Lahey Behavioral Health Services, MA Department of Public health, MA Health Policy Commission,

Kids Weekend Food Program

Description: The Kids Weekend Food program was designed for kids who do not have access on weekends and long vacations to the free or reduced-price breakfast and lunch that they get at school. Beverly Bootstraps launched the program at all Beverly Elementary Schools. This was a direct result of a need identified by a local elementary school with a number of children at extreme risk. Beverly Bootstraps partners with the Beverly Public School, school administrators, nurses and teachers to provide food to elementary-age (pre-K to fourth grade) children identified as food insecure. Beverly Bootstraps Food Pantry staff is in regular contact with the school nurses from all five Beverly elementary schools to ensure that we are reaching all of the needy children in the city.

Goal: Provide a warm and welcoming environment at convenient times for those in need of food and services. Provide snack bags of food for children to bring home and include vouchers for the Food Pantry to allow an extra visit if they are an existing client, or a voucher for a first-time visit if they have not previously used the Food Pantry. Ensure that the food purchased or donated for our Food Assistance program is of high nutritional value. Make sure to communicate often with the other programs available to clients.

Outcome: Monthly average number of participants: 157-194

Community Partners: Bootstraps and Beverly Public Schools

Beverly Hospital "Cuddler" Program

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

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

Outcome: Twelve trained volunteers spent 426 hours cuddling babies in the Beverly Hospital Special Care Nursery.

Child Passenger Safety Program

Description: The Rehabilitation and Sports Medicine Department has three certified child passenger safety technicians on staff at Beverly and Addison Gilbert Hospitals who offer free car seat inspections for the community at both hospitals.

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

Outcome: In FY18, the Child Passenger Safety Program inspected 107 car seats and provided 26 new car seats to community families in need.

FY18 Community Outreach Overview

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

In FY18, NHC:

- Provided funding to support summer reading initiatives in Gloucester and Beverly.
- Sponsored four American Red Cross blood drives.
- Partnered with Center for Healthy Aging on a Falls Awareness & Prevention event.
- Provided a free supermarket guided nutrition tour.
- Held a Holiday Gift and Mitten Tree Drive during the season to assist local residents.
- Held food drives to support the Beverly and Gloucester food pantries.
- Provided financial service guidance at Cape Ann Farmers Market.
- Offered a Get Fit Challenge to participants of the Gloucester Sidewalk Bazaar.
- Participated in Healthy Kid Day in Beverly, Gloucester and Ipswich.
- Supported the Danvers Kiwanis Bike Rodeo and offered helmet fittings.
- Participated in 12 health fairs with the goal of providing health education and screenings in the community.
- Supported 10 road races with over 3,030 total participants.
- Sponsored several community events, including Danvers Family Festival, Beverly's First Night, Beverly Halloween Event, Rockport's First Night, Gloucester Block Parties, Gloucester Pride Stride and Beverly Homecoming.

GLOSSARY OF TERMS

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

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

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

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

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

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

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

EXPENDITURES

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

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

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

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

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

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

Hospital: A nonprofit acute care hospital, as defined by Chapter 118G of the Massachusetts General Laws, to include the teaching hospital of the University of Massachusetts Medical School and any hospital licensed under Section 51 of Chapter 111, and which contains a majority of medical-surgical, pediatric, obstetric and maternity beds, as defined by the Department of Public Health.

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

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

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

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