Community Benefits Report

Fiscal Year 2022

Beth Israel Lahey Health
Anna Jaques Hospital

TABLE OF CONTENTS

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 and her physician's commitment to the community and its needs. AJH proudly continues that tradition today 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, AJH's 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 is 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 healthcare 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 responsiveness care; and

- **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.

Priority Cohorts
Anna Jaques Hospital is committed to improving the health status and well-being of those living throughout its entire CBSA. In FY22, the AJH CBAC voted to refine the CBSA to the following cities and towns, which includes (note – population census based off 2020 data):

- Amesbury (17,366)
- Haverhill (67,787)
- Merrimac (6,723)
- Newburyport (18,289)
- Salisbury (9,236)

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 AJH's FY19 Community Health Needs Assessment (CHNA) and FY20-22 Implementation Strategy (IS):

- In response to the rising need of food access, AJH strengthened partnerships and programming with the YWCA Haverhill, Our Neighbors' Table, Nourishing the Northshore, and the Newbury Food Pantry. Specifically, the partnership with the YMCA Haverhill supports BILH and AJH's mission to increase health equity in Gateway Municipalities, and continue to serve the underserved, through a grant to address social determinants of health needs and increase food access through the introduction of a freight container to operate a hydroponic farm.
- With the increasing need of housing support, AJH established partnerships with the YWCA of Greater Newburyport, Emmaus, and Link House, Inc., to support temporary and long-term housing. AJH strengthened its partnership with Emmaus through "Mitch's Place Emergency Shelter" that serves adults impacted by homelessness in the Greater Haverhill area and experienced a significant increase in need during the pandemic. AJH supported unexpected financial burdens to ensure that state safety measures related to COVID-19 were in place to keep patrons safe during the pandemic.
- The COVID-19 pandemic placed a heavy burden on immunocompromised patients, including those impacted by cancer. AJH's shifted its annual support of the YMCA Haverhill to its Cornerstone program, a collaborative health & wellness program providing essential daily living support to cancer patients, cancer survivors, and their immediate families.
- AJH formalized a new partnership with Essex County Outreach to directly support its efforts of community educational and awareness around substance use disorder, mental/behavioral health to access to necessary services related to substance use, mental or behavioral health needs and access.

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 AJH Community Benefits team completed a hospital self-assessment form (Section VII, page 37). The Anna Jaques Hospital 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 AJH'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 non-profit 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 AJH'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.

AJH 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 AJH Community Benefits program is spearheaded by a Community Benefits Manager. The Community Benefits Manager has direct access and is accountable to the AJH President and the BILH Vice President of Community Benefits and Community Relations, the latter of whom reports directly to the BILH Chief, Diversity, Equity and Inclusion. 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

Michelle Braiser, Practice Manager, Beth Israel Lahey Primary Care – Haverhill

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

Tracy Fuller, Regional Executive Director, Haverhill YMCA

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

Officer Dani Sinclair, Newburyport Police, Inspector

Jean Trim, Managing Director & Portfolio Manager, Vigilant Capital Management, LLC; AJH Board of Trustee Member

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 9, 2021
- March 11, 2022
- May 12, 2022
- June 9, 2022 (Public Meeting)
- August 10, 2022

Community Partners

Anna Jaques Hospital (AJH) recognizes its role in serving its community, but that in order to be successful it needs to collaborate with its community partners and those it serves. AJH's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy 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 its mission.

AJH serves and collaborates with all segments of the population. However, in recognition needing to make the most impact in communities most in need, AJH focuses its Community Benefits efforts on improving the health status of the low-income, underserved populations living in: Amesbury, Georgetown, Groveland, Haverhill, Merrimac, Newbury, Newburyport, Salisbury, Rowley, and West Newbury. This decision was to select the communities with regional resources that best serve and address health needs.

AJH relies heavily on its community partners to implement its Community Benefits initiatives. AJH has leveraged its community partners' expertise and the vital connections that these organizations have with the residents and other community-based organizations that operate in the communities they serve. Simply, AJH supports and partners with community programs who specialize in addressing certain health needs – beyond the care that AJH provides in the hospital.

AJH's Board of Trustees along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its service area and beyond. Providing the highest clinical expertise, education and research along with an underlying commitment to health equity are the primary tenets of its mission. AJH's Community Benefits Department, under the direct oversight of AJH's Board of Trustees, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations.

The following is a comprehensive listing of the community partners with which AJH 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 37).

Community Partners

- Amesbury Chamber of Commerce
- The Arc of Greater Haverhill-Newburyport
- The BEACON Coalition
- Boys & Girls Club
- Coastal Trails Coalition
- Community Action, Inc./Women, Infants & Children (WIC)
- Councils on Aging (Amesbury, Newburyport, Merrimac, Salisbury, Haverhill)
- Elder Services of the Merrimack Valley/Home Health VNA
- Emmaus, Inc.
- Essex County Asset Builder Network
- Essex County Outreach
- Family Services of the Merrimack Valley
- Girls, Inc.
- Greater Haverhill Chamber of Commerce
- Greater Lawrence Family Health Center – Haverhill Office
- Greater Newburyport Chamber of Commerce
- Greater Newburyport Ovarian Cancer Awareness – Ovations for the Cure
- Haverhill Farmers Market/Creative Haverhill
- Home Health VNA/Merrimack Valley Hospice
- Jeanne Geiger Crisis Center
- Link House, Inc.
- Lucy's Love Bus
- Lions Clubs (Amesbury, Haverhill, Newburyport)
- Merrimac Senior Center & Council on Aging
- Merrimack Valley Black & Brown Voices
- New England Elder Transportation
- Newbury Food Pantry
- Newburyport DEI Alliance
- Newburyport Farmers' Market
- Newburyport Public Schools
- Newburyport Yankee Homecoming
- Newburyport Youth Services
- Newburyport Society for the Relief of Aged Women
- North of Boston Cancer Resource
- Nourishing the Northshore

- Opportunity Works
- Our Neighbors' Table
- Partnership of Amesbury Community & Teens (PACT)
- Pennies for Poverty
- Pentucket Perinatal Mental Health Coalition
- The Pettengill House
- Regional Social Services Collaborative
- Rotary Clubs (Amesbury, Haverhill, Newburyport)
- Salisbury Parks & Recreation Department
- Salvation Army
- Tough Warrior Princesses
- Veterans' Services
- 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 FY 2022 CHNA Key Health-Related Findings

Chronic Disease:

- 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

Priority Health Need: Behavioral Health **Program Name:** Behavioral Health Crisis Consultation **Health Issue:** Mental Health/Mental Illness/Substance Use Disorder	
Brief Description or Objective	To provide 24/7/365 behavioral health crisis evaluation in the emergency department (ED) and throughout other hospital units for individuals experiencing mental health and substance use related crisis. Services are payer agnostic and provided via in-person or telehealth by a multidisciplinary team of qualified professionals, including Psychiatrists, independently licensed and Master's level clinicians, Nurse Practitioners, Registered Nurses, Certified Peer Specialists, and Family Partners. The services include initial assessments for risks, clinical stabilization, treatment initiation, care coordination, and ongoing evaluation to ensure appropriate level of care placement.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to clinical and non-clinical support services for those with mental health and substance use issues, by providing behavioral health services in the hospital.
Goal Status	A multidisciplinary team, comprised of qualified behavioral health providers, psychiatry, family partners, and peer specialists, is employed to provide behavioral health crisis consultations in the Emergency Department or medical floors of the hospital. The team served 432 patients in FY22.
Program Year: Year 3	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Behavioral Health **Program Name:** Beth Israel Lahey Health Collaborative Care Model **Health Issue:** Mental Health/Mental Illness	
Brief Description or Objective	In order to increase access to mental health services, AJH has implemented the Collaborative Care model, a nationally recognized primary care–led program that specializes in providing behavioral health services in the primary care setting. The services, provided by a BILH licensed behavioral health clinician, include counseling sessions, phone consultations with a psychiatrist, and coordination and follow-up care. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treat a variety of medical and mental health conditions.

Program Type	☒ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population or Community Wide Intervention
Program Goal(s)	To increase access to behavior health services.
Goal Status	AJH offered this collaborative care model in three locations in FY22: Amesbury (2) and Haverhill (1), and served a total of 529patients.
Program Year: Year 3	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Behavioral Health
Program Name: Essex County Outreach
Health Issue: Mental Health/Mental Illness; Substance Use

Brief Description or Objective	The Essex County Outreach is a collaborative effort involving all 34 police departments within Essex County, as well as the sheriff's department, partnering with social service agencies, peer specialists, and other community supports to assist with: • Substance Use Disorder (SUD) • Mental or Behavioral Health needs • High risk (of overdosing) referrals • Harm Reduction Strategies • Additional supports to families and children impacted by SUD • Supports for those that have lost a loved one to SUD
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☒ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒ Total Population or Community Wide Intervention
Program Goal(s)	Increase community awareness, education, programming and resources to support substance use, mental health or behavioral health needs and access. High risk individuals are identified through law enforcement driven database and major goal is to assist the 34 law enforcement agencies in Essex County with performing follow up outreach with the individual and/or family members and loved ones.
Goal Status	ECO established an office space in Salisbury where meetings will be held, landline established, and potential for drop in visits as a space for individuals in need to come to for support and resources. Essex County was divided into 4 manageable regions with identified coordinators for each region to meet quarterly and discuss successes, obstacles, areas for improvement, etc. within the county.

	A SIM workshop was completed in May 2022 with the assistance of PRA and community partners and areas for collaboration were identified. An employee portal via the ECO website has been established for communication among partners, document, and event sharing. Additional status hired to assist with daily tasks, program goals, as well as create a pool of Recovery Coaches to be used as resource throughout Essex County.

Program Year: Year 2	**Of X Years: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Behavioral Health **Program Name:** Family Services of the Merrimack Valley Samaritans Program **Health Issue:** Mental Health/Mental Illness; Substance Use	
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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Reduce incidence of suicide and increase community awareness, education, programming and resources to support substance use, mental health or behavioral health needs and access.
Goal Status	Despite many challenges due to the ongoing pandemic, Family Services' Samaritans program report the following outcomes for FY2022. • Expanded crisis helplines: The Samaritans has been an accredited crisis call center for the National Suicide Prevention Lifeline (NSPL) for almost two years now. In 2020, Congress designated the new 988 dialing code to be operated through the existing National Suicide Prevention Lifeline. Because the 988 crisis call centers are required to operate 24/7/365, the program added 30 new staff and 5 volunteers to provide this coverage. Staff also collaborated with Emergency Service Providers to help those in need of additional services with a warm hand off. The Program currently receives about 1,800 calls per month and has an answer rate of 92%. • Provided four 8-week sessions of the suicide attempt survivor support group. The group reaches numerous individuals over age 18 who have attempted suicide and need connection with others with same experiences. Two new members were added to the group in 2022. During the eight-

	week group series, participants discussed topics such as safety planning, coping skills, self-he effects of COVID-19, and processing past events. • Completed 28 hours of "Gatekeeper" training with 210 gatekeepers of middle-aged persons, primarily mental health professionals, as well as people who work with older adults. • Conducted 10 outreach training sessions to community groups and schools that reached 170 people. This included educational support for schools, mental health providers, businesses, youth and senior centers, first responders, and other groups. • Organized 48 Safe Place Support groups for suicide loss survivors (two support groups twice per month). Because of COVID-19, most of the year these were held virtually. Since September, one group meets in person while one is still virtual to accommodate more people. The program added 20 newly bereaved loss survivors in these support groups in 2022.
Program Year: Year 3	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Behavioral Health **Program Name:** Girls Inc. **Health Issue:** Mental Health/Mental Illness; Substance Use	
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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to programming and positive outlets to empower girls.
Goal Status	In Fiscal Year 2022, Girls Inc. program provided services to 164 girls.
Program Year: Year 2	**Of X Years: Year 2** / **Goal Type: Process Goal**

Priority Health Need: Behavioral Health **Program Name:** Jeanne Geiger Crisis Center Survivor Services **Health Issue:** Mental Health/Mental Illness; Substance Use	
Brief Description or Objective	Jeanne Geiger Crisis Center's 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. The Center's primary goal to provide domestic violence survivors with the holistic services and support they need to stabilize their lives and heal from the long-term effects of trauma was achieved, despite the unprecedented circumstances brought on by Covid-19, recession, and on-going housing crisis. In FY22 the Center supported 1,216 adult and child survivors of domestic violence with 14,238 services. This year required flexibility, resilience, and innovation as we saw a 35% increase in the number of adult survivors we served over the last year. The program staff utilized their collective, expansive expertise to provide survivor-driven work.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Decrease the rates of domestic violence incidents by supporting resources and a wide range of advocacy services and supports to adult and child survivors.
Goal Status	• In fiscal year 2022, our advocacy programs provided 5,154 services to 955 survivors, free of charge. • In fiscal year 2022, our clinical programs provided 4,331services to 327 survivors, free of charge. • In fiscal year 2022, our legal services program provided 2,791 services to 409 survivors, free of charge. *Note- if you add up the survivors served in each program it is greater than the number of survivors served because many survivors access services in more than one program.

Program Year: Year 2	**Of X Years: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Behavioral Health **Program Name:** Patient Care Navigator at Anna Jaques Hospital **Health Issue:** Mental Health/Mental Illness; Substance Use	
Brief Description or Objective	The Patient Care Navigator 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 Patient Care Navigator serves women in recovery and seeking additional support, who have suffered from trauma or abuse, or who have been diagnosed with mental health disorders. The 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.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Support patient sobriety by setting individualized treatment goals such as securing mental health counseling, obtaining stable housing, discontinuing marijuana use, or following up with Early Intervention, or connecting with local resources, recovery support services, or mental health providers to help achieve their goals.
Goal Status	Served 251 women either in recovery and seeking additional support, who have suffered from trauma or abuse, or who have been diagnosed with mental health disorders.
Program Year: Year 2	**Of X Years: Year 2** / **Goal Type: Process Goal**

Priority Health Need: Behavioral Health **Program Name:** Pettengill House Substance Addiction/Mental Health Initiative **Health Issue:** Mental Health/Mental Illness; Substance Use	
Brief Description or Objective	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.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	• By the end of FY22, The Pettengill House will screen 30 new individuals, who are seeking substance mis-use and/or mental health needs.

	• By the end of FY22, The Pettengill House will assist 30 individuals to access substance/mental health care and treatment across the spectrum of care. • By the end of FY22, The Pettengill House will offer services to 50 individuals to support mental health and substance use recovery. • By the end of FY22, The Pettengill House will offer Family Support Services to 12 family members of individuals seeking substance and mental health supports.
Goal Status	1. Goal met and exceeded: 53 new individuals were screened for mental health and substance mis-use needs. 2. Goal Met and Exceeded. 87 individuals accessed substance and mental health treatment across the spectrum of care. Care and treatment include but is not limited to: # of individuals with: **Inpatient Treatment**: - Detoxification: 34 - Medical Inpatient: 7 - Clinical Stabilization/Transitional Stabilization: 5 **Outpatient Treatment:** - Intensive Outpatient Program: 4 - Outpatient Counseling: 15 - Psychopharmacology: 6 Medication Assisted Treatment: 17 Partial Hospitalization Program 1 Residential: 9 Treatment <29 days 3 Treatment +30 days 7 **Other medical or specialty care:** Section 12 or 35: 19 (Note: count is not unique as individuals access multiple levels of care) 3. Goal met and exceeded (details below): 248 individuals received 1607 interventions / services including but not limited to: Comprehensive Case Management: 305 case management interventions Recovery Support 391 recovery support interventions Client Outreach & Contact: 614 Collateral Contacts & Consultations: 185 Harm Reduction Services and Psycho-education: 44 interventions OD/At-Risk Outreach Visits: 68 4. Goal met and exceeded (details below)

	Family Consults: 91 family members received 189 consultation sessions

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic Disease
Program Name: Breast Care Navigator
Health Issue: Chronic Disease

Brief Description or Objective	The Breast Care Navigator at the Gerrish Breast Care Center is a Nurse Practitioner 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 for patient-related concerns.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase supports and access to services to patients through cancer journey, from health care services through to survivorship programs.
Goal Status	In FY22, the Breast Care Navigator provided support services and care coordination to over 300 women scheduled for image-guided breast biopsies and more than 100 Gerrish Breast Care Center (GBCC) patients and families undergoing breast surgery for both benign and malignant conditions.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic Disease **Program Name:** Coastal Trails Coalition's Adopt-A-Trail **Health Issue:** Chronic Disease	
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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to outdoor options to promote physical activity and a healthier community.
Goal Status	Full year sponsorship of the 30-mile multi-use bike and pedestrian path
Program Year: Year 3	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Chronic Disease **Program Name:** Haverhill Farmers' Market **Health Issue:** Chronic Disease	
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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to fresh produce and healthy food options.
Goal Status	Haverhill Farmers' Market hosted markets weekly from June through October 2022 (total of 19). The market served roughly 700-800 residents per week. Farmers markets are crucial in providing fresh local produce and healthy food options. In 2022 Market also had an increase in SNAP/WIC benefits that helps lower income families have better access to more locally grown produce.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic Disease **Program Name:** Newburyport Farmers' Market **Health Issue:** Chronic Disease	
Brief Description or Objective	AJH's support of the Newburyport Farmers' Market supports the Greater Newburyport community's access to healthy, affordable food choices - especially fruits and vegetables. Eating healthy can help reduce people's risk for heart disease, high blood pressure, diabetes, osteoporosis, and several types of cancer, as well as help them maintain a healthy body weight. AJH supports efforts and spread the word of EBT and Snap vouchers accepted at the Market for lower-income families.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to fresh produce and healthy food options.
Goal Status	• 30 Markets held from May through November 2022 • 1,200 - 1,600 people attended weekly

Program Year: Year 2	**Of X Years: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Chronic Disease **Program Name:** North of Boston Cancer Resource Speaker Series **Health Issue:** Chronic Disease	
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. The sessions are offered free of cost online and some replays are made available through the website. https://www.nbcancerresource.org/events
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to programs and resources to support people and families impacted by cancer.
Goal Status	NBCR hosted 10 Speaker Series events for a total of 122 participants. Topics included: • Accessible Chair Yoga for All • Writing for Comfort and Joy • Ask the Nurses • The Non-Toxic Home • Release, Relax and Reset with Reiki • How an Oncology Social Worker Can Help You Navigate the New Normal • Rejuvenating Adventures • Overcoming Cancer Related Fatigue • Nourishing the Deepest Part of Yourself with Acupuncture and Chinese Medicine • 61 gift certificates were also distributed to be used for oncology massage, acupuncture, guided imagery, manual lymph drainage, reiki, health coaching or meals.
Program Year: Year 3	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Chronic Disease **Program Name:** YMCA Haverhill Cornerstone Program **Health Issue:** Chronic Disease	
Brief Description or Objective	YMCA's Cornerstone Program is a collaborative program providing essential daily living support to cancer patients, cancer survivors, and their families. The program provides a membership to the Y for people diagnosed within the past five years, access to specialized programs to help those with cancer and recovering from cancer, special drop-in babysitting for parents who are currently in treatment, weeks of summer camp is offered for families who have been affected by cancer and the program provides an overall sense of community to support survivorship.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Support programs and resources that promote survivorship for people impacted by cancer.
Goal Status	• The Haverhill YMCA extended 49 Cornerstone memberships during the pandemic to support healthy living to families dealing with cancer. • The Haverhill YMCA provided 12 Cornerstone families with a week of summer camp in 2022, providing a sense of normalcy.
Program Year: Year 2	**Of X Years: Year 2** / **Goal Type: Process Goal**

Priority Health Need: Chronic Disease **Program Name:** YWCA Newburyport "Encore" Program **Health Issue:** Chronic Disease	
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. The program includes both land and water fitness geared to all fitness levels with a strong focus on strength, functionality, core strength and balance and access to peer support groups. The program will expand to include targeted personal training to qualified individuals to empower them to join the Encore program.

Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Survivorship exercise program for people impacted by cancer.
Goal Status	The Encore program goal continues to be to work with as many thrivers as possible who have experienced a cancer journey. The program has slowly seen an uptick in participation as COVID 19 numbers continue to drop due to safety protocols and increased public awareness. We welcomed close to 20 new members this year with promising attendance. The YWCA also continued to collaborate with the Tough Warrior Princesses making the "Warrior Chat" free support group program available.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name:** Emmaus' Mitch's Place Shelter **Health Issue:** Housing/Homelessness	
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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase housing stability for those at risk for eviction or homelessness.
Goal Status	Emmaus served 222 individuals at Mitch's Place overnight emergency shelter in FY'22 July 2021 - June 2022), up from 119 in FY'21 when it operated as a 24/7 program during the height of the pandemic. The number of individuals served in FY '22 approached pre-pandemic levels when 267 different individuals used the shelter. In FY'22, Emmaus continued to prioritize generating and maintaining permanent housing solutions for those impacted by homelessness. The agency expanded its

	rapid rehousing program, placing 56 individuals into permanent housing with attached supportive services in the 12-month period. The rapid re-housing initiative kept the length of stay in shelter under 30 days for 71% of the Mitch's Place shelter guests. Less than 5% of shelter guests remained in shelter for more than six months. Emmaus continues to manage 99 units of permanent affordable housing that it owns and operates, including 59 units designated for individual adults. Residents pay 30% of their income and are re-assessed annually. The majority of these residents have lived stably in Emmaus properties for many years. There is very little turnover in these units.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health
Program Name: Interpreter Services
Health Issue: Additional Health Need (Access)

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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to translation services at no cost to AJH patients
Goal Status	AJH Interpreter Services supported 5,747 encounters patients with limited English proficiency/in need of patient interpreter services in FY21. While Spanish,

	Continental Portuguese, and ASL are the most commonly utilized services, AJH service offered hundreds of language translations as needed.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health
Program Name: Link House's Women's Independent Sober Housing
Health Issue: Housing/Homelessness

Brief Description or Objective	Link House's Women's Independent Sober Housing (WISH) is independent sober housing, where women sustain their long-term recovery in a supportive, safe, and sober. Members must be free of substance use for a minimum of one year, and contract to abstain from all substance use and other addictive behaviors, attend appropriate AA/NA meetings, participate in house meetings, consent to the house rules and fully participate in all additional aspects of recovery. To ensure a successful transition to independent living, clients are required to work and pay for rent. Case management and the peer-mentorship are the cornerstones of the residences, building upon positive relationships amongst residents to assist each other with relapse prevention skills, effectively manage daily life stressors, coordination with community supports and empower them on their own recovery journey. WISH has a House Manager, who lives on site in a separate apartment, and is responsible for ensuring a safe and supportive environment.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase housing stability for those at risk for eviction or homelessness
Goal Status	The $5,000 donation for WISH (women's independent sober housing) was used in the following manner over the course of the calendar year to assist the residents: • Assisting with transition into the facility (initial rent payment). • Assisting residents with purchasing supplies for their rooms (blanket, bedding, etc.). • Some funds were utilized assisting residents with purchasing a monthly MART bus pass. • Some funds were utilized assisting residents with purchasing groceries and other essentials (shampoo, soap, etc.) • Some funds were utilized for purchasing paper towels, toilet paper, and/or laundry detergent. The residents of WISH were grateful for the generous donation from the hospital and these funds were used in a practical manner to better their respective lives.

Program Year: Year 2	Of X Years: Year 2	Goal Type: Process Goal

Priority Health Need: Social Determinants of Health
Program Name: Our Neighbors' Table Weekly Meal
Health Issue: Additional Health Needs (Food Access)

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 2020 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. As of October 2021, ONT served a record 20,000+ meals through the Wednesday Meal program in 2021, a 29% increase over 2020, and an astounding 66% increase over 2019. 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 is 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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to low-cost healthy foods for AJH priority cohorts.
Goal Status	Support provided by AJH sponsored six weeks' worth of meals for ONT guests. In 2022, ONT has provided 8,387 adults and 1,181 children with a weekly free meal and introduced them to ONT's Grocery Program where they can access groceries of their choice once a week at no cost to them. Approximately 82% of Meal recipients are returning guests each week.

Program Year: Year 3	Of X Years: Year 3	Goal Type: Process Goal

Priority Health Need: Social Determinants of Health **Program Name:** Newbury Food Pantry **Health Issue:** Additional Health Needs (Food Access)	
Brief Description or Objective	One of every 10 neighbors in Newbury Food Pantry's service area do not have a reliable source of healthy food, according to the Greater Boston Food Bank. The First Parish Newbury Food Pantry supports neighbors in need, including residents of Newburyport, Salisbury, and other surrounding towns with free food donations every Friday, typically serving between 250 and 300 people through deliveries or food pickup.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to low-cost healthy foods for AJH priority cohorts
Goal Status	Guests placed 8,900 orders in 2022, obtaining food to serve 19,400 people during the year. Guest roster in 2022 included 1,090 guests in 498 households. Nearly 60% of the households included a guest over the age of 65. Overall, 44% of guests were adults under the age of 65, 23% were children and 33% were seniors.
Program Year: Year 2	**Of X Years: Year 2** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name:** Nourishing the Northshore **Health Issue:** Additional Health Needs (Food Access)	
Brief Description or Objective	Nourishing the Northshore's VEGOUT Program brings healthy, local produce to members in the community that often do not have access to these food choices. Nourishing the North Shore combines excess produce from local farms with food that is grown in their garden and distributes produce directly through the community's food access agencies as well as NNS-run Farmers' Market style produce stands. All produce is free to those who are visiting the food access sites.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to low-cost healthy foods for AJH priority cohorts.
Goal Status	- Distributed 38,000 pounds of local produce to food insecure individuals through 2 mobile markets and 6 area food access agencies, providing 148,000 servings of vegetables - Provided 120 Thanksgiving produce bags, distributed through Pettengill Pantry, First Parish Newbury Food Pantry and Kelleher Park.

	- Delivered curated bags of local produce to 33 senior households at Heritage House in Newburyport for 8 consecutive weeks. - Worked with 11 partner farms and 6 area food access agencies. - Created a story-telling project about the impact of VEGOUT; participants included our partners, volunteers & pantry guests.

Program Year: Year 2	**Of X Years: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health
Program Name: Patient Financial Counseling
Health Issue: Additional Health Need (Access)

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).
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	1. 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. 2. 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.

Goal Status	Total applications for FY22: 305 Age groups: • 0-17 14% • 18-35 66% • 36-53 82% • 54-70 119% • 71-107 24% There were 15 financial assistance and 1 extension applications processed and approved.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health
Program Name: Transportation Services
Health Issue: Additional Health Need (Access)

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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to transportation support or provide transportation reimbursement to patients who are uninsured or have limited resources
Goal Status	AJH distributed $6,090.12 of emergency funds to patients in FY22.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinant of Health **Program Name:** YMCA Haverhill Freight Farm **Health Issue:** Additional Health Need (Food Access)	
Brief Description or Objective	In order to increase health equity in Gateway Municipalities, and continue to serve the underserved, a grant was awarded to the YMCA to address social determinants of health needs and increase food access through the introduction of a freight container to operate a hydroponic farm.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to low-cost healthy foods for AJH priority cohorts by purchasing the freight container for the hydroponic farm
Goal Status	FY22 goals include finalizing the grant agreement and agreed upon program metrics. Program will monitor the following: ➢ Direct Distribution of produce to residents/students ➢ Demographic profile of participants (race/ethnicity, age, gender, income) per quarter ➢ Average number of units (head of lettuce, bunch of spinach, etc.) distributed per week • Description of variety of produce each quarter ➢ Distribution of Produce
Program Year: Year 1	**Of X Years: Year 1** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name:** YWCA ROOF Over Head Collaborative **Health Issue:** Housing/Homelessness	
Brief Description or Objective	YWCA's ROOF Over Head Collaborative rental housing for low-income working families with dependent children from Amesbury, Newburyport and Salisbury. Case managers assist families to move toward permanent housing. Eligible families must be from and homeless or at-risk of becoming homeless.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase housing stability for those at risk for eviction or homelessness
Goal Status	Case managers supported four households facing homelessness (total of 8 individuals) to retain their housing for one year by helping households apply for

	and receive state rental assistance and by helping them manage stress during the pandemic.

Program Year: Year 2	**Of X Years: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Infrastructure to Support Community Benefits
Program Name: Infrastructure to support Community Benefits collaborations across BILH hospitals
Health Issue: All

Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital worked together to plan, implement, and evaluate Community Benefits programs. Staff worked together to plan and implement the FY22 Community Health Needs Assessment and each created an Implementation Strategy that is uniform across all of the hospitals. Community Benefits staff continued to understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH continues to refine the Community Benefits (CB) database, as part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits
Program Goal(s)	1. By September 30, 2022, plan and implement the Community Health Needs Assessment and create the Implementation Strategy to address the priorities that is approved by the hospital Board of Trustees. 2. By September 30, 2022, in partnership with MGB, create and implement a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits data to more accurately capture and quantify CB/CR activities and expenditures.
Goal Status	1. All 10 BILH Community Benefits hospitals received Board of Trustee approval on their Community Health Needs Assessment and Implementation Plan. 2. All FY22 regulatory reporting data were entered into the Community Benefits Database.

Program Year: Year 2	**Of X Years: Year 2**	**Goal Type: Process Goal**

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$400,640.00	
Community-Clinical Linkages	$44,254.00	$5,000.00
Total Population or Community Wide Interventions	$83,504.00	$44,250.00
Access/Coverage Supports	$140,039.00	$16,683.00
Infrastructure to Support CB Collaborations	$99,559.00	
Total Expenditures by Program Type	$767,996.00	$65,833.00
CB Expenditures by Health Need		
Chronic Disease	$165,934.80	$16,250.00
Mental Health/Mental Illness	$308,710.05	$7,000.00
Substance Use Disorders	$69,988.70	$5,000.00
Housing Stability/Homelessness	$21,903.35	$13,000.00
Additional Health Needs Identified by the Community	$201,459.10	$24,683.00
Total by Health Need	$767,996.00	$65,833.00
Leveraged Resources	$519,555.00	
Total CB Programming	$1,287,551.00	
Net Charity Care Expenditures		
HSN Assessment	$578,897.79	
Free/Discounted Care	0	
HSN Denied Claims	$37,068.15	
Total Net Charity Care	$696,434.93	
Total CB Expenditures	$1,983,985.93	

Additional Information	
Net Patient Services Revenue	**$130,084,000**
CB Expenditure as % of Net Patient Services Revenue	1.53%
Approved CB Budget for FY22 (*Excluding expenditures that cannot be projected at the time of the report)	**$1,983,985.93**
Bad Debt	**$2,064,119.11**
Bad Debt Certification	Yes
Optional Supplement	
Comments	

SECTION VI: CONTACT INFORMATION

Anna Jaques Hospital
Community Benefits & Community Relations
25 Highland Avenue
Newburyport, MA 01950
Office:

SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

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

I. Community Benefits Process:

- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? ☒ Yes ☐ No

  If so, please list updates:

  Anna Jaques Hospital (AJH) has worked to align its Community Benefits Advisory Committee (CBAC) membership to reflect the demographics included in AJH's Community Benefits Service Area (CBSA). Additionally, AJH has worked to have its CBAC membership include the following sectors: local public health department; municipal staff; education; housing/community development; social service agencies; regional planning/transportation; private sector; and community-based organizations. AJH welcomed new CBAC member with: *Tracy Fuller, Regional Executive Director, Haverhill YMCA*

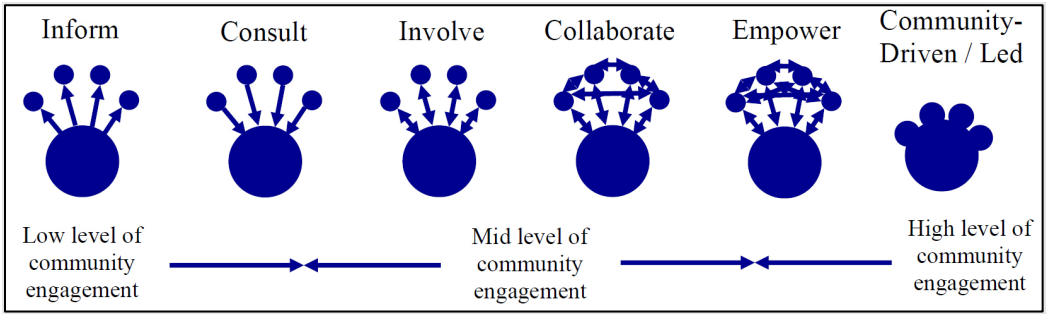
II. Community Engagement:

- 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
Nourishing the Northshore	Caitlyn Kenney, Executive Director	Social service agency; food access	AJH strengthened its support of Nourishing the Northshore's VEGOUT Program which brings healthy, local produce to members in the community that often do not have access to these food choices. Nourishing the North Shore combines excess produce from local farms with food that is grown at their garden and distribute produce directly through the community's food access agencies as well as NNS-run Farmers' Market style produce stands. All produce is free to those who are visiting the food access sites.
YMCA Haverhill	Tracy Fuller, Executive Director	Social service organization; food access	In order to increase health equity in Gateway Municipalities, and continue to serve the underserved, Beth Israel Lahey Health (BILH) awarded the

			YMCA of the North Shore/Haverhill YMCA a grant to address social determinants of health needs and increase food access through the introduction of a freight container to operate a hydroponic farm.

- 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.



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

[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.

Evaluating progress in executing Implementation Strategy	Collaborate	Yes	Collaborate
Updating Implementation Strategy annually	Consult	Yes	Collaborate

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

  Anna Jaques Hospital (AJH) remains committed to community engagement. During FY22, AJH conducted a comprehensive triennial community health needs assessment and prioritization process. Guided by AJH's Community Benefits Advisory Committee and conducted in collaboration with community partners, this initiative's guiding principles include community engagement, equity, collaboration and capacity building. In FY22, AJH continued to work with its CBAC and community partners to engage the community including holding an annual public meeting. Additionally, AJH will engage with our community by:
  - Conducted three focus groups comprised of harder to reach populations including youth, people who utilize social service offerings, and people in recovery of substance use disorder
  - Collaborated with 773 community partners to encourage participation in the hospital's Community Health Needs Assessment including: partnering with food banks to distribute surveys and information, presenting at events and meetings, and attending coalition meetings
  - Hosted 2 Community Listening Sessions
  - Worked hand-in-hand with the community to have 773 surveys completed to invite residents to share first-hand knowledge and feedback on how best to support the health and wellness of our community

- COVID Question: Please describe how the COVID-19 pandemic impacted the hospital's process for engaging its community and developing responsive Community Benefits programming.

  For the FY22 reporting year, AJH continued to dedicate a great deal of time and resources at the local level in response to the COVID-19 global pandemic. AJH was intentional when assessing risk factors within our CBSA and worked closely with our local health department(s). Clinical staff provided infection control expertise to local

health departments during their reopening plans. AJH worked with BILH as a system to develop and distribute written materials (in nine languages) to the communities most impacted by COVID-19, to help slow the spread. AJH redeployed staff and procured tangible necessities for both the community at large and hospital staff, such as personal protective equipment (PPE), food, hand sanitizer, and other critical items. Additionally, working with BILH, AJH opened a vaccination site in our community to vaccinate thousands of individuals including those disproportionately impacted by the pandemic.

While in-person meetings were hindered in the community, AJH sought creative ways of engaging with our community, including:

- Cancer Center staff partnered with North of Boston Cancer Resource to host Zoom education and support sessions throughout the year;
- AJH supported area food pantries shift to offer to-go meals to patrons
- Identified new partnerships with social service agencies in our CBSA that are directly working in our communities, including Essex County Outreach focused on providing resources and supports to people impacted by substance use disorder and mental or behavioral health.

Many of the programs highlighted in this report had to be modified significantly due to COVID-19 and related safety guidelines. In some cases, programs were expanded. In others, programs were cut or significantly reduced because of the pandemic.

- 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 held a public meeting in conjunction with its CBAC on June 9, 2022. Additionally, AJH shared highlights of its Community Benefits program at meetings throughout its CBSA when engaging with the community during the triannual CHNA.

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