Community Benefits Report

Fiscal Year 2020

Beth Israel Lahey Health
Anna Jaques Hospital

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SECTION I: SUMMARY AND MISSION STATEMENT

Summary and Mission Statement
Anna Jaques Hospital (AJH) is a member of Beth Israel Lahey Health (BILH). BILH brings together an exceptional array of clinical organizations spanning the full continuum of health care delivery – academic and teaching hospitals, community hospitals, ambulatory and urgent care centers, behavioral health programs, and home care – in a shared mission to expand access to great care and advance the science and practice of medicine through groundbreaking research and education.

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. BILH Community Benefits staff are committed to working collaboratively with BILH's communities to address leading health issues and create a healthy future for individuals, families, and communities.

The mission of Anna Jaques Hospital is to provide high-quality, compassionate medical care in partnership with its medical staff, to improve the health of its communities. Established in 1884 through the vision and charity of Miss Anna Jaques, the hospital stands as a testament to one woman's and her physician's commitment to the community and its needs. AJH proudly continues that tradition by actively serving its community – by addressing the most pressing health needs, supporting the underserved in the hospital's service area, and addressing disparities in access to care and health outcomes.

The following annual report provides specific details on how AJH is honoring its commitment and striving to create a healthy future for its community. The report includes information on its Community Benefits Service Area (CBSA), community health priorities, target populations, and community partners, and detailed descriptions of its Community Benefits programs and their impact.

More broadly, the AJH Community Benefits mission is fulfilled by:

- **Involving AJH's staff**, including its leadership and dozens of community partners in the community health assessment process as well as in the development, implementation, and oversight of the hospital's three-year Implementation Strategy;

- **Engaging and learning from residents** throughout AJH's service area in all aspects of the Community Benefits process, including assessment, planning, implementation, and evaluation. The hospital pays special attention to engaging those community members who are not patients of AJH and those who are often left out of assessment, planning, and program implementation processes;

- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to identify unmet health-related needs and to characterize those in the community who are most vulnerable and face disparities in access and outcomes;

- **Implementing community health programs and services** in AJH's CBSA that are geared toward improving the current and future health status of individuals, families, and communities by removing barriers to care, addressing social determinants of health, strengthening the health care system, and working to decrease the burden of leading health issues;

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

- **Facilitating collaboration and partnership** within and across sectors (e.g., public health, health care, social services, business, academic, and community health) to advocate for, support, and implement effective health policies, community programs, and services.

Target Populations
Anna Jaques Hospital is committed to improving the health status and well-being of those living throughout its entire CBSA, which includes:

- Haverhill (63,639)
- Newburyport (18,060)
- Amesbury (17,218)
- Salisbury (9,400)
- Georgetown (8,688)
- Newbury (7,079)
- Merrimac (6,913)
- Groveland (6,697)
- West Newbury (4,545)
- Rowley (1,416)

Per the Commonwealth's updated Community Benefits guidelines, AJH's Implementation Strategy (IS) will focus on populations that are most at risk. The Community Health Needs Assessment (CHNA) showed that although all geographic, demographic, and socioeconomic segments of the population face challenges that can hinder the ability to access care or maintain good health, the populations listed below were identified as facing the greatest health disparities and being the most at risk.

- Youth and Adolescents
- Older Adults
- Individuals with Chronic/Complex Conditions

Basis for Selection

- Community health needs assessments
- Available public health data
- Private resources (foundations, advocacy groups)
- Insight and data from Anna Jaques Hospital

Key Accomplishments for Reporting Year
The accomplishments highlighted in this report are based upon priorities identified and programs contained in Anna Jaques Hospital's FY19 Community Health Needs Assessment (CHNA) and FY20-22 Implementation Strategy (IS).

During FY20, Anna Jaques Hospital dedicated significant time and resources to respond to COVID-19 needs. AJH worked with community health centers to expand community testing access. The hospital also worked with BILH to develop and distribute written materials (in nine languages) to the communities most impacted by COVID-19 to help slow the spread of the virus. BILH and AJH redeployed staff, supplies, and other materials both to the community and within hospitals, including Personal Protective Equipment (PPE), food, hand sanitizer, etc.

Because of COVID-19, several programs highlighted in this report were modified. In some cases, programs were expanded, and in others, programs were reduced in response to the pandemic and its impact on our community. Highlights included:

- Virtual offerings: supported online cancer support groups and resources; dedicated online COVID-19 family resource with information to support mental health; online fitness opportunities.
- Heightened SDOH needs: the pandemic quadrupled the number of clients using food assistance services with Our Neighbors' Table; AJH sponsored to-go weekly meals. Domestic violence needs rose drastically; AJH support Jeanne Geiger Crisis Center. Housing and shelters were restricted in capacity for social distancing; AJH supported Mitch's Place 24/7 shelter in Haverhill.
- Substance use/Mental health: supported ongoing local case management services to support households impacted by substance use disorder and mental health with numbers heavily increasing in the past year.

Plans for Next Reporting Year

In FY19, Anna Jaques Hospital conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included qualitative and quantitative data collection, robust community engagement activities, and an inclusive prioritization process. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY19. In response to the FY19 CHNA, AJH will focus its FY20-22 Implementation Strategy on four priority areas; these priority areas collectively address the broad range of health and social issues facing residents living in AJH's CBSA who face the greatest health disparities. These four priority areas are:

1) **Social Determinants of Health (Housing, Food Access, Support for Vulnerable Communities):** In the past decade, evidence has made it increasingly clear that the utilization of medical services is not the primary determinant of community health. Rather, the social conditions in which people are born, grow, live, work, and age play a key role in determining health outcomes and health disparities. According to data compiled by the Greater Boston Food Bank and Feeding America, there are approximately 6,000 people who are food insecure – people who are worrying about running out of food or actually going without – living in northeastern Essex County.
2) **Chronic Disease Management and Prevention (Cancer):** The CHNA findings revealed a need to address the many risk factors associated with chronic and complex health conditions, with a focus on cancer.
3) **Behavioral Health (Mental Health and Substance Use):** A key finding was the continued impact that substance use has on the community, including the use of e-cigarettes/vaping and alcohol by youth and

the opioid epidemic, which continues to impact individuals, families, and communities, including youth and pregnant women.

4) **Access to Care:** Ensure access to preventive measures, testing, screening, and treatment for those at risk for or exposed to COVID-19 and mitigate the impacts of the pandemic on the social determinants of health.

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). Anna Jaques Hospital'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 FY19 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions that are being used to inform and refine Anna Jaques Hospital's efforts. In completing the FY19 CHNA and FY20-22 Implementation Strategy, Anna Jaques Hospital, along with its other health, public health, social service, and community partners, is committed to improving the health status and well-being of all residents living throughout its CBSA. As discussed above, based on the CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that Anna Jaques Hospital's FY20-22 Implementation Strategy should prioritize certain demographic, socioeconomic, and geographic population segments that have complex needs and face barriers to care and a service gap as well as other adverse social determinants of health. These factors put these segments at greater risk, limit their access to needed services, and can often lead to disparities in health outcomes. More specifically, the FY19 CHNA identified the importance of supporting initiatives that targeted low-income populations, youth, older adults, racially/ethnically diverse populations, limited-English-proficiency populations, and LGBTQ populations.

Anna Jaques Hospital partners with dozens of community-based organizations and service providers to execute its Implementation Strategy, including public agencies, social service providers, community health organizations, academic organizations, and businesses.

Hospital Self-Assessment Form

Working with its Community Benefits leadership team and its Community Benefits Advisory Committee (CBAC), the Anna Jaques Hospital Community Benefits team completed a hospital self-assessment form (Section VII, page 83). The AJH Community Benefits team also shared the Community Representative Feedback Form with many CBAC members and community stakeholders who participated in AJH's CHNA.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team and Community Benefits Advisory Committee (CBAC)

The membership of Anna Jaques Hospital's Community Benefits Advisory Committee (CBAC) aspires to be representative of the constituencies and priority populations served by AJH'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 nonprofit community organizations. Senior management is actively engaged in the development and implementation of the Community Benefits plan, ensuring that hospital policies and resources are allocated to support planned activities.

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

Anna Jaques Hospital is a member of BILH. While AJH oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Strategy Officer. This structure ensures that Community Benefits efforts, prioritization, planning, and strategy align and are integrated with local and system strategic and regulatory priorities.

The Anna Jaques Hospital Community Benefits program is spearheaded by the Manager of Community Benefits and Community Relations at AJH. The Manager has direct access and is accountable to the Anna Jaques Hospital President and the BILH Vice President of Community Benefits and Community Relations, the latter of whom reports directly to the BILH Chief Strategy Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of underserved populations are considered every day in discussions on resource allocation, policies, and program development.

This is the structure and methodology 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 Community Benefits.

Community Benefits Advisory Committee

Andrea (Andi) Egmont, City of Newburyport, Newburyport Youth Services/The BEACON Coalition, Director

Ilene Harnch-Grady, YWCA of Newburyport, Encore Program Leader

Tina Los, Essex County Asset Builder Network, Project Coordinator

Tiffany Nigro, Executive Director, The Pettengill House

Pam Palombo, RN, City of Newburyport, Newburyport Public Health Nurse and Nourishing the Northshore (hiatus during pandemic)

Officer Dani Sinclair, Newburyport Police, Inspector

Shari Wilkinson, The Newburyport Farmers Market, Market Coordinator

Hospital Representation

Kelley Sullivan, Manager of Community Benefits & Community Relations

Danielle Perry, Vice President of Business Development & Marketing, AJH Senior Leadership Representative

Christine Healey, Director of Community Benefits, North Region, Beth Israel Lahey Health Representative

Community Benefits Committee Meetings

- December 12, 2020 – One-on-one CBAC member meetings
- August 31, 2020 – CBAC Update
- September 17, 2020 – CBAC Meeting

Community Partners

As a long-standing community hospital that is part of a larger health system, as well as the largest employer in its community, Anna Jaques Hospital recognizes – and prides itself on – the role it plays in the overall health and strength of the communities it serves. Together with community partners, AJH is able to do so much more.

Anna Jaques Hospital's CHNA and the associated IS were completed in close collaboration with AJH's staff, its health and social service partners, and the community at-large. AJH's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of AJH's mission.

Anna Jaques Hospital currently supports dozens of educational, outreach, community health improvement, and health system strengthening initiatives. In so doing, AJH collaborates with many of the leading health care, public health, and social service organizations across the Merrimack Valley and North Shore.

These health centers are ideal Community Benefits partners as they are rooted in their communities and, as federally qualified health centers, are mandated to serve low-income, underserved populations.

The following is a comprehensive listing of the community partners with which Anna Jaques Hospital 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 83).

- Amesbury Chamber of Commerce
- Amesbury Council on Aging
- The Arc of Greater Haverhill-Newburyport
- The BEACON Coalition
- Coastal Trails Coalition
- Elder Services of the Merrimack Valley/Home Health VNA
- Emmaus, Inc.
- Essex County Asset Builder Network
- Family Services of the Merrimack Valley
- Girls, Inc.
- Greater Haverhill Chamber of Commerce
- Greater Haverhill Farmers Market/Creative Haverhill
- Greater Newburyport Chamber of Commerce
- Greater Newburyport Ovarian Cancer Awareness – Ovations for the Cure
- Health Partnership of the Lower Merrimack Valley and Seacoast Region
- Institution for Savings
- Jeanne Geiger Crisis Center
- Link House, Inc.
- Merrimac Senior Center & Council on Aging
- Merrimack Valley Hospice – Home Health Foundation
- Miss Pink Organization
- Newburyport Council on Aging
- Newburyport Farmers' Market
- Newburyport Lions Club
- Newburyport Public Schools
- Newburyport Yankee Homecoming
- Newburyport Youth Services
- Newburyport Rotary Club
- Newburyport Society for the Relief of Aged Women
- North of Boston Cancer Resource
- Nourishing the Northshore
- Opportunity Works
- Our Neighbors' Table
- The Pettengill House
- Salisbury Parks & Recreation Department
- Salisbury Senior Center & Council on Aging
- Tough Warrior Princesses
- Triton Education Foundation
- YMCA of Northshore/Haverhill
- YWCA of Greater Haverhill
- YWCA of Newburyport

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY19 Community Health Needs Assessment (CHNA) and the associated FY20-22 Implementation Strategy were developed over a ten-month period from October 2018 to August 2019. 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 Anna Jaques Hospital'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 Anna Jaques Hospital's dedication to its mission, its covenant to the underserved, and its commitment to community health improvement.

As mentioned above, Anna Jaques Hospital's most recent CHNA was completed during FY19. FY20 Community Benefits programming was informed by the FY19 CHNA and aligns with AJH's FY20-22 Implementation Strategy. The following is a summary description of the FY19 CHNA approach, methods, and key findings.

Approach and Methods
The FY19 CHNA was conducted in three phases, which allowed AJH to:

1) Compile an extensive amount of quantitative and qualitative data;
2) Engage and involve key stakeholders, AJH clinical and administrative staff, and the community at-large;
3) Develop a report and detailed strategic plan; and
4) Comply with all Commonwealth Attorney General and Federal IRS community benefits requirements.

AJH's Community Benefits program is predicated on the notion of partnership and dialogue with its many communities. AJH's understanding of these communities' needs is derived from discussions with and observations by health care and health-related workers in the neighborhoods as well as more formal assessments through available public health data, focus groups, surveys, etc. This data was then augmented by demographic and health status information gleaned from a variety of sources, including The Massachusetts DPH, The Boston Public Health Commission, and federal resources such as the Institute of Medicine and Centers for Disease Control and Prevention, and from a review of literature relevant to a particular community's needs.

Primary data for the CHNA is derived from shared resources and available data from community partnerships and organizations. Members of the CBAC collaborated with the Community Benefits Manager, through meetings and conversations between 2018 and 2019, to connect AJH with useful resources and reports, both from members' own organizations as

well as publicly reported data, that reflect the significant health needs facing communities served by AJH.

The members of the CBAC represent the interests of AJH's most vulnerable populations, including low-income, minority, homeless, and other underserved or high-risk populations. Additionally, Pam Palombo, a member of the CBAC, serves as Newburyport Public Health Nurse, and provided insight and suggestions to the CBAC regarding the health needs of that community.

Demographic data was collected using publicly available data from the U.S. Census Bureau, health indicators from the Massachusetts Department of Public Health, and the Centers for Disease Control and Prevention (CDC). Health indicator data such as mortality, incidence, prevalence, and hospitalization rates were provided by the Massachusetts DPH, and by use of other state, regional, and national information sources on cancer incidence and opioid use trends.

After a comprehensive review of all the quantitative and qualitative information collected in the Anna Jaques Hospital CHNA, the key health-related findings identified were the following:

- In January 2019, the CBAC determined that after three years of focusing on obesity, cancer, and substance use as its significant health priorities, the data and available resources consulted reflected positive changes for obesity but that cancer and substance use should remain the program's core focus.
- The CBAC voted, in order to address the most pressing health needs in our community and incorporate statewide goals/social determinants of health in the most impactful and realistic way, to prioritize cancer and substance use (noting connection with mental health) as the most significant health needs facing its community for FY19-FY21.

While obesity is not a primary focus, the World Cancer Research Fund estimates that about 20% of all cancers diagnosed in the U.S. are related to body fatness, physical inactivity, excess alcohol consumption, and/or poor nutrition. Thus, access to healthy foods as well as opportunities for exercise will help us address factors impacting both cancer and substance use.

Summary of FY19 CHNA Key Health-Related Findings

<u>Chronic Disease:</u>

- Across nearly all categories reported – including incidence of diabetes, heart disease, high blood pressure, high cholesterol, asthma, disability, and arthritis – the Greater Haverhill community is comparable to or better than the state average. Only adult asthma shows a slightly higher incidence rate than the state average.

- In Massachusetts, deaths due to all cancers are slightly higher than the state average. Lung cancer deaths are higher than the state average overall, and significantly higher in Merrimac, Salisbury, Haverhill, and Amesbury.

Mental Health and Substance Use:

- Behavioral Health issues (i.e., substance use and mental health) are having a negative effect on individuals, families, and communities in every geographic region and every population segment in AJH's CBSA.

- Depression, anxiety, suicide, opioid and prescription drug dependency, and alcohol and marijuana use, particularly in youth, are major health issues and are having a tremendous impact on the population as well as adding a burden on the service system. The fact that physical and behavioral health are so intertwined compounds the impact of these issues. Of particular concern are the increasing rates of opioid abuse in the Commonwealth.

Social Determinants of Health:

Social Determinants of Health (e.g., economic stability, education, and community/social context) continue to have a tremendous impact on many segments of the population, particularly following the impact of the COVID-19 pandemic. Jeanne Geiger Crisis Center has reported that emerging data shows that since the outbreak of COVID-19, violence against women and girls, and in particular domestic violence, has intensified. Our Neighbors' Table experienced an 89% increase in people they serve each week during the pandemic, with the greatest among them being families with children, and men and women in recovery.

- **Food Insecurity:** There are approximately 6,000 people who are food insecure living in northeastern Essex County. More than 2,500 of those people live in Amesbury and Newburyport combined, but there are children, adults, and seniors struggling with hunger in every one of AJH's CBSA.
- **Homelessness:** Despite the Greater Newburyport area's reputation for affluence, homelessness is a reality for many living in Newburyport, Newbury, Rowley, Salisbury, and Amesbury. In 2016, homelessness was on the rise within all five communities.
- **Access to Care:** Key barriers to obtaining health care include transportation, access to available resources, affordability, insurance coverages, inadequate services, lack of health care providers, and language barriers. Transportation was the largest concern throughout all communities in the Greater Haverhill area.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Behavioral Health (Substance Use and Mental Health)

- Beth Israel Lahey Health Collaborative Care Model
- Essex County Asset Builder COVID-19 Family Resource
- Family Services of the Merrimack Valley Samaritans Program
- Link House
- Persist Program at Anna Jaques Hospital
- The Pettengill House

Behavioral Health – Beth Israel Lahey Health Collaborative Care Model	
Brief Description or Objective	The National Alliance on Mental Illness (NAMI) reports that one in four individuals experiences a mental illness each year, underscoring a critical need for mental health care access across all patient populations. In the 2019 AJH CHNA, mental health – including depression, anxiety, stress, serious mental illness, and other conditions – was overwhelmingly identified as one of the leading health issues for residents of the service area. In an effort to meet this need, Lahey Health Primary Care adopted the Collaborative Care Model (CoCM). The model will be expanded to additional communities throughout the Beth Israel Lahey Health service area. Collaborative Care is a nationally recognized primary care–led program that specializes in providing behavioral health services in the primary care setting. The services are provided by a licensed behavioral health clinician and include counseling sessions, phone consultations with a psychiatrist, and coordination for 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.

Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Amesbury • **Gender:** All • **Age Group:** All • **Race/Ethnicity:** All • **Language:** English • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs

Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☒ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
The primary care provider and the behavioral health clinician will develop a treatment plan that is specific to the patient's personal goals. A consulting psychiatrist may advise the primary care provider on medications that may be helpful.	AJH offered this collaborative care model in three locations, Amesbury (2) and Haverhill (1), and served a total of 313 patients.	2	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
n/a	n/a

Contact Information
n/a

Behavioral Health – Essex County Asset Builder COVID-19 Family Resource	
Brief Description or Objective	The COVID-19 pandemic has created an increased level of need for families in the Greater Newburyport area. Local social work agencies and mental health care providers have been working together to connect families in need with much-needed resources, including access to a local food pantry, clothing, or help with grant applications for assistance funding. Many families have also been struggling to manage their mental health in the midst of these constantly changing and uncertain times. More time at home, changed schedules, and need for flexibility have required families to adapt quickly. The Essex County Asset Builder (ECAB) Network is committed to finding ways to support young people and families. Many families were seeking resources on how to handle these new situations, from remote learning to finding time for self-care. The ECAB Network website (ECABNetwork.org) created a COVID-19 Family Resource section compiled with articles, videos, and highlighted tips for families and children of all ages. There you will find information on self-care, assessing mental health, and where to go to access local resources.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Newburyport, Amesbury, Salisbury, Newbury, Byfield, Georgetown, Rowley • **Gender:** All • **Age Group:** Teenagers, Adults, All • **Race/Ethnicity:** African, American Indian/Alaskan Native; Asian; Black; European; Hispanic/Latinx; Middle Eastern; Native Hawaiian/Pacific Islander; White • **Language:** English, Portuguese, Spanish • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History

	☒ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☒ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☒ Housing/Homelessness ☒ Mental Health and Mental Illness ☒ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☒ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Provide virtual resources for families to find much-needed local resources.	The resource website received over 2,000 hits; hosted 7 parent speaker or webinar opportunities including "Teens, Tweens & Quarantines" (335 sign-ups), "Parents Through a Pandemic" (322 sign-ups), and "Good News About Bad Behavior" (216 sign-ups); and mailed support materials to 3,200 households.	1	2	Process Goal

Partners

Partner Name, Description	Partner Web Address
Essex County Asset Builder Network	https://ecabnetwork.org/covid-19-family-resources/

Contact Information
Tina Los
TLos@CityofNewburyport.com

Behavioral Health – Family Services of Merrimack Valley's Samaritans Program

Brief Description or Objective	The Samaritans of Merrimack Valley aims to reduce the incidence of suicide in northeastern Massachusetts by providing a host of prevention and after-care services including community outreach, trainings, survivor support, and a 24-hour crisis hotline.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** All of Massachusetts • **Gender:** All • **Age Group:** Teenagers, Adults, Elderly • **Race/Ethnicity:** All • **Language:** English • **Environment Served:**

	☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History ☒ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☒ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention

☐ Research
☒ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Recruit and train 10 new crisis-line volunteers during period 7/1/20-6/30/21.	Five volunteers were trained in August 2020 and an additional four volunteers are scheduled to begin training in December 2020.	1	3	Process Goal
Become an accredited crisis call center for the National Suicide Prevention Lifeline (NSPL).	All accreditation materials have been submitted; Met with accrediting body in January 2021.	1	3	Process Goal
Provide three 8-week series of the Suicide Attempt Survivor Support Group.	One of the three groups is being held now (virtually). The other two groups will be held over the winter and spring of 2021.	1	3	Process Goal
Complete 80 hours of suicide prevention trainings.	16 hours of training have been completed to date.	1	3	Process Goal
Conduct 50 outreach and training sessions to community groups and schools.	No outreach sessions to schools have yet been provided.	1	3	Process Goal
Provide 48 Safe Place support groups (2/month at two locations).	10 (2x monthly) support groups have been provided.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Family Services of the Merrimack Valley	www.FSMV.org

Contact Information
Sarah Winslow

swinslow@fsmv.org

Behavioral Health – Link House, Inc. Bridge Consultations	
Brief Description or Objective	Anna Jaques Hospital partners with Link House's Center for Behavioral Health and Addiction Treatment Services (CBHATS) to find a pathway for referring patients who are in need of outpatient psychiatric services upon discharge. The Bridge Consultation program is focused on increasing the likelihood of patients attending outpatient treatment and counseling. Bridge Consultations are facilitated by a master's-level clinician who can answer questions, reduce concerns regarding the transition to a new provider, and even conduct the intake assessment. The goal of the partnership is to decrease no-show rates, reduce ER visits and crisis calls from the patient, and improve the well-being for the patient who is transitioning from inpatient to outpatient care.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Amesbury, Newburyport, Salisbury • **Gender:** All • **Age Group:** Adults, Teenagers, Elderly • **Race/Ethnicity:** All • **Language:** English • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Type:	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☒ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☒ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Increase the percentage of AJH psychiatric patients utilizing outpatient support post-discharge.	Approx. 8-12 patients referred to outpatient treatment monthly	1	1	Process Goal

Partners

Partner Name, Description	Partner Web Address
Link House, Inc.	https://linkhouseinc.org/

Contact Information
Gary Gastman, Executive Director
ggastman@linkhouseinc.org

Behavioral Health – Persist Program at Anna Jaques Hospital

Brief Description or Objective	The Persist Program at AJH supports women with Substance Use Disorder (SUD) and/or Neonatal Abstinence Syndrome (NAS), a condition that impacts about 14.5 cases per 1,000 births in Massachusetts. The Persist Program serves women in recovery and seeking additional support, who have suffered from trauma or abuse, or who have been diagnosed with mental health disorders. A dedicated Patient Care Navigator champions women throughout their pregnancy and into the first year of motherhood, working in collaboration with Women's Health Care and the Anna Jaques Birth Center & Neonatal Care Center. The Patient Care Navigator is available to meet with any patient prenatally who has a history of or current SUD or who is at high risk for SUD. This includes patients with mental health disorders and/or socioeconomic disparity, and women whose support persons have SUD. By identifying patients prenatally, the Patient Care Navigator is able to help them access services, such as housing, therapists, food

	stamps, and medication-assisted treatment. Mothers are more likely to maintain their sobriety and are better prepared to be parents. The Patient Care Navigator helps patients with active SUD create a "Plan of Safe Care" and helps prepare them for the process of mandatory reporting to the Department of Children and Family Services. This decreases the need for Social Service and Case Management during the short inpatient stay.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Newburyport, Amesbury, Haverhill • **Gender:** Female • **Age Group:** Adults, Teenagers, Infants • **Race/Ethnicity:** All • **Language:** English • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History ☐ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable

EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☒ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☒ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Patients will set individualized treatment goals such as maintaining sobriety, securing mental health counseling, obtaining stable housing, discontinuing marijuana use, or following up with Early Intervention. Women will be connected with local resources, recovery support services, or mental health providers to help achieve their goals.	Served 182 women either in recovery and seeking additional support, who have suffered from trauma or abuse, or who have been diagnosed with mental health disorders. There has been a decline in the number of substance-exposed babies from a high of 91 in 2017, to 56 in 2018, down to 24 in 2019, and 56 in 2020. In FY18, 78% of patients met their treatment goals, in FY19, 83% met their goals and in FY20, 86% met their treatment goals.	3	3	Process Goal

Decrease the length of stay for the substance-exposed newborn by encouraging parent bonding and interaction and decreasing illicit polysubstance use.	Average length of stay has decreased from 19.1 days in FY17 and 26.17 days in FY18 to 10 days in FY19 and FY20. Prior to our program start, only 36% of women were successful in stopping illicit use during pregnancy; FY20 showed 75% of women were successful.	3	3	Process
Increase the percentage of substance-exposed newborns who are discharged home with a parent or family member instead of into foster care.	We were successful in increasing this rate from 88% of babies in 2017 to 93% in 2020.	3	3	Process

Partners

Partner Name, Description	**Partner Web Address**
Women, Infants and Children (WIC)	DeAnna Tashjian 978-374-2191 dtashjian@communityactioninc.org
Community Action, Inc.	Bob Gould Director of Community Services 978-373-1971 https://www.communityactioninc.org/
YWCA of Greater Haverhill	Renee McGuire 978-374-6121 https://ywcahaverhill.org/
Early Intervention	Deidre Katz and Linda Schaeffer 978-363-5553 https://www.thomchild.org/

Amesbury Psychological	Rose Baker 978-388-5700 https://www.facebook.com/AmesburyPsych/
Link House Services	Christine Turner 978-834-6583 https://linkhouseinc.org/
Department of Children and Family Services	Christine Sciacca 978-469-8800 https://www.mass.gov/orgs/massachusetts-department-of-children-families

Contact Information
Eileen Pekarski, Patient Navigator
Anna Jaques Hospital
ePekarski@ajh.org

Behavioral Health – Pettengill House Substance Addiction/Mental Health Initiative

Brief Description or Objective	As the area's lead social service agency, The Pettengill House, Inc. continues to be on the front lines, witnessing firsthand the impact COVID-19 is having on the Greater Newburyport communities. The team is working hard to continue to provide essential services for the most vulnerable, at-risk individuals, children, and families in the face of unprecedented challenges. This pandemic has and will continue to have an enormous impact on all of us in many different ways. The toll has been visible in busy hospitals, empty school buildings, and shuttered businesses. Less visible, though, is the impact on our mental and physical health, home and family lives, children, social support networks, and overall well-being. The vast majority of the at-risk adults, children, and families served on a daily basis at The Pettengill House, Inc. were

	already facing unimaginable challenges before the pandemic, including but not limited to poverty, homelessness, hunger, disability, mental and physical health, and substance addiction. These challenges have become more severe as a result of COVID-19. The accompanying fear, stress, and anxiety are already taking a toll on the health and well-being of many individuals and their family support, and we are seeing an increased rate of substance relapse in individuals. The Pettengill House Substance Addiction/Mental Health Initiative provides professional assessments, support services, and interventions to Greater Newburyport residents in need. Realizing the complexity of substance addiction and mental health, and knowing the need for individualized treatment, The Pettengill House implements its therapeutic system of care model, which provides comprehensive case management, advocacy, and intensive follow-up on behalf of the identified individuals in need.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Newburyport, Amesbury, Salisbury, Merrimac, West Newbury, Newbury, Byfield, Groveland, Rowley • **Gender:** All • **Age Group:** All • **Race/Ethnicity:** African (Cape Verdean); Asian; Black; Caribbean Islander; European; Hispanic/Latinx; Middle Eastern; White; Brazilian • **Language:** English; interpreters available as needed • **Environment Served:** ☐ All ☐ Urban ☒ Rural ☒ Suburban • **Additional Target Population Status:** ☒ Disability Status ☒ Domestic Violence History ☒ Incarceration History ☒ LGBTQ Status ☒ Refugee/Immigrant Status ☒ Veteran Status

Program Type:	☐ Direct Clinical Services ☒ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☒ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☒ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
By the end of FY20, The Pettengill House will screen 40 individuals who are seeking resources and support to address substance use and/or mental health needs.	Goal met and exceeded: 83 individuals were screened for mental health and substance misuse needs.	1	3	Process Goal
By the end of FY20, The Pettengill House will assist 40 individuals to access substance/mental health care and treatment across the spectrum of care. Care and treatment includes but is not limited to: Inpatient treatment. Outpatient treatment, Medication-assisted treatment, Residential/sober living, and other medical or specialty care provider.	Goal met and exceeded: 67 individuals accessed substance and mental health treatment across the spectrum of care. Number of individuals with: • Inpatient treatment: • Detoxification 33 • Medical unit 9 • Clinical stabilization 10 • Transitional stabilization 1 • Partial hospitalization program 1 Outpatient treatment: Intensive Outpatient Program: 11 Outpatient counseling 46 Psychopharmacology 18 Medication-assisted treatment: 38 Residential (short term): 5 Sober living: 27	1	3	Process Goal
By the end of FY20, The Pettengill House will offer services to 40 individuals to support mental health and substance-use	Goal met and exceeded (details below): Number of individuals who received: • Comprehensive case	1	3	Process Goal

recovery. These services include: Comprehensive case management Recovery coaching Home/community outreach and wellness visits Referrals to external self-help, mutual aid, and peer supports	management: 45 individuals received 184 case management sessions • Recovery coaching: 49 individuals • Community outreach and wellness visits: 43 • Referrals to external self-help, mutual aid, and other peer supports: 32 • Harm reduction services and psycho-education: 30			
By the end of FY20, The Pettengill House will offer Family Support Services to 10 family members of individuals seeking substance use and mental health supports. Family Support Services include: Family support consults (information, education, counseling, referrals, and navigation offered to family members) Family stabilization funds assistance (gift cards, rental, medical, utility assistance) Engagement with external family providers	Goal met: 10 families received services (details listed below): Family Support Services include: Family support consults (information, education, counseling, referrals, and navigation offered to family members) Family consults: 204 consults to 10 families (including multiple family members) Family stabilization fund assistance: (gift cards, rental, medical, utility assistance) Gift card: 18 Rental assistance: 10 Other financial assistance: 5 Utility assistance: 3 Medical or medicine assistance: 3 Engagement with external	1	3	Process

	family providers: 13 family members engaged with external providers after referral			

Partners

Partner Name, Description	**Partner Web Address**
The Pettengill House	http://www.pettengillhouse.org/home.aspx

Contact Information
Tiffany Nigro, Executive Director
tnigro@pettengillhouse.org

Chronic Disease (Cancer)

- Amesbury Chamber of Commerce's "Fitness by the Falls"
- Amesbury Council on Aging Health & Wellness Fest
- Breast Care Navigator
- Cancer Support Groups at Anna Jaques Hospital
- Coastal Trails Coalition
- Greater Newburyport Ovarian Cancer Awareness (GNOCA) 5K
- Haverhill Farmers Market
- North of Boston Cancer Resource Virtual Offerings
- YWCA Encore Program

Chronic Disease – Amesbury Chamber of Commerce's "Fitness by the Falls"	
Brief Description or Objective	AJH sponsored weekly in-person outdoor workouts through the Amesbury Chamber of Commerce during the month of August. Following strict safety guidelines with social distancing, masking, and infection-control measures in place, the free workouts were open to all ages and levels of fitness. This offering provided a safe, socially distant opportunity to engage in fitness hosted by local fitness studios with workouts ranging from yoga to boot camps to weight training.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Amesbury • **Gender:** All • **Age Group:** All • **Race/Ethnicity:** All • **Language:** English • **Environment Served:** ☐ All ☒ Urban ☒ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	**Goal Status**	**Program Is in X Year**	**Of X Years**	**Goal Type**
Offer a variety of workout classes to encourage people of all ages and fitness levels to try different workouts.	Hosted a total of 4 free classes for 90+ community participants hosted by four different local businesses.	1	3	Process Goal

Partners

Partner Name, Description	**Partner Web Address**
Amesbury Chamber of Commerce	https://amesburychamber.com/

Contact Information:

Phil DeCologero
phil@amesburychamber.com

Chronic Disease – Amesbury Council on Aging Health & Wellness Fest

Brief Description or Objective	AJH sponsored the Friends of Amesbury Council on Aging's "Health & Wellness Fest," which hosted free fitness and health opportunities every Wednesday in September as an opportunity for seniors to reconnect and receive direct services such as flu shots, fitness demonstrations, and healthy meals. Offerings were held in person with many safety measures in place and in full compliance with state safety guidelines. AJH supports the efforts of the Amesbury Council on Aging with programs dedicated to advocating for older adults and striving to meet their health, economic, social and cultural needs, and to improve overall quality of life.

Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Amesbury • **Gender:** All • **Age Group:** Adult, Elderly • **Race/Ethnicity:** All • **Language:** English • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs

Additional Program Descriptors (Program Tags)	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☒ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Support safe, socially distant programming that provides needed health care services and health education to seniors.	4 health and wellness days over the month of September welcomed 40 elders each day, administered 125 flu shots, and provided 200 grab-and-go lunches.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Amesbury Council on Aging	www.amesburyma.gov/senior-community-center

Contact Information
Doreen Arnfield, Director
arnfieldd@amesburyma.gov

Chronic Disease – Breast Care Navigator

Brief Description or Objective	The Breast Care Navigator at the Gerrish Breast Care Center is an RN with extensive oncology-specific clinical knowledge. The Navigator offers 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 patient visit, and discusses any concerns with the provider prior to patient visit. In addition, the Navigator maintains contact with referring and other collaborating physicians, to keep them up to date on the patient's care plan.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Newburyport, Haverhill, Amesbury • **Gender:** Females • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☒ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☒ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
The goal is to guide patients through the complexities of the disease, direct them to health care services for timely treatment and into survivorship, and to actively identify and help to address barriers to care that might prevent them from receiving timely and appropriate treatment. In addition, the Nurse Navigator connects patients with resources, health care, and support services in their communities and assists them in the transition from active treatment to survivorship.	In FY20, The Breast Care Navigator provided support to 68 individual patients and their families or caregivers. 61 patients were also provided Survivorship Care Plans.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
American Cancer Society; YWCA Encore Program; North of Boston Cancer Resource	https://www.cancer.org/; https://www.ywcanewburyport.org/wellness-plans/; https://www.nbcancerresource.org/

Contact Information
Gerrish Breast Care Center
978-463-8686

Chronic Disease – Cancer Support Groups at Anna Jaques Hospital	
Brief Description or Objective	For years, AJH has hosted two different free monthly support groups open to anyone in the community coping with a cancer diagnosis and to those with a breast cancer diagnosis. Both the Surviving & Thriving Cancer Support Group and Breast Cancer Support Group are facilitated by clinical professionals to provide a forum for people to gather to meet and discuss their situation with others who have faced similar issues. These groups welcome people to gather to discuss their situation with others who have faced similar issues. They share experiences, triumphs, challenges, and friendship. In FY19, these groups were hosted October 2019 through March 2020 and suspended due to COVID-19. Staff worked to provide remote and online resources for patients.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Newburyport, Amesbury, Haverhill • **Gender:** Female • **Age Group:** Adult, Elderly • **Race/Ethnicity:** All • **Language:** English • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☒ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Offer free ongoing support services for individuals and families facing a cancer diagnosis.	Hosted free monthly support groups through March 2020. Collaborated with area resources such as North of Boston Cancer Resource for featured speakers and programs.	1	3	Process Goal

Partners

Partner Name, Description	**Partner Web Address**
North of Boston Cancer Resource	https://www.nbcancerresource.org/

Contact Information
Kelley Sullivan, Anna Jaques Hospital
ksullivan@ajh.org

Chronic Disease – Coastal Trails Coalition's Adopt-A-Trail

Brief Description or Objective	The Coastal Trails Network is a 30-mile, public system of multi-use off-road bicycle and pedestrian trails and bike lanes linking the unique coastal features, town centers, neighborhoods, and transportation hubs in the communities of Amesbury, Newbury, Newburyport, and Salisbury. With over 20 miles completed, the trail network offers residents and visitors a healthy, alternative means of exercising, shopping, commuting, or simply enjoying the region's abundant natural, historic, and cultural resources. Anna Jaques Hospital sponsors an annual "Adopt-A-Trail" trail marker at milepost 0.5 on the Old Eastern Marsh Trail, and that sponsorship provides funds to manage the trail, ensures safety, and supports the overall positive asset and opportunity for healthy activity the trail provides to our communities.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Amesbury, Newburyport, Salisbury • **Gender:** All • **Age Group:** All • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban

	• **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☒ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Annually adopt a trail as part of the Coastal Trail Coalition to support the offering of a 30-mile bike path that promotes a healthier community. Offer a safe, outdoor option during the pandemic.	Sponsored a full year of a piece of the multi-use off-road bike and pedestrian trails for free for all residents.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Coastal Trails Coalition	https://coastaltrails.org/

Contact Information
Tracey Chalifour
tjchali4@aol.com

Chronic Disease – Greater Newburyport Ovarian Cancer Awareness (GNOCA) 5K

Brief Description or Objective	Anna Jaques and Women's Health Care sponsored the Greater Newburyport Ovarian Cancer Awareness (GNOCA) Group's GNOCA 5K Run/Walk in Honor of Jackie Poor during Ovarian Cancer Awareness Month. The walk efforts aim to promote awareness, honor people impacted by cancer, and acknowledge survivorship.

Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Newburyport • **Gender:** Female • **Age Group:** Adult • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs

Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Promote the mission of the GNOCA to raise awareness of ovarian cancer by participating in the walk and promoting monthly events.	Collaborated with 17 extended-care facilities in the community and reached out to 700 women in the community with education on ovarian cancer, including information on signs and symptoms.	1	3	Process

Partners

Partner Name, Description	Partner Web Address
Greater Newburyport Ovarian Cancer Awareness (GNOCA)	https://www.ocawareness.org/events/jackie-poor-memorial-walk/

Contact Information
Debra Green
greetingsbydesignnewburyport@gmail.com

Chronic Disease – Haverhill Farmers Market

Brief Description or Objective	Obesity and overweight rates among youth in Haverhill were above or the same as those seen at the state level. Haverhill had the highest level of overweight or obese youth at 40.2%.

	In addition, community feedback noted barriers to healthy foods and lack of education on how to prepare healthy foods. With an appreciation of how vital this resource is for the Haverhill community, the Haverhill City Council unanimously voted to continue to offer the market in 2020, with many safety measures in place and in full compliance with state guidelines. Restrictions included limiting the number of customers at a time and restricting live music or kids' entertainment, with public health safety measures in place. AJH sponsors the Haverhill Farmers Market, which is dedicated to promoting healthy eating and supporting local business, sustainability, and community spirit by providing fresh, local produce and baked and prepared foods, as well as handcrafted goods. Hosted in downtown Haverhill and easily accessible by public transportation.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Haverhill • **Gender:** All • **Age Group:** All • **Race/Ethnicity:** All • **Language:** English, Spanish • **Environment Served:** ☒ All ☒ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☒ Disability Status ☒ Domestic Violence History ☒ Incarceration History ☒ LGBTQ Status ☒ Refugee/Immigrant Status ☒ Veteran Status

Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
The goal in FY20 was to be able to offer this vital resource to the Haverhill Community, despite many COVID-19-related restrictions.	Goal met: Weekly Markets were hosted in Haverhill June through October 2020.	1	3	Process Goal

Partners	
Partner Name, Description	**Partner Web Address**
Haverhill Farmers Market (aka Team Haverhill)	http://teamhaverhill.org/projects/community/haverhill-farmers-market/

Contact Information
Jeff Grassie
jeffgrassie@yahoo.com

Chronic Disease – Mammogram Reminders	
Brief Description or Objective	AJH regularly promotes awareness on the importance of breast cancer screenings, and shines an extra spotlight during Breast Cancer Awareness Month through communitywide programs and collaborations. For example, AJH distributed mammogram reminder postcards and pens to local organizations in Newburyport, Salisbury, Amesbury, West Newbury, Groveland, Haverhill, and Merrimac in October with a reminder to schedule annual mammograms.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Newburyport, Salisbury, Amesbury, West Newbury, Groveland, Haverhill, Merrimac • **Gender:** Female • **Age Group:** Adults • **Race/Ethnicity:** All • **Language:** English • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Increase mammogram screenings.	In FY20, mammogram screenings were suspended from March through June due to COVID-19. Despite the restrictions, AJH conducted 9,894 screenings with many safety measures in place.	1	3	Process
Collaborate with local businesses to put a spotlight on prevention during Breast Cancer Awareness Month and raise awareness for women to schedule an annual mammogram.	Encouraged the public health message of "the best prevention is early detection" and distributed information throughout 7 communities about how to schedule a mammogram screening.	1	3	Process

Partners

Partner Name, Description	Partner Web Address
n/a	

Contact Information
n/a

Chronic Disease – North of Boston Cancer Resource Speaker Series

Brief Description or Objective	The North of Boston Cancer Resource Speaker Series is designed to educate and offer support to people affected by cancer. The sessions provide the opportunity for participants to learn about and experience healing practices that can help them ease the distress of a cancer diagnosis and treatment and enhance their well-being from diagnosis through treatment and beyond. This year, due to COVID-19, the sessions were offered via Zoom.

Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Newburyport, North of Boston • **Gender:** All • **Age Group:** Adults • **Race/Ethnicity:** All • **Language:** English • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs

Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☒ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Offer 6 "Speaker Series" sessions to provide support, especially during the impact of the pandemic on people with cancer.	9 Speaker Series sessions were offered with 84 participants. Topics included: • Tools for Mindful Living During Challenging Times • Easy Home Yoga for Relief • Journaling for Stress Relief and Wellness • Finding Ease through Meditation	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
North of Boston Cancer Resource	https://www.nbcancerresource.org/

Contact Information
Carol Gamble
gamblec30@gmail.com

Chronic Disease – YWCA Newburyport "Encore" Program	
Brief Description or Objective	Encore is a free 12-week program offered to any "thriver" who has experienced cancer at any time in their lives, which has served hundreds of women in our community. The YWCA Encore program is designed to empower women to reclaim their physical and emotional health and well-being after a cancer diagnosis and treatment. Due to COVID-19 restrictions, outdoor exercise class options are currently offered with a limit of 19 people along with hybrid Zoom classes incorporating both gentle land exercise and peer support groups. AJH sponsored at-home equipment and support needs to enable people to participate virtually.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Newburyport, Haverhill, Amesbury • **Gender:** Females • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All • **Language:** English • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☒ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Due to the pandemic, the goal of the Encore program quickly shifted to maintaining services and outreach access to all Encore participants. Despite a 3-month lapse due to state lockdown guidelines, the program resumed in June with Zoom and outdoor class options. This goal was met and maintained through weekly, multiple class offerings and special classes provided outdoors including Tai Chi and Yoga.	Despite the lack of quantifiable data relative to physical and mental health metrics normally taken during intake and during 6-week intervals, the program was consistently attended both outdoor and via Zoom, hence deeming the "revised" Encore program a success. Pre-COVID-19: Encore served 80 women. From March through October, 42 women were supported.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
YWCA Greater Newburyport	https://www.ywcanewburyport.org/

Contact Information
Ilene Grady, YWCA Newburyport
ihgrady@comcast.net

Social Determinants of Health (SDOH)

- Emmaus' Mitch's Place Shelter
- Girls Inc.
- Interpreter Services
- Jeanne Geiger Crisis Center's Survivor Services
- Our Neighbors' Table Wednesday Meals
- Patient Financial Counseling
- Transportation Services
- YWCA Haverhill COVID-19 Emergency Relief

Social Determinants of Health – Emmaus' "Mitch's Place" Shelter	
Brief Description or Objective	Emmaus serves homeless adults in the Greater Haverhill area through Mitch's Place emergency shelter. Mitch's Place is the primary point of entry for homeless individuals into an integrated network of services under one roof. Mitch's Place provides overnight shelter, nutritious meals, and needed support services year-round, including during extreme conditions, to homeless men and women who may otherwise spend the night engaging in high-risk, self-destructive, and/or illegal activities. The program also offers case management to support accessing needed services and job opportunities. AJH supported Mitch's Place during COVID-19 to ensure that safety measures were in place to keep patrons safe during the pandemic.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Lower Merrimack Valley, Haverhill • **Gender:** All • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All (American Indian/Alaskan Native; Black; White; Caribbean Islander; Native Hawaiian/Pacific Islander) • **Language:** English, Spanish • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☒ Disability Status

	☒ Domestic Violence History ☒ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☒ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☒ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☒ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
To provide emergency shelter and meals, as well as case management services, to men and women impacted by homelessness.	Despite the onset of the COVID-19 pandemic and the need to depopulate the shelter in order to comply with CDC social distancing guidelines, Emmaus was able to provide shelter to 267 different individuals during FY20.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Emmaus	https://emmausinc.org/

Contact Information
Donna Hansen, Development Associate
donna@emmausinc.org

Social Determinants of Health – Girls Inc.

Brief Description or Objective	Girls Inc. of the Seacoast Area is an affiliate of Girls Incorporated®, a national research, education, and direct advocacy organization that inspires girls to be strong, smart, and bold. The program offers research-based curriculums including STEAM (science, technology, engineering, art, and math); media literacy; economic literacy; growing up strong, smart, and bold (friendships and conflict resolution); and healthy living/self-care. Programs are offered during the academic school year, school vacations, and the summer. The 2019-2020 academic year started with programming in six area schools and strong engagement from our Girls Advisory. When COVID-19 hit, the program pivoted to virtual to finish the school year. Summer and fall programs were held in person in a safe, socially distanced setting. Feedback from the girls who were served this year, and the adults in their lives, highlighted how important these social connections were during a time that is defined by isolation, when girls are missing peer interactions.

Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Newburyport, Amesbury, Salisbury, Merrimac, West Newbury, Newbury, Byfield, Georgetown, Groveland, Rowley, Ipswich • **Gender:** Female, Transgender • **Age Group:** Children, Teenagers • **Race/Ethnicity:** Asian; Black; Hispanic/Latinx; White • **Language:** English • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☒ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs

Additional Program Descriptors (Program Tags)

☒ Community Education
☐ Community Health Center Partnership
☐ Health Professional/Staff Training
☐ Health Screening
☒ Mentorship/Career Training/Internship
☐ Physician/Provider Diversity
☒ Prevention
☐ Research
☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Serve 170 girls during the 2019-2020 school year.	Goal met: Served 193 girls during the 2019-2020 school year with programs in 6 schools.	1	3	Process Goal
Serve 150 girls during summer 2020 programs.	Goal partially met: Due to COVID-19, summer programs had to be fully restructured to comply with state regulations and ensure safety. The program was reduced to 25 to 30.	1	3	Process
Serve 75 girls during fall 2020 programming.	Goal partially met: Programs were moved from local schools to Girls Inc. offices to ensure safety and group sizes were limited to 10.	1	3	Process

Partners

Partner Name, Description	Partner Web Address
Girls Inc.	https://jeannegeigercrisiscenter.org/youth-empowerment-services/gisa/

Contact Information
Nicole Frizzo, Development Associate

nfrizzo@jeannegeiger.org

Social Determinants of Health – Interpreter Services	
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. According to the Centers for Disease Control and Prevention, non-Hispanic blacks have higher rates of premature death, infant mortality, and preventable hospitalization than do non-Hispanic whites. Hispanics have the highest uninsured rates of any racial or ethnic group in the United States. Asians are at a higher risk for developing diabetes than are those of European ancestry, despite a lower average body mass index. These disparities show the disproportionate and often avoidable inequities that exist within communities and reinforce the importance of understanding the demographic makeup of a community to identify populations more likely to experience adverse health outcomes. 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, AJH offers interpreter/translation services for non-English speaking and deaf patients at no cost.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Newburyport, Amesbury, Haverhill, Salisbury, Merrimac, West Newbury, Newbury, Byfield, Georgetown, Groveland, Rowley • **Gender:** All • **Age Group:** All • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:**

	☒ Disability Status ☒ Domestic Violence History ☒ Incarceration History ☒ LGBTQ Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is In Year	Of X Years	Goal Type
Provide a free interpreter/translation service to all Anna Jaques patients at no cost.	While Spanish, Continental Portuguese, and ASL are the most commonly utilized services, AJH service offered hundreds of language translations as needed. In FY20, AJH provided 900 encounters of patient interpreter service needs.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
n/a	n/a

Contact Information
Yvette Bailey, Director of Case Management, Anna Jaques Hospital
ybailey@ajh.org

Social Determinants of Health – Jeanne Geiger Crisis Center's Survivor Services

Brief Description or Objective	Jeanne Geiger Crisis Center's (Center) community-based services provide an integrated web of support as survivors' needs shift from crisis to independence. The Center coordinates with social service agencies, schools, hospitals, law enforcement, and other community partners to provide support for the survivors and their families as their needs change over time.

	With the rapid onset of the COVID-19 pandemic, survivors of domestic violence found themselves trapped in their homes with their abusive partners seemingly overnight. Others were forced to co-parent with former partners during times of incredible stress and immediately reported an increase in controlling and manipulative behaviors. This unprecedented global event meant that the Center had to quickly pivot to ensure that our services were accessible to survivors during a time of incredible risk and need. Since March, the Center worked to provide vital services remotely and virtually. The consistency of its services has proven invaluable to the survivors served at a time when there has been so much uncertainty and fear. During the same time, there has also been an incredible increased financial need from survivors with a 130% increase in requests for rental, utility, and basic needs support when compared to the same time last year. Staff continue to work to ensure that the needs of adult and child survivors of domestic violence do not go unmet.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Newburyport, Amesbury, Haverhill, Salisbury, Merrimac, West Newbury, Newbury, Byfield, Georgetown, Groveland, Rowley, Lawrence, Methuen • **Gender:** All • **Age Group:** All • **Race/Ethnicity:** All • **Language:** English, Spanish • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History ☒ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Type:	☐ Direct Clinical Services ☒ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☒ Built Environment ☒ Social Environment ☒ Housing ☒ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☒ Housing/Homelessness ☒ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☒ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Provide a wide range of advocacy services and supports to adult survivors of domestic violence.	Goal met: 779 adult survivors of domestic violence received advocacy services in FY20.	1	3	Process Goal
Offer evidence-based therapeutic services to adult and child survivors of domestic violence.	Goal met: 353 adult and child survivors of domestic violence received therapeutic services in FY20.	1	3	Process
Ensure that survivors' rights are protected in the civil and probate court by offering pro se advocacy, consultation, and representation.	Goal met: 117 adult survivors of domestic violence received legal services in FY20.	1	3	Process

Partners

Partner Name, Description	Partner Web Address
Jeanne Geiger Crisis Center	https://jeannegeigercrisiscenter.org/

Contact Information
Nicole Frizzo, Development Associate
nfrizzo@jeannegeiger.org

Social Determinants of Health – Our Neighbors' Table Weekly Wednesday Meal

Brief Description or Objective	Our Neighbors' Table's (ONT) Wednesday Meal is a free, open, communitywide dining experience offering a three-course, nutritious meal each week. In addition to the meal itself, the program offers socialization and connection to other resources and support for people living in the region, including ONT's grocery markets and SNAP. In response to public health guidelines related to COVID-19, ONT closed its dining room in March and pivoted swiftly to offer dinners as individual or family-sized meals to-go. ONT saw an 89% increase in people coming to receive a take-

	home meal each week, with the greatest among them being families with children and men and women in recovery. Families with children have represented the greatest increase in attendance and have highlighted some positive programmatic changes resulting from the pandemic. Anonymity and the convenience of a grab-and-go, family-sized dinner are a draw for families who don't have adequate food at home nor the time or ability to prepare dinner while juggling parenting, homeschooling, and work. AJH's support was focused on the needs related to offering meals to-go on a weekly basis, year-round.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Newburyport, Amesbury, Haverhill, Salisbury, Merrimac, West Newbury, Newbury, Georgetown, Groveland • **Gender:** All • **Age Group:** All • **Race/Ethnicity:** All • **Language:** English • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☒ Disability Status ☒ Domestic Violence History ☒ Incarceration History ☐ LGBTQ Status ☒ Refugee/Immigrant Status ☒ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
In 2020, ONT will maintain weekly meals to guests in a way that is safe and follows COVID-19 protocols.	Goal met: Take-out meals were immediately made available and sustained. The adapted program model met the needs of an 89% increase in people served compared to 2019. From January through August 2020, ONT served 5,650 dinner guests and provided 606 home deliveries.	1	3	Process Goal
ONT will provide a nutritious menu of meals each week.	Goal met: ONT has maintained quality food supply in 2020, ensuring well-balanced meals each week including fresh/frozen vegetables and proteins in quantities for individuals and families. In FY20, ONT distributed 13,262 meals.	1	3	Process
ONT will connect Wednesday Meal guests to ONT's grocery and SNAP programs.	Goal partially met: ONT provided repeated advertising materials and word-of-mouth referrals to ONT's grocery/SNAP programs. A monthly newsletter in 3 languages provides details to guests.	1	3	Process

Partners

Partner Name, Description	Partner Web Address
Our Neighbors' Table	www.ourneighborstable.org/

Contact Information
Lyndsey Haight, Executive Director
lyndsey@ourneighborstable.org

Social Determinants of Health – Patient Financial Counseling	
Brief Description or Objective	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 have 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 this assessment shows that while the vast majority of the area's residents have access to care, significant 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, transportation, cultural/linguistic barriers, and a shortage of providers willing to serve Medicaid-insured or uninsured patients. To address these gaps, AJH employs two full-time, certified financial counselors who can screen patients and assist them in applying for state aid. They also provide estimates for the patient's financial responsibility (copay, deductible, coinsurance, self-pay).
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Newburyport, Amesbury, Haverhill, Salisbury, Merrimac, West Newbury, Newbury, Byfield, Georgetown, Rowley, Groveland • **Gender:** All • **Age Group:** All, Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History

	☐ Incarceration History ☐ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is In Year	Of X Years	Goal Type
Meet with patients who are uninsured or underinsured to assess their eligibility for and align them with state financial assistance and hospital-based financial assistance programs.	Financial Counseling completed a total of 503 applications. • Percentages per age group of applications done. ○ 0-17 years (1%) ○ 18-35 years (26%) ○ 36-53 years (29%) ○ 54-70 years (39%) ○ 71-107 years (5%)	1	3	Process Goal
Facility-based Financial Assistance and Presumptive Eligibility: Financial Coordinators work with patients who have been denied state assistance to see if they qualify for facility-based financial assistance or presumptive eligibility.	Two applications completed for financial assistance so far and both have been approved.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
n/a	n/a

Contact Information
Darlene Lavin, Registration Manager, Anna Jaques Hospital
dlavin@ajh.org

Social Determinants of Health – Transportation Services	
Brief Description or Objective	In an effort to support vulnerable communities and limit barriers so patients receive the care they need, AJH Case Management Department has an emergency fund to provide Transportation reimbursement to patients who have limited resources and social supports. This program is offered to any patient who meets the criteria of need decided by a Social Worker. The Social Worker advocates for the patient to ensure the appropriate financial support. They also work to refer patients to Financial Coordinators to assist patients with applications for Medicaid or disability; they work with primary care physicians or free clinics to ensure medical follow-up, and extend referrals to other needs.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Newburyport, Haverhill, Amesbury • **Gender:** All • **Age Group:** All • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBTQ Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

DoN Health Priorities (Select up to 3)	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Meet with patients who are uninsured or have limited resources to provide transportation support or reimbursement.	AJH distributed $5,217 of emergency funds to patients in FY20.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
n/a	n/a

Contact Information
Yvette Bailey, Director of Case Management, Anna Jaques Hospital
ybailey@ajh.org

Social Determinants of Health – YMCA Haverhill COVID-19 Emergency Relief	
Brief Description or Objective	AJH's annual support of the YMCA's Healthy Kids Day Event shifted to support essential needs related to COVID-19 to aid in the Y's efforts to meet the heightened needs in the Greater Haverhill community. Support enabled the Y to provide critical childcare for 150 children of health care workers and first responders, support efforts to fight food insecurity, and support 600+ children and 500 residents who were served by the Y.
Target Population (indicate/select as many as needed for all fields)	• **Regions Served:** Haverhill • **Gender:** All • **Age Group:** All • **Race/Ethnicity:** All • **Language:** English, Spanish • **Environment Served:** ☒ All ☒ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☒ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☒ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

DoN Health Priorities (Select up to 3)	☐ Built Environment ☒ Social Environment ☒ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need	☒ Chronic Disease ☒ Housing/Homelessness ☒ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (Program Tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
The Haverhill YMCA will provide meals to 100 families while schools are closed due to the pandemic.	Goal exceeded: The Haverhill YMCA provided meal delivery to over 200 families, and collaborated with Community Action to expand delivery to additional youth and families.	1	1	Process Goal
The Haverhill YMCA will provide summer literacy programming to 50 children to address the achievement gap.	Goal exceeded: The Haverhill YMCA provided 86 children with Y Summer Literacy programming, during which students achieved an average of 5 months of reading gains in the 6 weeks of the program.	1	1	Process
Provide critical childcare needs.	Goal met: Provided critical childcare for 150 children of health care workers and first responders.	1	1	Process

Partners

Partner Name, Description	Partner Web Address
YMCA Haverhill	www.northshoreymca.org/locations/haverhill-ymca

Contact Information
Tracy Fuller, Regional Executive Director
fullert@northshoreymca.org

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$79,277	
Community-Clinical Linkages	$11,000.00	
Total Population or Communitywide Interventions	$31,152.00	
Access/Coverage Supports	$117,051.00	
Infrastructure to Support CB Collaborations	$48,991.80	
Total Expenditures by Program Type	$287,471.80	
CB Expenditures by Health Need		
Chronic Disease	$67,822.00	
Mental Health/Mental Illness	$22,248.00	
Substance Use Disorders	$67,103.00	
Housing Stability/Homelessness	$13,248.00	
Additional Health Needs Identified by the Community	$117,051.00	
Total by Health Need	$287,472.00	
Leveraged Resources	**$147,096.00**	
Total CB Programming	**$287,471.80**	
Net Charity Care Expenditures		
HSN Assessment	$1,712,540	
Free/Discounted Care	n/a	
HSN Denied Claims	$480,672	
Total Net Charity Care	**$2,193,212**	
Total CB Expenditures	**$2,627,779.80**	

Additional Information	
Total Revenue	$134,051,000
Net Patient Services Revenue	$128,609,000
CB Expenditure as Percentage of Net Patient Services Revenue	2.04%
Approved CB Budget for FY22 (*Excluding expenditures that cannot be projected at the time of the report)	$2,193,000
Bad Debt	$1,402,840.00
Bad Debt Certification	
Optional Supplement	
Comments	

SECTION VI: CONTACT INFORMATION

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Community Benefits & Community Relations
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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

See attached.

Office of the Massachusetts Attorney General

Hospital Self-Assessment Update Form – Years 2 and 3

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

I. Community Benefits Process:

- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? ☒ Yes ☐ No
    - If so, please list updates:
      Anna Jaques Hospital welcomed new CBAC members in: Tiffany Nigro, Executive Director, The Pettengill House. Danielle Perry, Vice President of Business Development & Marketing, joined as Anna Jaques Hospital senior management representative, and now as part of Beth Israel Lahey Health, Christine Healey, Director of Community Benefits, North Region, Beth Israel Lahey Health, joined as the system representative.

II. Community Engagement:

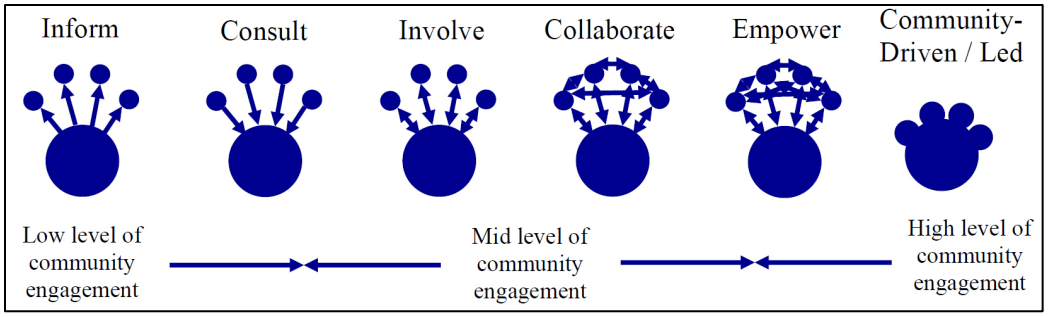
1. If there have been any updates to the key partners with whom the hospital collaborates, please indicate in the table below. Please feel free to add rows as needed.

Organization	Name and Title of Key Contact	Organization Focus Area	Brief Description of Engagement
Our Neighbors' Table (ONT)	Lyndsey Haight, Executive Director	Social service organizations	AJH and ONT expanded its relationship by supporting ONT's "Wednesday Meal" program (full year rather than one meal) – a free, weekly three-course meal open to the community. In 2019, the weekly meal fed 5,267 guests and 787 home deliveries. In response to COVID-19, ONT had to close its dining room and shifted sit-down dinners to meals-to-go for individuals and family-sized meals. ONT saw an 89% increase in people utilizing take-home meals each week, the greatest among them: families with children and men and women in recovery. Between January and August of 2020 alone, ONT fed 5,650 guests and 606 home deliveries.
The Pettengill House	Tiffany Nigro, Executive Director	Behavioral health and mental health organizations	AJH partnered with The Pettengill House's Substance Addiction/Mental Health Initiative which provides professional assessments, support services and interventions to Greater Newburyport residents in need. Realizing the complexity of substance addiction and mental health, and knowing the need for

			individualized treatment, Pettengill House implements its therapeutic system of care model which provides comprehensive case management, advocacy, and intensive follow-up on behalf of the identified individuals in need.
Jeanne Geiger Crisis Center (JGCC)	Nicole Frizzo, Development Associate	Social service organizations	AJH supported JGCC's "Survivor Services" programming. JGCC helps approx. 1,200 - 1,400 adults and children each year move from crisis to safety and long-term independence. Last year, staff and volunteer advocates answered 10,126 hotline and advocacy assistance calls. During the pandemic, when stay at home orders were in place, JGCC helped 359 adult and child survivors of domestic violence remotely via phone or secure video platform.
Girls Inc. of the Seacoast Area (Girls Inc.)	Nicole Frizzo, Development Associate	Social service organizations	AJH partnered with Girls Inc. by supporting its Youth Empowerment Programming in response to the growing need related to the pandemic. The programs are based on research, education and direct advocacy organization that inspires girls to be strong, smart, and bold. Despite schools closing early last year due to COVID-10, programming was provided to students in 10 schools in the towns we serve, virtually and Summer Camp took place in a safe, social-distanced manner, offering value to young girl's lives.

2. 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.

[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.



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	Involve	Yes	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Consult	Yes	Consult
Implementing Community Benefits programs	Collaborate	Yes	Collaborate
Evaluating progress in executing Implementation Strategy	Collaborate	Yes	Collaborate
Updating Implementation Strategy annually	Consult	Yes	Involve

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

  n/a

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

AJH did not conduct a public meeting in FY20 but looks forward to engaging with the community through a CB Public Meeting in FY21.

The AJH CB Manager did attend public meetings and continued on-going participation on local coalitions held within the CBSA, and when relevant, shared higlights of CB efforts. Groups included: Essex County Asset Builder Network Steering Committee, Newburyport Youth Services/BEACON Coalition meetings; Newburyport Social Service Group.

III. Updates on Regional Collaboration:

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

   AJH is part of the Beth Israel Lahey Health (BILH) system community health planning process. In 2019, BILH formed a system-wide Community Benefits Committee (CBC). This Committee provides strategic direction for all 10 BILH hospitals and its affiliates and seeks to ensure that strategies are in place to meet the health care needs of at-risk, underserved, uninsured, and government payer patient populations in the communities. Guided by the CBC, hospitals' Community Benefits staff meet regularly to review regulatory requirements and share community health programming best practices. Together, hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact.

   As a system, BILH came together to meet the needs of patients hospitalized with COVID. In addition to treating the critically ill, BILH hospitals collaborated with one another and with many community organizations on supply and resource distribution. All BILH hospitals reacted to urgent and unforeseen needs by restructuring/realigning Community Benefits programs to meet emerging and ongoing issues and challenges related to the pandemic.

2. If the hospital entered a regional collaboration in the past year, please provide the information requested of regional collaborations on p. 5 in the **Year 1 Hospital Self-Assessment Form.**
   n/a