# Community Benefits Report

## Fiscal Year 2024

Beth Israel Lahey Health
Anna Jaques Hospital

# TABLE OF CONTENTS

# SECTION I: SUMMARY AND MISSION STATEMENT

Anna Jaques Hospital (AJH) is a member of Beth Israel Lahey Health (BILH). The BILH network of affiliates is an integrated health care system committed to expanding access to extraordinary patient care across Eastern Massachusetts and advancing the science and practice of medicine through groundbreaking research and education. The BILH system is comprised of academic and teaching hospitals, a premier orthopedics hospital, primary care and specialty care providers, ambulatory surgery centers, urgent care centers, community hospitals, homecare services, outpatient behavioral health centers, and addiction treatment programs. BILH's community of clinicians, caregivers and staff includes approximately 4,000 physicians and 35,000 employees.

At the heart of BILH is the belief that everyone deserves high-quality, affordable health care. This belief is what drives BILH to work with community partners across the region to promote health, expand access, and deliver the best care in the communities BILH serves. Anna Jaques Hospital's Community Benefits staff are committed to working collaboratively with its communities to address the leading health issues and create a healthy future for individuals, families and communities.

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

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

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.

More broadly, Anna Jaques Hospital's Community Benefits mission is fulfilled by:

- **Involving AJH's staff**, including its leadership and dozens of community partners in the Community Health Needs Assessment (CHNA) process as well as in the development, implementation, and oversight of the hospital's three-year Implementation Strategy (IS);

- **Engaging and learning from residents** throughout AJH's Community Benefits Service Area (CBSA) in all aspects of the Community Benefits process, with special attention focused on engaging diverse perspectives, from those, patients and non-patients alike, who are often left out of similar assessment, planning and program implementation processes;

- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to understand unmet health-related needs and identify communities and population segments disproportionately impacted by health issues and other social, economic and systemic factors;

- **Implementing community health programs and services** in AJH's CBSA that address the underlying social determinants of health, barriers to accessing care, as well as promote equity to improve the health status of those who are often disadvantaged, face disparities in health-related outcomes, experience poverty, and have been historically underserved;

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

- **Facilitating collaboration and partnership within and across sectors** (e.g., state/local public health agencies, health care providers, social service organizations, businesses, academic institutions, community health collaboratives, and other community health organizations) to advocate for, support, and implement effective health policies, community programs, and services.

The following annual report provides specific details on how AJH is honoring its commitment and includes information on AJH's CBSA, community health priorities, priority cohorts, community partners, and detailed descriptions of its Community Benefits programs and their impact.

**Priority Cohorts**

In 2022, Anna Jaques Hospital conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included extensive data collection activities, substantial efforts to engage Anna Jaques Hospital's partners and community residents, and thoughtful

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

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

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 agreed 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)

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

**Key Accomplishments for Reporting Year**
The accomplishments and activities highlighted in this report are based upon priorities identified and programs contained in AJH's FY 2022 Community Health Needs Assessment (CHNA) and FY 2023-2025 Implementation Strategy (IS):

- 171 children were seen by Link House's Children and Teen Center for Help (CATCH) program, which provides behavioral health services to children and teens.
- The YMCA Haverhill Freight Farm, funded with seed money from Beth Israel Lahey Health, provided produce to 3,200 people and STEM educational opportunities to 30 students.
- Permanent housing was secured for 48 unhoused individuals and 274 individuals received shelter, food, and supportive shelter through Emmaus, Inc.'s Mitch's Place.

- Food insecure community members received 47,500 pounds (190,000) servings of free, local produce through a network of 12 food access partners as part of Nourishing the North Shore's VEGOUT Program.
- 150 individuals received outreach and care coordination to provide greater stabilization and well-bring for individuals and their families struggling with mental health and/or substance misuse through Pettengill House's Behavioral Event and Substance Support Team (BESST).

**Plans for Next Reporting Year**

In FY 2022, Anna Jaques Hospital conducted a comprehensive and inclusive CHNA that included extensive data collection activities, substantial efforts to engage AJH's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. In response to the FY 2022 CHNA, AJH will focus its FY 2023 - 2025 IS on four priority areas. These priority areas collectively address the broad range of health and social issues facing residents living in AJH's CBSA who face the greatest health disparities. These four priority areas are:

- Equitable Access to Care
- Social Determinants of Health
- Mental Health and Substance Use
- Complex and Chronic Conditions.

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). AJH's priorities are also aligned with the priorities identified by the Massachusetts Department of Public Health (DPH) to guide the Community-based Health Initiative (CHI) investments funded by the Determination of Need (DoN) process, which underscore the importance of investing in the Social Determinants of Health (i.e., built environment, social environment, housing, violence, education, and employment).

The FY 2022 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions being used to inform and refine AJH's efforts. In completing the FY 2022 CHNA and FY 2023 - 2025 IS, AJH, along with its other health, public health, social service, and community partners, is committed to promoting health, enhancing access and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identify, sexual orientation, disability status, immigration status, or age. As discussed above, based on the FY 2022 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that for AJH's FY 2023 - 2025 IS, it should work with its community partners to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, AJH's Community Benefits investments and resources will continue to focus on improving the health status, addressing disparities in health outcomes, and promoting health equity for its priority cohorts, which

include youth; low-resourced populations; racially, ethnically and linguistically diverse populations; older adults; and individuals with disabilities.

AJH partners with clinical and social service providers, community-based organizations, public health officials, elected/appointed officials, hospital leadership and other key collaborators throughout its CBSA to execute its FY 2023 – 2025 IS.

- **Equitable Access to Care**
  - Anna Jaques Hospital will continue to support Northern Essex Elder Transport (NEET), which provides transportation to local and out-of-town medical appointments for those that are 60 or older who cannot access and/or afford other means.

- **Social Determinants of Health**
  - Anna Jaques Hospital will continue its support of Nourishing the North Shore, Our Neighbors' Table, and Haverhill Public Schools to increase access to healthy food and meals in the hospital's CBSA.

- **Mental Health and Substance Use**
  - Anna Jaques Hospital will continue its partnership with Link House to support increased awareness of and access to behavioral health services for children, teens, and adults.

- **Complex and Chronic Conditions**
  - Anna Jaques Hospital will continue its partnership with Sarah's Place Adult Day Health Center to increase outreach and education of their services to the Spanish-speaking population.

**Hospital Self-Assessment Form**

Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), the AJH Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 56). The AJH Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members and asked them to submit the form to the AGO website.

# SECTION II: COMMUNITY BENEFITS PROCESS

**Community Benefits Leadership/Team**
Anna Jaques Hospital's Board of Trustees along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its CBSA and beyond. AJH 's Community Benefits Department, under the direct oversight of Anna Jaques Hospital's Board of Trustees, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations. Hospital senior leadership is actively engaged in the development and implementation of the AJH's Implementation Strategy, ensuring that hospital policies and resources are allocated to support planned activities.

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

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

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The Anna Jaques Hospital Community Benefits program is spearheaded by Community Benefits Community Relations Manager. The Community Benefits Community Relations 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 Diversity, Equity and Inclusion Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of cohorts who have been historically underserved are considered every day in discussions on resource allocation, policies, and program development.

This structure and methodology are employed to ensure that Community Benefits is not the purview of one office alone and to maximize efforts across the organization to fulfill the mission and goals of BILH and Anna Jaques Hospital's Community Benefits program.

**Community Benefits Advisory Committee (CBAC)**
The Anna Jaques Hospital Community Benefits Advisory Committee (CBAC) works in collaboration with Anna Jaques Hospital's hospital leadership, including the hospital's governing board and senior management to support Anna Jaques Hospital's Community Benefits mission to improve the health and well-being of residents within our Community Benefits Service Area (CBSA). The CBAC provides input into the development and implementation of Anna Jaques Hospital's Community Benefits programs in furtherance of Anna Jaques Hospital's Community Benefits mission. The membership of Anna Jaques Hospital's CBAC aspires to be representative of the constituencies and priority cohorts served by Anna Jaques Hospital's programmatic endeavors, including those from diverse racial and ethnic backgrounds, age, gender, sexual orientation and gender identity, as well as those from corporate and non-profit community organizations.

The Anna Jaques Hospital CBAC met on the following dates:

- December 14, 2023
- March 13, 2024
- June 12, 2024
- September 12, 2024 (Public Meeting)

**Community Partners**
Anna Jaques Hospital (AJH) recognizes its role in serving the community, but that in order to be successful it needs to collaborate with its community partners and those it serves. Anna Jaques Hospital's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy (IS) were completed in close collaboration with Anna Jaques Hospital's staff, community residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership and other key collaborators from throughout its CBSA. Anna Jaques Hospital's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of Anna Jaques Hospital's mission.

Anna Jaques Hospital currently supports numerous educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA. In this work, Anna Jaques Hospital collaborates with many of its local community-based organizations, public health departments, municipalities and clinical and social service organizations. Anna Jaques Hospital has a particularly strong relationship with the Behavioral Event and Substance Support Team (BESST) operated by Pettengill House. This relationship includes

providing substance misuse/behavioral health support for individuals of all ages and families, including navigation to treatment; case management and coordination; outreach and check-ins; and wraparound supports. BESST works closely with Anna Jaques Hospital's in-patient unit and social workers to coordinate care.

The following is a comprehensive listing of the community partners with which Anna Jaques Hospital joins in assessing community needs 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).

- Common Ground Ministries
- Eliot Community Human Services
- Emmaus, Inc.
- Essex County Asset Builder Network
- Essex County Outreach
- Haverhill Farmers' Market/Creative Haverhill
- Haverhill Public Schools
- Jeanne Geiger Crisis Center
- Link House, Inc.
- Merrimack Valley Transit
- New England Elder Transportation
- Newburyport Farmers' Market
- Newburyport Recreation and Youth Services
- North of Boston Cancer Resource
- Northern Essex Elder Transport
- Nourishing the North Shore
- Our Neighbors' Table
- The Pettengill House
- Regional Social Services Collaborative
- Rotary Club of Haverhill
- Rotary Club of Newburyport
- Sarah's Place Adult Health Center
- YMCA of Northshore/Haverhill
- YWCA of Newburyport

# SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY 2022 Community Health Needs Assessment (CHNA) along with the associated FY 2023-2025 Implementation Strategy was developed over a twelve-month period from September 2021 to September 2022. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill the 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 cohorts who have been historically underserved, and its commitment to community health improvement.

As mentioned above, Anna Jaques Hospital's most recent CHNA was completed during FY 2022. FY 2024 Community Benefits programming was informed by the FY 2022 CHNA and aligns with Anna Jaques Hospital's FY 2023 – FY 2025 Implementation Strategy. The following is a summary description of the FY 2022 CHNA approach, methods, and key findings.

**Approach and Methods**

The FY 2022 assessment and planning process was conducted in three phases between September 2021 and September 2022, which allowed Anna Jaques Hospital to:

- assess community health, defined broadly to include health status, social determinants, environmental factors and service system strengths/weaknesses;
- engage members of the community including local health departments, clinical and social service providers, community-based organizations, community residents and Anna Jaques Hospital's leadership/staff;
- prioritize leading health issues/population segments most at risk for poor health, based on review of quantitative and qualitative evidence;
- develop a three-year Implementation Strategy to address community health needs in collaboration with community partners, and;
- meet all federal and Commonwealth Community Benefits requirements per the Internal Revenue Service, as part of the Affordable Care Act, the Massachusetts Attorney General's Office, and the Massachusetts Department of Public Health.

Anna Jaques Hospital's Community Benefits program is predicated on the hospital's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address inequities and socioeconomic barriers to accessing care, as well as the current and historical discrimination and injustices

that underlie existing disparities. Throughout the CHNA process, efforts were made to understand the needs of the communities that Anna Jaques Hospital serves, especially the population segments that are often disadvantaged, face disparities in health-related outcomes, and who have been historically underserved. Anna Jaques Hospital's understanding of these communities' needs is derived from collecting a wide range of quantitative data to identify disparities and clarify the needs of specific communities and comparing it against data collected at the regional, Commonwealth and national levels wherever possible to support analysis and the prioritization process, as well as employing a variety of strategies to ensure community members were informed, consulted, involved, and empowered throughout the assessment process.

Between October 2021 and February 2022, Anna Jaques Hospital conducted 18 one-on-one interviews with key collaborators in the community, facilitated three focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 750 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 800 community residents, clinical and social service providers and other community partners.

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

**Summary of FY 2022 CHNA Key Health-Related Findings**

***Equitable Access to Care***

- Individuals identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system level, meaning that the issues stem from the way in which the system does or does not function. System level issues included providers not accepting new patients, long wait lists, and an inherently complicated healthcare system that is difficult for many to navigate.
- There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forego or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.

***Social Determinants of Health***

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

define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to economic insecurity, education, food insecurity, access to care/navigation issues, and other important social factors.

- There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, survey, and listening sessions suggested that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, food security/nutrition, and economic stability.

***Mental Health and Substance Use***

- Anxiety, chronic stress, depression, and social isolation were leading community health concerns. The assessment identified specific concerns about the impact of mental health issues for youth and young adults, the mental health impacts of racism, discrimination, and trauma, and social isolation among older adults. These difficulties were exacerbated by COVID-19.
- In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services.
- Substance use continued to have a major impact on the CBSA; the opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities, including mental health, housing, and homelessness. Individuals engaged in the assessment identified stigma as a barrier to treatment and reported a need for programs that address common co-occurring issues (e.g., mental health issues, homelessness).

***Complex and Chronic Conditions***

- Chronic conditions such as cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease contribute to 56% of all mortality in the Commonwealth and over 53% of all health care expenditures ($30.9 billion a year). Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

For more detailed information, see the full FY 2022 Anna Jaques Hospital Community Health Needs Assessment and Implementation Plan Report on the hospital's website.

# SECTION IV: COMMUNITY BENEFITS PROGRAMS

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| **Priority Health Need: Equitable Access to Care**<br>**Program Name: BILH Workforce Development**<br>**Health Issue: Additional Health Needs Identified by the Community (Access to Care)** | | |
| **Brief Description or Objective** | BILH is strongly committed to workforce development programs that enhance the skills of its diverse employees and provide career advancement opportunities. BILH offers incumbent employees "pipeline" programs to train for professions such as Patient Care Technician, Central Processing Technician and Associate's degree Nurse Resident. BILH's Employee Career Initiative provides career and academic counseling, academic assessment, and pre-college and college-level science courses to employees at no charge, along with tuition reimbursement, competitive scholarships and English for Speakers of Other Languages (ESOL) classes. BILH is also committed to making employment opportunities available to qualified community residents through training internships conducted in partnership with community agencies and hiring candidates referred by community programs. | |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community-Wide Interventions<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits | |
| **Program Goal(s)** | In FY24, Workforce Development will continue to encourage community referrals and hires. | |
| **Goal Status** | In FY24, 412 job seekers were referred to BILH and 111 were hired across BILH hospitals. | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |
| **Program Goal(s)** | In FY24, Workforce Development will attend events and give presentations about employment opportunities to community partners. | |
| **Goal Status** | In FY24, 33 events and presentations were conducted with community partners across the BILH service area. | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |

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| **Program Goal(s)** | In FY24, Workforce Development will offer employees career development services. | |
| **Goal Status** | In FY24, 1,044 BILH employees received career development services. | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |
| **Program Goal(s)** | In FY24, Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees. | |
| **Goal Status** | In FY24, 14 BILH employees attended citizenship classes, 15 BILH employees attended career development workshops and 207 BILH employees attended financial literacy classes. Anna Jaques Hospital employees participated in these offerings. | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |
| **Program Goal(s)** | In FY24, Workforce Development will offer English for Speakers of Other Languages (ESOL) classes to BILH employees. | |
| **Goal Status** | In FY24, 82 employees across BILH were enrolled in ESOL classes. Anna Jaques Hospital employees participated in these classes. | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |
| **Program Goal(s)** | In FY24, Workforce Development will offer internships in BILH hospitals to community members over the age of 18. | |
| **Goal Status** | In FY24, 107 community members placed in internships across BILH hospitals to learn valuable skills. Anna Jaques Hospital participated in offering these internships. | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |
| **Program Goal(s)** | In FY24, Workforce Development will hire interns hired after internships and place in BILH hospitals. | |
| **Goal Status** | In FY24, 37 interns were hired permanently in BILH hospitals. Anna Jaques Hospital participated in these hirings. | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |

| **Priority Health Need: Equitable Access to Care**<br>**Program Name: Northern Essex Elder Transport**<br>**Health Issue: Additional Health Needs Identified by the Community (Access to Care, Transportation)** | | |
|---|---|---|
| **Brief Description or Objective** | Northern Essex Elder Transport, Inc., "NEET", is an innovative, no-cost medical transportation program for those over the age of 60, and others as deemed necessary by the member communities. The mission is to provide dependable and compassionate transportation assistance to older adults, ensuring they can access vital medical appointments with ease. Through the dedicated team of volunteer drivers, they aim to bridge the transportation gap and alleviate the challenges faced by older adults in reaching healthcare services. The program is committed to promoting the wellbeing and health of older adults by facilitating their access to essential medical care, thereby enhancing their overall quality of life. | |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community-Wide Interventions<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits | |
| **Program Goal(s)** | To increase the number of new volunteer drivers by two per month. This is essential to increase ridership. | |
| **Goal Status** | From May-September 2024, 12 new volunteers were recruited. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** |

| **Priority Health Need: Equitable Access to Care**<br>**Program Name: AJH Welcome Visits**<br>**Health Issue: Additional Health Needs Identified by the Community (Access to Care)** | |
|---|---|
| **Brief Description or Objective** | The AJH Birth Center started a "Welcome Visit" program in January 2023. This is offered to all patients, however, a Registered Nurse outreaches to patients who fall into high-risk categories and coordinates with social work services to ensure that the most vulnerable patients attend this visit. The visit is free of charge and provides education on infant feeding, reviewing any birth preferences and preparing for labor and delivery, as well as the opportunity to fill out paperwork ahead of time, tour the unit, and meet the team who will care for them in the hospital. Interpreter services are used when appropriate, to ensure that all patients have equitable access to education. |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☐ Total Population or Community-Wide Interventions<br>☒ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal(s)** | To orient and support expectant patients, especially those deemed "high-risk," by preparing them for a hospital delivery and initial newborn care. |
| **Goal Status** | This new program had 206 "Welcome Visits" with patients in FY24. Patient, physician, midwife, and neonatal provider feedback has been overwhelmingly positive. Patients feel a sense of safety when they come to give birth after having completed this preparatory visit as they have had an opportunity to share their preferences and the staff an opportunity to educate patients in a trauma-informed manner. |

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| | In both FY2023 and FY2024, first-time mothers who attended a prenatal welcome visit had a lower incidence of having a cesarean section as compared to first-time mothers who did not attend.<br><br>FY 2024 also had the highest discharge breastfeeding rate (tracked since 2007): 88% of mothers delivering at Anna Jaques Hospital were discharged home with their babies breastfeeding. This is an increase from 85% in FY 2023. |

| Time Frame Year: Year 2 | Time Frame Duration: Year 3 | Goal Type: Process Goal |
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| **Priority Health Need: Equitable Access to Care**<br>**Program Name: Interpreter Services**<br>**Health Issue: Additional Health Needs Identified by the Community (Access to Care)** | |
|---|---|
| **Brief Description or Objective** | An extensive body of research illustrates the health disparities and differences in health care access and utilization that exist for diverse individuals/cohorts and foreign-born populations. Language barriers pose significant challenges to providing effective and high-quality health and social services. To address this need, and in recognition that language and cultural barriers are major difficulties to accessing health and social services and navigating the health system.<br><br>Anna Jaques Hospital offers free interpreter services for non-English speaking, limited-English speaking, deaf and hard-of-hearing patients. These services are provided in person; by phone using a portable speaker phone to connect patients, their care team and an interpreter; and through video-based remote interpreter service using a computer to connect patients with an interpreter. Professional interpretation services in hundreds of languages are available 24/7. |
| **Program Type** | ☐ Direct Clinical Services ☒ Access/Coverage Supports<br>☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits<br>☐ Total Population or Community-Wide Interventions |
| **Program Goal(s)** | Provide access to interpretation and translation services at no cost to Anna Jaques Hospital patients. |
| **Goal Status** | In FY24, Anna Jaques Hospital Interpreter Services supported 1,953 encounters. Spanish and Portuguese were the most requested languages for interpretation. |

| Time Frame Year: Year 1 | Time Frame Duration: Year 3 | Goal Type: Process Goal |
|---|---|---|

| **Priority Health Need: Equitable Access to Care**<br>**Program Name: Transportation Services**<br>**Health Issue: Additional Health Needs Identified by the Community (Transportation, Access to Care)** | |
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| **Brief Description or Objective** | To support vulnerable communities and limit barriers so patients receive the care they need, AJH provides transportation assistance to patients who have limited resources and social support. This program is offered to any patient who meets the criteria of need decided by a social worker. |
| **Program Type** | ☐ Direct Clinical Services ☒ Access/Coverage Supports<br>☐ Community Clinical Linkages |

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| | ☐ Total Population or Community-Wide Interventions ☐ 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** | In FY24, AJH assisted with 189 rides for patients. | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |

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| **Priority Health Need: Equitable Access to Care**<br>**Program Name: Financial Assistance Counselors**<br>**Health Issue: Additional Health Needs Identified by the Community (Access to Care)** | | |
| **Brief Description or Objective** | Significant segments of the community population living within the hospital's CBSA, particularly low-resourced and BIPOC populations, face significant barriers to care. The hospital's Financial Assistance Program offers emergency and other medically necessary services at low or no cost to qualified patients (when qualifying family income is at or below 400% of the Federal Poverty Level). The hospital's Financial Counseling staff screen people and assist them in applying for all eligible financial assistance programs. | |
| **Program Type** | ☐ Direct Clinical Services ☒ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population or Community-Wide Interventions | |
| **Program Goal(s)** | To assist patients throughout the BILH Systems who are uninsured and under insured to obtain eligibility for and align them with state financial assistance and hospital-based financial assistance programs. This includes MassHealth, MassHealth ACOs, Health Connector, Pharmacy Programs and Hospital Charity programs | |
| **Goal Status** | In FY 2024, Anna Jaques screened 622 patients for a State Assistance or Hospital Charity program, of which 216 were enrolled in a MassHealth Program and 64 were enrolled in a Connector plan. The number of uninsured patients who utilized the Health Safety program was 100. | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |

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| **Priority Health Need: Equitable Access to Care**<br>**Program Name: Diversity, Equity and Inclusion**<br>**Health Issue: Additional Health Needs Identified by the Community (Access to Care)** | | |
| **Brief Description or Objective** | BILH Community Benefits sits within the Office of Diversity, Equity and Inclusion (DEI). BILH's Office of Diversity, Equity, and Inclusion develops and advocates for policies, processes and business practices that benefit the communities and our workforce. The DEI vision is to "Transform care delivery by dismantling barriers to equitable health outcomes and become the premier health system to attract, retain and develop diverse talent." | |
| **Program Type** | ☐ Direct Clinical Services ☒ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population or Community-Wide Interventions | |

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| **Program Goal(s)** | Across BILH, increase BIPOC representation among new leadership (directors and above) and clinical (physicians and nurses) hires with an aim of at least 25% representation. | |
| **Goal Status** | Across BILH, 18% of new hires in leadership (directors and above) and clinical (physicians and nurses) positions identified as BIPOC. | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Outcome Goal** |
| **Program Goal(s)** | Increase spend with diverse businesses by 25% over the previous fiscal year across the system. | |
| **Goal Status** | More than $70 million was contracted to Women and Minority-owned Business Enterprises (WMBE) in FY24. This is a 28% increase over FY23. | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Outcome Goal** |

| **Priority Health Need: Equitable Access to Care**<br>**Program Name: Facilitating Primary Care Access**<br>**Health Issue: Additional Health Needs Identified by the Community (Access to Care)** | | |
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| **Brief Description or Objective** | Throughout Anna Jaques Hospital's Community Benefits Service Area, AJH subsidizes primary care services provided by the hospital's Affiliated Physician's Group. | |
| **Program Type** | ☒ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☐ Total Population or Community-Wide Interventions | ☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal(s)** | Provide access to primary care for uninsured and underinsured patients. | |
| **Goal Status** | In FY24, Anna Jaques Hospital provided primary care in five practices in CBSA. | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |

| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Emmaus, Inc. Mitch's Place**<br>**Health Issue: Additional Health Needs Identified by the Community (Housing)** | | |
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| **Brief Description or Objective** | 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 access to services and job opportunities. | |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community-Wide Interventions | ☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal(s)** | At least 45 adult men and women (18 and older) who are receiving shelter and services at Mitch's Place will access permanent housing annually during the 2 year grant period (July 1, 2023 - June 30, 2024 and July 1, 2024 - June 30, 2025). | |
| **Goal Status** | In the first year of the grant period (July 1, 2023 - June 30, 2024), 48 Mitch's Place guests exited into permanent housing. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** |

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| **Program Goal(s)** | Mitch's Place individual shelter will provide overnight emergency shelter, food, and supportive services to at least 200 different adult men and women (18 and older) annually during the 2 year grant period (July 1, 2023 - June 30, 2024 and July 1, 2024 - June 30, 2025). | |
| **Goal Status** | Mitch's Place emergency overnight shelter for individuals, provided overnight emergency shelter, food and supportive services to 274 different adult men and women (18 and older) during the 1st grant period (July 1, 2023 - June 30, 2024). | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** |

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Nourishing the North Shore**<br>**Health Issue: Additional Health Needs Identified by the Community (Access to Healthy Foods)** | | |
| **Brief Description or Objective** | Nourishing the North Shore's (NNS) VEGOUT Program brings healthy, local produce to members in the community that often do not have access to these food choices. NNS 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. | |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community-Wide Interventions<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits | |
| **Program Goal(s)** | Between June 2024 - November 2024 Nourishing the North Shore's VEGOUT program will distribute over 70,000 pounds (280,000 servings) of local produce to food insecure community members through their network of 9 food access partners. | |
| **Goal Status** | The VEGOUT program has distributed over 47,500 pounds (190,000) servings of local produce to insecure community members through their network of 12 food access partners as of September 2024. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** |
| **Program Goal(s)** | Between June 2024 - November 2024 NNS will expand the VEGOUT program's reach through their partnership with Community Action Inc. (based in Haverhill, MA) by distributing 10 bulk deliveries of local produce (twice a month for 5 months), valued at $14,800. | |
| **Goal Status** | Nourishing the North Shore succeeded in achieving this goal. Through their partnership with Community Action Inc, the VEGOUT program introduced seasonal eating to over 80 low-income families, by providing 10 bulk deliveries of locally procured vegetables (valued at $14,800) at no cost to program participants. Between June 2024 and September 2024, Nourishing the North Shore staff packed and delivered over 2,686 pounds or 10,744 servings for fresh, local produce to Community Action Inc. staff who then distributed this fresh food through a choice style Community Supported Agriculture (CSA). Program participants also received educational materials about the produce and recipe ideas created by Nourishing the North Shore at each distribution. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** |

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| **Program Goal(s)** | Between November 2024-November 2025, Nourishing the North Shore will partner with 2 additional Essex County farms and increase the volume of produce delivered to current food access partners by 20%. | |
| **Goal Status** | Nourishing the North Shore has met this goal. In the 2024 season NNS partnered with over 30 local farmers (compared to the 13 local farmers who partnered with in 2023). NNS has expanded their capacity and volume distributing goals by providing low-income families and individuals with over 47,500 pounds of fresh, local produce so far this year—that's 190,000 servings, a 43% increase from this same time last year. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Outcome Goal** |

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Our Neighbors' Table Wednesday Meal**<br>**Health Issue: Additional Health Needs Identified by the Community (Access to Healthy Foods)** | | |
| **Brief Description or Objective** | Our Neighbors' Table's (ONT) Wednesday Meal is a free, 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. | |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community-Wide Interventions<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits | |
| **Program Goal(s)** | Operate and sustain weekly meal program for 250-300 low-income individuals, seniors, and families, providing approximately 300 meals per week through the funding period. | |
| **Goal Status** | ONT's Community Meal is on track to meet its SMART goal. The meal serves an average of 263 guests per week. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** |

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: YMCA Haverhill Freight Farm**<br>**Health Issue: Additional Health Needs Identified by the Community (Access to Healthy Foods)** | | |
| **Brief Description or Objective** | 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. | |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community-Wide Interventions<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits | |
| **Program Goal(s)** | The farm will educate the community about freight farming, nutrition, and farming. | |

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| **Goal Status** | There were three community education events/opportunities offered from April to September, reaching approximately 350 people. | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |
| **Program Goal(s)** | The farm will provide produce to students and individuals identified as food insecure, as well as local food pantries. | |
| **Goal Status** | Since April, the program has served 3,200 people. Of these, 90% were under 18 years of age, 61% were low-income, and 44% identified as Hispanic. The program served students at the Gateway Academy and YMCA Afterschool Programs, YMCA Summer Camp program and shared produce with Somebody Cares New England Food Pantry and Emmaus' Family Shelter. | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |
| **Program Goal(s)** | The farm will provide STEM and nutrition education opportunities to students. | |
| **Goal Status** | In collaboration with the Gateway Academy, 30 students aged 10-13 and 10 students aged 5-9 participated in STEM and nutritional activities during the school year and in afterschool programs. | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Haverhill PS McKinney Vento Program**<br>**Health Issue: Additional Health Needs Identified by the Community (Access to Healthy Foods)** | | |
| **Brief Description or Objective** | Haverhill Public Schools' McKinney Vento Program provides support for students and their families who are unhoused. Anna Jaques Hospital's support for the program assists with maintaining ongoing food resources within Haverhill schools, such as Haverhill High School's Backpack 68 program and school food closets. In addition, this funding will support creating an additional two school food closets and a small food pantry in the McKinney Vento Office. | |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community-Wide Interventions<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits | |
| **Program Goal(s)** | Enhance partnerships with five local organizations, agencies and food banks to help support the food closets/ pantries within Haverhill Public Schools. | |
| **Goal Status** | The McKinney Vento Liaisons have reached out to 5 local organizations to help support the food closet. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** |
| **Program Goal(s)** | Expand network of food resources in Haverhill Public Schools: Two new food closets will be added in schools by the end of December 2024. | |
| **Goal Status** | Two schools have been identified as a high priority and also have the capability to expand their food closet to not only meet the food insecurities but will also allow limited personal hygiene items. The first food closet will be open by November 2024 and the second by December 2024. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** |

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| **Program Goal(s)** | Connect McKinney Vento Students and their families, as well as other families within Haverhill Public Schools to our growing food resources within our schools. | |
| **Goal Status** | The schools have been able to identify families with food insecurity needs. The food programming will first expand to families without access to government assistance, such as EBT/SNAP benefits, including newcomers. Specific food and hygiene needs have also been assessed. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** |

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Common Ground Ministries: Feeding, Clothing, Caring**<br>**Health Issue: Additional Health Needs Identified by the Community (Access to Healthy Food)** | | |
| **Brief Description or Objective** | Common Ground Café is open 365 days a year to provide for the foundational needs for the unhoused and/or lower income population in the Haverhill area. The program provides food, clothing, hygiene products, resources, and care for this specific population. Common Ground collaborates with local service providers and the Haverhill police regularly to understand and address the needs of the unhoused population. | |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community-Wide Interventions | ☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal(s)** | Common Ground's goal is to provide foundational needs such as food, clothing, hygiene items, and security to the unhoused and lower income population. | |
| **Goal Status** | Common Ground has seen an increase in those served from about 60 to over 80 people per day during the last three months (July-September 2024). | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** |

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

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| | ☒ Total Population or Community-Wide Interventions | | |
| **Program Goal(s)** | Implement effective and efficient programs that support the community health needs of the Community Benefits Service Area. | | |
| **Goal Status** | Anna Jaques Hospital supported and implemented 15 programs through grants to local organizations. | | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** | |
| **Program Goal(s)** | Offer evaluation capacity workshops to partner organizations and grantees to better understand impact. | | |
| **Goal Status** | BILH offered two evaluation workshops to 30 organizations and grantees. 100% of organizations and grantees who attended were Satisfied or Very Satisfied with the workshops and 90% stated it was directly relevant to their role at their organization. | | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** | |

| **Priority Health Need: Mental Health and Substance Use**<br>**Program Name: Pettengill House BESST Program**<br>**Health Issue: Mental Health, Substance Use Disorders** | | |
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| **Brief Description or Objective** | The Behavioral Event and Substance Support Team (BESST) is an initiative to unite a broad network of local providers dedicated to breaking down barriers and providing substance misuse/behavioral health support for individuals and families of all ages. The BESST model takes an "upstream" approach to addressing urgent mental health and substance misuse challenges along with additional social determinants of health, identifying core needs and implementing systemic solutions rooted in best practices and person-centered care. | |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community-Wide Interventions<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits | |
| **Program Goal(s)** | Continue building upon positive relationships and collaborative efforts with healthcare partners including Anna Jaques Hospital, with BESST social worker providing visits to the hospital for patient care meetings, discharge care coordination and planning, collateral contact with hospital staff and care team, and bridge visits on a minimum weekly basis and as needed (104 visits within two-year grant period of May 1, 2024 - May 1, 2026). | |
| **Goal Status** | During the grant period 5/1/2024 through 9/30/2024, the Pettengill House BESST team received and responded to 33 referrals directly from a hospital or healthcare provider, which resulted in contact with the client, provider, and/or care team.<br><br>During the grant period, Pettengill House social workers participated in 48 hospital patient care meetings, and provided 26 OD/BHE/at-risk visits or follow-ups. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** |
| **Program Goal(s)** | Continue to host, facilitate, and manage a monthly BESST taskforce meeting (24 meetings within two-year grant period of May 1, 2024 - May 1, 2026), bringing a wide network of regional BESST partner providers together for | |

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| | collaborative case consultation, updates, and sharing of resources and expertise. Additional taskforce meetings and partner consultations will be facilitated as needed. | |
| **Goal Status** | During the grant period 5/1/2024 through 9/30/2024, Pettengill House BESST Coordinator has continued to facilitate a meeting of the broader network of BESST partners occurring once a month, with the exception of July, during which summer vacations presented a barrier for scheduling. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** |
| **Program Goal(s)** | Provide active outreach and care coordination to foster increased client engagement in services (evidenced by documentation of service provision within PGH's case management database) with the intention of improving greater stabilization and well-being for individuals and families struggling with mental health and/or substance misuse. | |
| **Goal Status** | During the grant period 5/1/2024 through 9/30/2024, 150 individuals were actively enrolled in BESST. In addition, there were 42 individuals who were documented as "unenrolled", as they were not actively engaged in the BESST program, but who had still received a BESST service. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** |

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| **Priority Health Need: Mental Health and Substance Use**<br>**Program Name: Link House Children and Teen Center for Help**<br>**Health Issue: Mental Health, Substance Use Disorders** | | |
| **Brief Description or Objective** | Link House, Inc. created CATCH (Children and Teen Center for Help) to address the growing unmet needs in the community for school-aged children and teens. The program goals include improving access to mental health and substance-use treatment and education and equitable access to an underserved population. | |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community-Wide Interventions<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits | |
| **Program Goal(s)** | To add a mental health clinician to at least one additional school in Link House's service area by 2025. | |
| **Goal Status** | CATCH currently has been welcomed into the Amesbury school system. For the time being, the work within schools will mainly be focused in Amesbury High School, Amesbury Innovation High School, and Amesbury Middle School based on our clinical availability. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Outcome Goal** |
| **Program Goal(s)** | To hire one additional clinician (total of 3) to increase Link House's capacity by Jan 1, 2025 | |
| **Goal Status** | Link House hired a new Outpatient Clinical Director and combined children's and adult's outpatient services into one location. CATCH has changed the focus to provide more services within the school system and community settings. Link House is limiting the number of CATCH clinicians to two full time until FY26: one clinician is school-based and one will be seeing patients in office. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Outcome Goal** |

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| **Program Goal(s)** | To provide increased mental health access to at least 10% more youth by 2025. | |
| **Goal Status** | At the close of FY24, CATCH saw 171 children of which 95 are active patients. In FY24 CATCH served 89 kids and their caretakers in "family consultations". CATCH will continue working to expand access to services for children in its catchment area and finding new ways to reach more children. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Outcome Goal** |

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| **Priority Health Need: Mental Health and Substance Use**<br>**Program Name: Wellness Delivered**<br>**Health Issue: Mental Health, Substance Use Disorders** | | |
| **Brief Description or Objective** | Wellness Delivered is a comprehensive behavioral health education program that is delivered in easily accessed public gathering spaces for low-resource populations in Haverhill, Salisbury, Amesbury, Newburyport, and Merrimac. This program expands the reach of Link House, Inc.'s (LHI) outpatient services by taking comprehensive behavioral health education programming "on the road" to meet the community where it lives. In addition, LHI's outreach will provide professional education for the public, educators, therapists, and others whose work intersects with those struggling with mental health. | |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community-Wide Interventions<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits | |
| **Program Goal(s)** | 100 community health and safety professionals including therapists, educators, and first responders will participate in CEU training sessions provided by LHI staff through four different two-hour programs, by April 1, 2027. | |
| **Goal Status** | Work on this goal is planned to begin in FY25. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** | **Goal Type: Outcome Goal** |
| **Program Goal(s)** | LHI will increase the number of people served in residential and outpatient programs by 5% by April 1, 2027. | |
| **Goal Status** | The program is evaluating whether it will be on track for a 5% increase by April 2027. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** | **Goal Type: Outcome Goal** |
| **Program Goal(s)** | LHI's professional staff will hold at least 15 sessions in the five project service areas to educate members of the public and connect them with the continuum of behavioral health care in the community, and to provide accessible continuing education to other professionals in the behavioral health care field by April 1, 2027. | |
| **Goal Status** | Wellness Delivered held two sessions in collaboration with local housing authorities during FY24. The program is in the process of scheduling additional sessions for FY25 and is on schedule to complete this goal on time. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** | **Goal Type: Outcome Goal** |

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| **Priority Health Need: Mental Health and Substance Use**<br>**Program Name: Jeanne Geiger Crisis Center Youth Empowerment Series**<br>**Health Issue: Mental Health** |

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| **Brief Description or Objective** | Jeanne Geiger Crisis Center's Youth Empowerment Services (YES) use research-based and nationally recognized approaches to educate girls, boys and students who are non-binary. These violence prevention programs teach elementary, middle and high school students how to lead conversations about healthy relationships, recognize signs of an abusive relationship, and become empowered to make positive and healthy decisions. |
| **Program Type** | ☐ Direct Clinical Services ☐ Access/Coverage Supports<br>☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits<br>☒ Total Population or Community-Wide Interventions |
| **Program Goal(s)** | The overall goal for this funding is to provide school- and community-based prevention programming to youth in Amesbury, Newburyport, and Haverhill. The participants will be students from elementary to high school age. The program will expand its reach by 25% – adding an incremental 100 to 150 participants above and beyond the roughly 580 served last year by these programs in these communities. |
| **Goal Status** | Over the summer of 2024 YES had three week-long Girls Inc summer programs. While the reach was slightly lower than expected (27 individuals), the programs were rich and fulfilling for all participants. YES is busy planning for the 2024-2025 school year with their partners in Amesbury, Newburyport and Haverhill. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** \| **Goal Type: Outcome Goal** |

| **Priority Health Need: Mental Health and Substance Use**<br>**Program Name: Patient Care Navigator**<br>**Health Issue: Mental Health, Substance Use Disorders** | |
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| **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 9.1 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 supports 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 ☐ Access/Coverage Supports<br>☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits<br>☐ Total Population or Community-Wide Interventions |
| **Program Goal(s)** | Support patient sobriety and encourage positive coping skills to prevent substance use disorder, by setting individualized 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** | In FY24, the Patient Care Navigator served 285 women either in recovery and seeking additional support, who have suffered from trauma or abuse, or who have been diagnosed with mental health disorders. |

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| | The Birth Center served a total of 597 women in FY24, therefore almost 50% of patients were deemed "high risk" due to anxiety/depression, substance use, or other social determinants of health. This is similar to the numbers served in 2023, an increase from FY22, and almost double the number of patients in FY21.<br><br>In FY24, a warm handoff program was created with Thom Pentucket Early Intervention. This serves to ensure that any baby who qualified for services had the opportunity to meet a program representative during their hospital stay and complete intake paperwork ahead of discharge. |

| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |
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| **Priority Health Need: Mental Health and Substance Use**<br>**Program Name: Behavioral Health Crisis Consultation**<br>**Health Issue: Mental Health, 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 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<br>☐Community Clinical Linkages<br>☐Total Population or Community Wide Intervention<br>☐Access/Coverage Supports<br>☐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 providing a total of 1,377 screens. |

| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |
|---|---|---|

| **Priority Health Need: Mental Health and Substance Use**<br>**Program Name: Beth Israel Lahey Health Collaborative Care Model**<br>**Health Issue: Mental Health, Substance Use Disorders** | |
|---|---|
| **Brief Description or Objective** | BILH provides a range of behavioral health, substance use, and addiction recovery services and counseling for adults, youth and families including inpatient and outpatient psychiatry, outreach and community services.<br><br>Collaborative Care Model (CoCM) has been adopted in BILH Primary Care practices to provide behavioral health services in the primary care setting. 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 |

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| | psychiatrist may advise the primary care provider on medications that may be helpful. |
| **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 behavioral health services. |
| **Goal Status** | AJH offered this collaborative care model in three locations, Amesbury (2) and Haverhill (1), and served a total of 83 patients in FY24.<br><br>In FY24 AJH offered 7,953 office- and outreach-based sessions in Haverhill, serving 402 patients. |

| | | |
|---|---|---|
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |

| **Priority Health Need: Mental Health and Substance Use**<br>**Program Name: BILH Behavioral Health Access Initiative**<br>**Health Issue: Mental Health, Substance Use Disorder, and Additional Health Needs (Access to Care)** | |
|---|---|
| **Brief Description or Objective** | To support increased access to mental health and substance use services and supports, Anna Jaques Hospital participated with other BILH hospitals to pilot Behavioral Health Navigator grant programs, offer Mental Health First Aid (MHFA) trainings, provide behavioral health navigation and digital literacy trainings to BILH physical health navigators and amplify anti-stigma messaging, resources and supports. |
| **Program Type** | ☐ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒ Total Population or Community-Wide Interventions |
| **Program Goal(s)** | Increase knowledge and awareness of available behavioral health services and supports among clinical and non-clinical staff who provide patients/clients with physical and/or social determinants of health navigation services. |
| **Goal Status** | 28 BILH, Community Health Center, and Community Behavioral Health Center staff were trained. Trainees reported a 35% increase in identifying the essential elements of the behavioral health treatment systems of care; a 49% increase in feeling confident they can navigate patients to the appropriate level of behavioral health care, including outpatient, self-help, hotlines, and helplines; a 26% increase in feeling comfortable using different ways to promote patient engagement and activation; and a 37% increase in explaining the process of referrals to agencies. |

| | | |
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| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** |

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|---|---|
| **Program Goal(s)** | Offer Mental Health First Aid (MHFA) training to community residents and BILH staff across the BILH Community Benefits Service Area (CBSA). |
| **Goal Status** | More than 350 community residents and BILH staff attended one of 21 MHFA trainings provided across the BILH CBSA, of which 75% (274) completed all pre- and post-training requirements to receive Mental Health First Aid certification. |

| | | |
|---|---|---|
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Outcome Goal** |

| | | |
|---|---|---|
| **Program Goal(s)** | Support Grantees in creating a 3-year logic model and evaluation plan for development and implementation of their Behavioral Health Navigator program. | |
| **Goal Status** | All four grantees worked with both BILH Director of Evaluation and Data and external evaluator to develop logic model and evaluation plan and are in the process of hiring and onboarding their Behavioral Health Navigator. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |

| | | |
|---|---|---|
| **Priority Health Need: Complex and Chronic Disease**<br>**Program Name: Sarah's Place Adult Health Center, Inc.**<br>**Health Issue: Chronic Disease, Additional Health Needs Identified by the Community (Access to Care)** | | |
| **Brief Description or Objective** | Sarah's Place Adult Day Health Center provides medical oversight and assistance with activities of daily living while promoting a sense of purpose and a community of caring for participants. With increased awareness, access to adult day health program keeps aging adults healthy and independent in the community. Anna Jaques Hospital's grant funding supports bilingual outreach to provide education about the resources and benefits of adult day health programs. | |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community-Wide Interventions<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits | |
| **Program Goal(s)** | By September 2024, Sarah's Place will reach out to area senior/elder housing communities in Haverhill, Amesbury, Newburyport, Merrimac, and Salisbury to schedule planned visits to provide onsite education and literature to increase awareness of adult day health programs. | |
| **Goal Status** | Sarah's Place has visited 4 senior residences in Haverhill: Judson House, Mission Towers, Hadley West and Merrivista. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** |
| **Program Goal(s)** | By May 2025, Sarah's Place will visit a minimum of 12 senior/elder independent housing communities to provide education about the benefits of adult day services to individuals who are dealing with chronic and/or progressive health issues and their family members/caregivers. | |
| **Goal Status** | Sarah's Place has visited 4 senior housing sites and met with 15 - 40 residents at each location. The have provided outreach, education and awareness of Adult Day Health (ADH) programs in English and Spanish. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** |
| **Program Goal(s)** | By May 2025, Sarah's Place will have increased its Latino population to 15% of enrolled participants. | |
| **Goal Status** | This goal remains in process. Sarah's Place has increased its Latino staff by 10%. With continued outreach by bilingual staff, Sarah's Place hopes to attain its goal of increasing the Latino participant population. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Outcome Goal** |

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|---|
| **Priority Health Need: Complex and Chronic Disease**<br>**Program Name: AJH "Baby and Me" Classes** |

| **Health Issue: Chronic Disease, Mental Health/Mental Illness, Additional Health Needs Identified by the Community (Access to Healthy Food)** | | |
|---|---|---|
| **Brief Description or Objective** | Anna Jaques offers free support groups to all birthing parents within the community. These groups help to answer questions that may arise throughout the parenting journey and provide support, encouragement, and advice. These groups are facilitated by a Birth Center Lactation Consultant/Registered Nurse to support every person's parenting experience. The program lead also has a certification in Perinatal Mental Health from PSI International, to help serve the emotional needs of the birthing parents.<br><br>The CDC recommends breast feeding to reduce the risk of some chronic diseases, such as asthma, obesity, and Type 1 diabetes. In addition, breast feeding can also lower the risk for the mother to have high blood pressure, Type 2 diabetes, as well as breast and ovarian cancers. A person does not need to be breastfeeding/chest feeding to enjoy this group. All aspects of parenting are discussed. Guest speakers present periodically on topics such as car seat safety, infant nutrition, and infant growth and development. Weekly classes are offered in both Newburyport and Haverhill. | |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community-Wide Interventions | ☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal(s)** | Support new parents and their infants with parenting information, local resources, lactation/feeding consultation, and peer-to-peer support to reduce parental stress/anxiety and strive for proper infant nutrition. | |
| **Goal Status** | The program is free of charge and functions as a drop-in program. In Newburyport, the program averaged 10 parents weekly. In Haverhill, the program has approximately five parents per week participate. | |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** | **Goal Type: Process Goal** |

| **Priority Health Need: Complex and Chronic Disease**<br>**Program Name: North of Boston Cancer Resource**<br>**Health Issue: Chronic Disease, Mental Health/Mental Illness** | | |
|---|---|---|
| **Brief Description or Objective** | The North of Boston Cancer Resource (NBCR) offers support and education to people affected by cancer from diagnosis, through treatment and beyond. Through the Gift Certificate/Voucher Program they fund supportive services from their resource guide to recipients. Services include oncology massage, manual lymph drainage, acupuncture, reiki, personal training, yoga therapy, guided imagery, health coaching and nutrition counseling. Through their monthly Speaker Series, NBCR provides information and that promotes empowerment through knowledge and self-care. | |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community-Wide Interventions | ☐ Access/Coverage Supports<br>☐ 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 sessions for 240 attendees. In addition, | |

| | | |
|---|---|---|
| | NBCR supported 226 sessions of complementary care for those impacted by cancer, including 99 sessions of oncology massage, 70 sessions of manual lymph drainage and 37 sessions of acupuncture. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** | **Goal Type: Process Goal** |

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|---|---|---|
| **Priority Health Need: Complex and Chronic Disease**<br>**Program Name: Haverhill Farmer's Market**<br>**Health Issue: Chronic Disease, Additional Health Needs Identified by the Community (Access to Healthy Food)** | | |
| **Brief Description or Objective** | 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, baked and prepared foods, and handcrafted goods. Several vendors accept payment from the Supplemental Nutrition Assistant Program (SNAP) and Women, Infants, and Children (WIC) helping lower income families access locally grown fresh produce. The market is accessible by free, public transportation. | |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community-Wide Interventions<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits | |
| **Program Goal(s)** | Increase access to fresh produce and healthy food options. | |
| **Goal Status** | The Haverhill Farmers' Market hosted markets weekly from June through October 2024. Farmers' markets are crucial in providing fresh local produce and healthy food options. This year Haverhill Farmers' Market had over 50 vendors joining, the largest amount to date. One new vendor was the Haverhill Farmers' market's first certified organic farm, who accepts SNAP, WIC, and EBT. Lower income families are now able to purchase organic produce at the market. To maintain access, Merrimack Valley Transit provided service from downtown to the market every hour. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** | **Goal Type: Process Goal** |

| | | |
|---|---|---|
| **Priority Health Need: Complex and Chronic Disease**<br>**Program Name: YWCA Newburyport Encore and After Encore**<br>**Health Issue: Chronic Disease** | | |
| **Brief Description or Objective** | Encore and After Encore is a unique survivorship program for those who have experienced cancer at any point in their lives. The program provides free access to a tailored exercise program, incorporating land and water exercises appropriate for all fitness levels at any point in their treatment journey and beyond. Encore supports the YWCA's mission and provides accessible health and wellness goals for the cancer community. | |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community-Wide Interventions<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits | |
| **Program Goal(s)** | The goal of the Encore program is to empower participants to share their experiences and concerns and to reclaim their physical stamina and resume activities and exercise in an inviting, safe and social environment. | |

| | | |
|---|---|---|
| **Goal Status** | The program had 48 participants in 2024, 99% of which were women. The program welcomed an average of 2-3 new participants per month. 79% of the attendees participated more than once per week. | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** | **Goal Type: Process Goal** |

# SECTION V: EXPENDITURES

| Item/Description | Amount |
|---|---|
| **CB Expenditures by Program Type** | |
| Direct Clinical Services | $6,985,270 |
| Community-Clinical Linkages | $47,046 |
| Total Population or Community Wide Interventions | $172,449 |
| Access/Coverage Supports | $267,814 |
| Infrastructure to Support CB Collaborations | $10,455 |
| Total Expenditures by Program Type | $7,483,034 |
| **CB Expenditures by Health Need** | |
| Chronic Disease | $3,019,543 |
| Mental Health/Mental Illness | $2,641,649 |
| Substance Use Disorders | $496,161 |
| Housing Stability/Homelessness | $10,227 |
| Additional Health Needs Identified by the Community | $1,315,454 |
| Total Expenditures by Health Need | $7,483,034 |
| **Leveraged Resources** | |
| Total Leveraged Resources | $851,747 |
| **Net Charity Care Expenditures** | |
| HSN Assessment | $697,205 |
| Free/Discounted Care | $0 |
| HSN Denied Claims | $608,508 |
| Total Net Charity Care | $1,305,713 |
| **Total CB Expenditures** | $9,640,494 |

| Additional Information | |
|---|---|
| Net Patient Services Revenue | $137,070,539 |
| CB Expenditure as % of Net Patient Services Revenue | 7.03% |
| Approved CB Budget for FY25 (*Excluding expenditures that cannot be projected at the time of the report) | $8,131,039 |
| Bad Debt | $1,683,521 |

| | |
|---|---|
| **Bad Debt Certification** | **Yes** |
| **Optional Supplement** | |
| **Comments:**<br>**Statewide CHI Fund Payment for AJH Tier 1 CT Scanner** | **$10,082** |

# SECTION VI: CONTACT INFORMATION

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# SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

**Hospital Self-Assessment Update Form – Years 2 and 3**

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

## I. Community Benefits Process:

- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? ☒ Yes ☐ No
  - If so, please list updates:

Anna Jaques Hospital added the following members in FY24:

- Noah Berger, Administrator, Merrimack Valley Transit
- Lynn Catarius, Director of Student Services, Amesbury Public Schools
- Rosa Conn, Newburyport Resident
- Dianne Connolly, Director of Title I and Community Outreach, Haverhill Public Schools
- Mary Connolly, RN, COA Director/Public Health Director, City of Haverhill
- Tina Los, Associate Director, Services and Supports, Newburyport Youth and Recreational Services/Essex County Asset Builders
- Lauri Murphy, BESST Coordinator, Pettengill House
- Laura Vlasuk, Director of Public Health, City of Newburyport
- Dr. Timothy Pike, Associate Chief Medical Officer, Anna Jaques Hospital

The following members stepped off the off the committee in FY24:

- Lynn Catarius, Director of Student Services, Amesbury Public Schools
- Andrea Egmont, Director, Newburyport Youth and Recreational Services
- Michael McCarthy, Vice President of Philanthropy, Anna Jaques Hospital
- Tiffany Nigro, Executive Director, Pettengill House.
- Jean Trim, Anna Jaques Hospital Board of Trustees Representative

## II. Community Engagement

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

| **Organization** | **Name and Title of Key Contact** | **Organization Focus Area** | **Brief Description of Engagement** (including any decision-making power given to organization) |
|---|---|---|---|
| Link House | Christine Turner, Executive Director | Behavioral health and mental health organizations | Link House is an important community partner and grantee of Anna Jaques Hospital. In FY24, Link House received a grant to implement Wellness Delivered throughout AJH's Community Benefits Service Area. This program will provide comprehensive behavioral health education for low-resource populations. In addition, AJH supports Link House's CATCH program, which provides individual and family mental health services for youth ages 5-18 years. Finally, Link House is an active participant in the Behavioral Event and Substance Support Team (BESST) which works collaboratively with AJH's emergency department, ICU, cancer unit, and on-site psychiatric unit. |
| Haverhill Public Schools | Maria Maldonado Cruz, McKinney Vento Liaison/Foster Care Point of Contact | Schools | AJH funded the Haverhill Public Schools McKinney Vento program for the first time in FY24 to provide additional food resources to unhoused children and their families over two years. This program will be opening food closets in two public schools Haverhill. In addition, AJH has strengthened its relationship with the Haverhill Public Schools in FY24 by inviting the Director of Title I and Community Outreach to join the Community Benefits Advisory Committee and sit on a grant allocation committee. |

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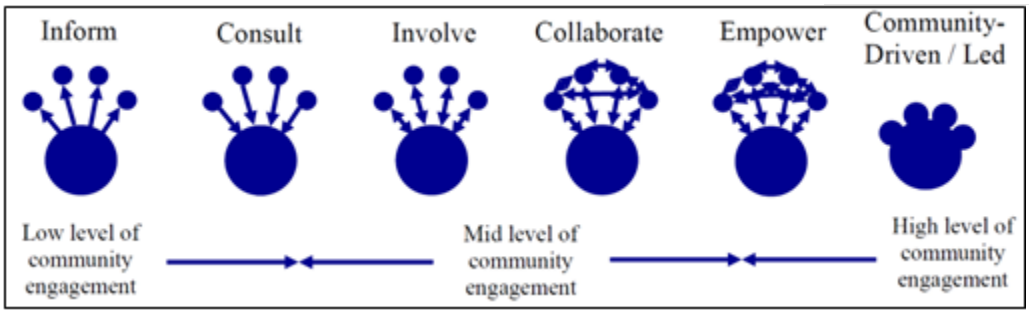
| | | | Finally, the Haverhill Public Schools distributed the FY25 Community Health Needs Assessment survey link to parents and shared the link on social media. |
| Merrimack Valley Transit (MeVa) | Noah Berger, Administrator | Other | In FY24, the Administrator of MeVa joined Anna Jaques Hospital CBAC. Public transportation is crucial to maintain access to care throughout AJH's CBSA. In the spring of 2024, MeVa and AJH worked together to move the public bus stop to the hospital's main entrance from a non-handicap-accessible location. In addition, AJH wrote a letter of support for MeVa's application for funding to increase free bus service between Lawrence, Haverhill, and Newburyport. This funding was approved, and the bus service began in September 2024. MeVa has also provided travel training to AJH's Pain Center staff. The success of this training was cited in a funding application by MeVa to expand this type of training throughout the region. Finally, MeVa assisted with the FY25 Community Health Needs Assessment by promoting the survey link in the bus stations and via electronic monitors on the bus. |

2. Please use the spectrum below from the Massachusetts Department of Public Health1 to assess the hospital's level of engagement with the community in implementing its plan to address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.




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

  N/A

2) 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 September 12, 2024 from 1-2:30PM at Anna Jaques Hospital 25 Highland Ave in Newburyport, MA. Twenty people attended the meeting.

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

      Anna Jaques Hospital's Community Health Needs Assessment includes comprehensive collection and review of primary and secondary data sources. Secondary data sources include March of Dimes, MDPH, National Center for Health Statistics. Data specific to maternal health are included in the hospital's data table under "Reproductive Health" and include low birth weight (%), mothers with late or no prenatal care (%), births to adolescent mothers (%), mothers receiving publicly funded pre-natal care (%) as well as data on screening for post-partum depression. In addition to secondary data capture and review, throughout the CHNA Anna Jaques Hospital engages with the community to collect primary data on priorities identified by community residents. This is through a community survey as well as focus groups.

   b) How have you measured the impact of your Community Benefits programs and what challenges have you faced in this measurement? (150-word limit)

      Anna Jaques Hospital partners with Thom Pentucket Early Intervention on maternal health initiative(s) and has done so since January of 2024. Additionally, Anna Jaques Hospital is a member of Beth Israel Lahey Health, which, as a system is working to address maternal health equity. Beth Israel Lahey Health established its Maternal Health Quality and Equity Council (MHQEC) in September of 2023. The Council's objective is to improve maternal health outcomes and eliminate inequities in care, with an overarching aim to reduce the occurrence of maternal morbidity and mortality. The Council is comprised of representatives from all of the BILH hospitals providing maternity services, as well as BILH leadership, including BILH Health Equity system leadership. BILH's Chief Clinical Officer serves as the Executive Sponsor. FY 24 was the Council's inaugural year and MHQEC established initial goals related to Equitable Access to Doulas & Midwifery, Perinatal Mental Health, and Severe Maternal Morbidity. Additionally, BILH established a health equity goal beginning in FY 25 – a year over year improvement in maternal transfusion rate (the goal is to reduce disparities in maternal transfusion rates measured at the system level).

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

Anna Jaques Hospital currently works with Thom Pentucket Early Intervention. Anna Jaques Hosptial's maternal health work will be guided by the MHQEC and Anna Jaques Hospital looks forward to spreading this work and collaborating with its myriad of long-standing community partners in pursuit of maternal health equity.

## III. Updates on Regional Collaboration

1. If the hospital reported on a collaboration in its **Year 2 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 9 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.

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 2 Hospital Self-Assessment Form**.

N/A