Community Benefits Report

Fiscal Year 2023

Beth Israel Lahey Health
Anna Jaques Hospital

Beth Israel Lahey Health

TABLE OF CONTENTS

SECTION I: SUMMARY AND MISSION STATEMENT

Anna Jaques Hospital 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*
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- ***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 Anna Jaques Hospital'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 Anna Jaques Hospital'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 Anna Jaques Hospital'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 Anna Jaques Hospital is honoring its commitment and includes information on Anna Jaques Hospital'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 Chronic/Complex Conditions

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 Anna Jaques Hospital'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 Anna Jaques Hospital's FY 2022 Community Health Needs Assessment (CHNA) and FY 2023-2025 Implementation Strategy (IS):

- The YMCA Haverhill Freight Farm, funded with seed money from Beth Israel Lahey Health, became fully operational in July, and served 1,040 people, of which 90% were children.
- Anna Jaques Hospital (AJH) increased access and support for new parents by establishing a "Welcome Visit" program through its Birth Center. This visit prepares for delivery, with targeted outreach to those who fall into high-risk categories and the most vulnerable patients. In addition, AJH resumed its in-person, free "Baby and Me" classes to support parents of infants in the community in both Newburyport and Haverhill.
- Anna Jaques supported the YWCA Greater Newburyport's Encore and After Encore program, a tailored exercise program for cancer survivors, in which 85% of those who attended regularly experienced an increase in functional movements, range of motion, strength, balance, and overall mental state.
- Anna Jaques Hospital supported Emmaus, Inc. Mitch's Place, an emergency overnight shelter, which expanded its bed capacity in response to the growing number of unsheltered men and women identified during the 2023 homeless count in Haverhill.
- Anna Jaques Hospital supported the Pettengill House's Behavioral Event and Substance Support Team (BESST) program, which was able to respond to the increased mental health and substance related needs. The program saw referrals increase 48.6% and corresponding services, referrals, interventions, and assessments offered to BESST clients reached an all-time high.

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 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. In response to the FY 2022 CHNA, Anna Jaques Hospital 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 Anna Jaques Hospital'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). Anna Jaques Hospital's priorities are also aligned with the priorities identified by the Massachusetts Department of Public Health (DPH) to guide the Community-based Health Initiative (CHI) investments funded by the Determination of Need (DoN) process, which

underscore the importance of investing in the Social Determinants of Health (i.e., built environment, social environment, housing, violence, education, and employment).

The FY 2022 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions being used to inform and refine Anna Jaques Hospital's efforts. In completing the FY 2022 CHNA and FY 2023 - 2025 IS, Anna Jaques Hospital, 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 Anna Jaques Hospital'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, Anna Jaques Hospital'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.

Anna Jaques Hospital partners with dozens of community-based organizations and service providers, including public agencies, social services providers, community health organizations, academic organizations, and businesses throughout its CBSA to execute its FY 2023 – 2025 IS.

- **Equitable Access to Care**
  - Anna Jaques Hospital supported 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 provided support for Our Neighbors' Table and Nourishing the North Shore, who increased access to healthy food and meals in the hospital's CBSA.

- **Mental Health and Substance Use**
  - Anna Jaques Hospital supported the CATCH (Children and Teen Center for Help) Program at Link House to increase access to mental health and substance-use treatment and education for school-aged children and teens.

- **Complex and Chronic Conditions**

- Anna Jaques Hospital supported the YMCA Cornerstone Program which provides a free YMCA membership and a week of summer camp to support cancer survivors and their families.

Hospital Self-Assessment Form
Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), the Anna Jaques Hospital Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 54). The Anna Jaques Hospital Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members who participated in Anna Jaques Hospital's CHNA 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. Anna Jaques Hospital'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 to meet its Community Benefits obligations. Hospital senior leadership is actively engaged in the development and implementation of the Anna Jaques Hospital's Implementation Strategy, ensuring that hospital policies and resources are allocated to support planned activities.

The Anna Jaques Hospital Community Benefits program is spearheaded by the 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 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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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.

AJH is committed to being an active partner and collaborator within the communities it serves. In 2019, as part of a merger of two health systems in the greater Boston region, AJH became part of Beth Israel Lahey Health (BILH) - a system of academic medical centers, teaching hospitals, community hospitals, and specialty hospitals with more than 35,000 caregivers and staff who are collaborating in new ways across professional roles, sites of care, and regions to make a difference for patients, communities, and one another. AJH, in partnership with the BILH system, is committed to providing the very best care and strives to improve the health of the people and families in its Community Benefits Service Area (CBSA).

The Anna Jaques Hospital CBAC met on the following dates:

- December 13, 2022
- March 21, 2023
- June 29, 2023
- October 4, 2023 (Public Meeting)

Community Benefits Advisory Committee Members

- Michelle Braiser, Practice Manager, Beth Israel Lahey Primary Care – Haverhill
- Andrea (Andi) Egmont, City of Newburyport, Newburyport Youth Services/The BEACON Coalition, Director
- Tracy Fuller, Regional Executive Director, Haverhill YMCA
- Ilene Harnch-Grady, YWCA of Newburyport, Encore Program Leader
- Stephany Infante, Greater Lawrence Family Health Center
- Tina Los, Essex County Asset Builder Network, Project Coordinator
- Tiffany Nigro, Executive Director, The Pettengill House
- Officer Dani Sinclair, Newburyport Police, Detective
- Jean Trim, Managing Director & Portfolio Manager, Vigilant Capital Management, LLC; AJH Board of Trustee Member
- Shari Wilkinson, The Newburyport Farmers Market, Market Coordinator

Hospital Representation

- Janel D'Agata-Lynch, Manager of Community Benefits & Community Relations
- Glenn Focht, M.D., President, Anna Jaques Hospital
- Christine Healey, Director of Community Benefits, North Region, Beth Israel Lahey Health Representative
- Sandra Levin, Vice President Support Services, Chief Quality Officer, Patient Safety Officer, Anna Jaques Hospital
- Michael McCarthy, Vice President Philanthropy, Anna Jaques Hospital

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 54).

- Emmaus, Inc.
- Essex County Asset Builder Network
- Essex County Outreach
- Family Services of the Merrimack Valley
- Greater Newburyport Village
- Haverhill Farmers Market/Creative Haverhill
- Link House, Inc.
- New England Elder Transportation
- Newbury Food Pantry
- Newburyport DEI Alliance
- Newburyport Farmers' Market
- Newburyport Recreation and Youth Services
- North of Boston Cancer Resource
- Northern Essex Elder Transport
- Nourishing the Northshore Our Neighbors' Table
- The Pettengill House
- Regional Social Services Collaborative
- Rotary Club of Newburyport
- 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 2023 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

Priority Health Need: Equitable Access to Care **Program Name: Northern Essex Elder Transport (NEET)** **Health Issue: Additional Health Needs (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. The mission is to provide dependable and compassionate transportation assistance to older adults, ensuring they can access vital medical appointments with ease. Through a dedicated team of volunteer drivers, NEET aims to bridge the transportation gap and alleviate the challenges faced by older adults in reaching healthcare services. NEET 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. They strive to create a supportive and caring environment where older adults feel valued and respected.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to medical care for older adults who have transportation barriers.	
Goal Status	In fiscal year 2023, 436 unique individuals received transportation to medical care resulting in 3,643 free rides provided by NEET volunteers. In fiscal year 2023, NEET volunteers drove 68,454 miles, a 30% increase from the year prior.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Interpreter Services** **Health Issue: Additional Health Needs (Access)**

Brief Description or Objective	An extensive body of research illustrates the health disparities and differences in health care access and utilization that exist for diverse individuals/cohorts and foreign-born populations. Language barriers pose significant challenges to providing effective and high-quality health and social services. To address this need, and in recognition that language and cultural barriers are major difficulties to accessing health and social services and navigating the health system, AJH offers interpreter/translation services for non-English speaking and deaf patients at no cost.		
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	Increase access to translation services at no cost to the AJH patients.		
Goal Status	AJH Interpreter Services supported 1,487 interpreter service sessions with limited English proficiency/in need of patient interpreter services in FY23. Spanish and Portuguese are the most requested languages. AJH interpreter service offered hundreds of language translations as needed.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Equitable Access to Care **Program Name: Transportation Services** **Health Issue: Additional Health Needs (Access)**		
Brief Description or Objective	To support vulnerable communities and limit barriers so patients receive the care they need, AJH Case Management Department has an emergency fund to provide transportation reimbursement to patients who have limited resources and social support. This program is offered to any patient who meets the criteria of need decided by a social worker. The social worker advocates for the patient to ensure the appropriate financial support. They also work to refer patients to financial coordinators to assist patients with applications for Medicaid or disability; they work with primary care physicians or free clinics to ensure medical follow-up and extend referrals to other needs.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to transportation support or provide transportation reimbursement to patients who are uninsured or have limited resources.	
Goal Status	AJH distributed $7,200 of emergency funds to approximately 240 patients in FY23.	

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

Priority Health Need: Equitable Access to Care **Program Name: Patient Financial Counseling** **Health Issue: Additional Health Needs (Access)**	
Brief Description or Objective	The extent to which a person has health insurance that covers or offsets the cost of medical services coupled with access to a full continuum of high-quality, timely, accessible health care services have been shown to be critical to overall health and well-being. Access to a usual source of primary care is particularly important because it greatly impacts one's ability to receive preventive, routine, and urgent care, as well as chronic disease management services. Despite the overall success of the Commonwealth's health reform efforts, information captured for this assessment shows that while the vast majority of the area's residents have access to care, significant segments of the population, particularly low-income and racial/ethnic minority populations, face significant barriers to care. These groups struggle to access services due to lack of insurance, cost, transportation, cultural/linguistic barriers, and a shortage of providers willing to serve Medicaid-insured or uninsured patients. To address these gaps, AJH employs two full-time, certified financial counselors who can screen patients and assist them in applying for state aid. They also provide estimates for the patient's financial responsibility (copay, deductible, coinsurance, self-pay).
Program Type	☐ Direct Clinical Services ☒Access/Coverage Supports ☐Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐Total Population or Community Wide Intervention
Program Goal(s)	Meet with patients who are uninsured or underinsured to assess their eligibility for and align them with state financial assistance and hospital-based financial assistance programs. Facility-based Financial Assistance and Presumptive Eligibility: Financial Coordinators work with patients who have been denied state assistance to see if they qualify for facility-based financial assistance or presumptive eligibility.
Goal Status	Total applications for FY23: 156 There were 15 Financial Assistance and 0 extension applications processed and approved. Age Groups • 0-17 1 • 18-35 37

	• 36-53 39 • 54-70 60 • 71-107 19		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Equitable Access to Care **Program Name: "Welcome Visits" at Anna Jaques Hospital** **Health Issue: Additional Health Needs (Access)**			
Brief Description or Objective	The AJH Birth Center started a "Welcome Visit" program in January of 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. Transportation assistance is given, if needed. The visit is free of charge and provides education on infant feed and preparing for labor and delivery, as well as opportunity to fill out paperwork ahead of time, tour the unit, and meet the team who will be caring for them in the hospital.		
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	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 130 "Welcome Visits" with patients in FY23.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Equitable Access to Care **Program Name: BILH Office of Diversity, Equity, and Inclusion** **Health Issue: Additional Health Needs (Access)**			
Brief Description or Objective	BILH's Diversity, Equity, and Inclusion (DEI) office 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 ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐Infrastructure to Support Community Benefits	

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. Increase spend with diverse businesses by 25% over the previous fiscal year across the system. Expand system-wide DEI learning, in alignment with enterprise learning management solution. Support creation or expansion of local DEI committees/resource groups.	
Goal Status	Across BILH there was a 25% increase in BIPOC leadership (directors and above) and clinical (physicians and nurses) hires over FY22. More than $50 million was contracted to Women and Minority-owned Business Enterprises (WMBE) in FY23. This is a 22% increase over FY22. 8 system-wide DEI trainings were conducted for all BILH staff and hospitals. Anna Jaques Hospital is forming a Diversity, Equity and Inclusion Council to guide the hospital's efforts to nurture and sustain a diverse, equitable and inclusive organizational culture – and to make meaningful and lasting change for our patients, our employees and our communities.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: BILH Workforce Development** **Health Issue: Additional Health Needs (Access)**	
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 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 ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	In FY23, Workforce Development will continue to encourage community referrals and hires. In FY23, Workforce Development will attend events and give presentations about employment opportunities to community partners. In FY23, Workforce Development will offer internships in BILH hospitals to community members over the age of 18. In FY23, Workforce Development will hire interns hired after internships and place in BILH hospitals. In FY23, Workforce Development will offer English for Speakers of Other Languages (ESOL) classes to BILH employees.	
Goal Status	In FY23, 225 job seekers were referred to BILH and 70 were hired across BILH hospitals. In FY23, 67 events and presentations were conducted with community partners across the BILH service area. In FY23, 54 community members placed in internships across BILH hospitals to learn valuable skills. Anna Jaques Hospital participated in offering these internships. In FY23, 22 interns were hired permanently in BILH hospitals. Anna Jaques Hospital participated in these hirings. In FY23, 45 employees across BILH were enrolled in ESOL classes. Anna Jaques Hospital employees participated in these classes.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: YWCA Newburyport Affordable Housing** **Health Issue: Additional Health Needs (Access to Food)**	
Brief Description or Objective	The YWCA Affordable Housing program focuses on the lowest-income households and households who have experienced homelessness. All households are below 60% of the Area Median Income. Households with incomes below 80% AMI are considered low income. At the Residences at Salisbury Square (RSS) site, 20 of 42 units are currently housing families whose income is at or

	below 30% of Area Median (which is considered extremely low income); 20 of 42 units are serving formerly homeless households; and three of the households have persons with disabilities, which would put them at risk of being in a nursing home or similar institution if they did not have this housing.		
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	Increase access to healthy, fresh food for low-income individuals and families living in three affordable housing programs.		
Goal Status	This program assisted approximately 100 tenants in FY23. The majority of produce went to the Residences at Salisbury Square (RSS) where all 42 households were able to receive produce from this program. Most of these households are families with children. Produce was also shared with households at YWCA at Hillside serving 10 individuals and YWCA Women's Residence serving 10 individuals.		
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**	

Priority Health Need: Social Determinants of Health **Program Name: Nourishing the North Shore VEGOUT Program** **Health Issue: Additional Health Needs (Access to Food)**		
Brief Description or Objective	Nourishing the North Shore combines excess produce from local farms with food that is grown in their garden and distributes produce directly through the community's food access agencies as well as NNS-run Farmers' Market style produce stands. VEGOUT is Nourishing the North Shore's (NNS) core food distribution program, providing thousands of pounds of free local produce to Northeast Essex County residents through partnerships with area food pantries and NNS' mobile markets. The target population is low-resourced and low-income people experiencing food insecurity.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to healthy, local produce, delivered through dignified means.	
Goal Status	NNS served approximately 1,000 unique households through community partners. Approximately 150 individuals were served through NNS weekly mobile markets, which run June-October. Seniors were one of NNS' focus populations. NSS partnered with the Newburyport Senior Center to host a mobile market, and	

	in addition NNS worked with the Newburyport Council on Aging to transport fresh produce to residents living in senior residences in Newburyport.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Emmaus, Inc.'s Mitch's Place Emergency Shelter** **Health Issue: Housing Stability**		
Brief Description or Objective	Mitch's Place is the primary point of entry for homeless individuals into an integrated network of services under one roof. Mitch's Place currently provides emergency shelter, nutritious meals, and needed support services nightly to 40 homeless men and women year-round and up to 45 individuals during the severe weather emergencies. Mitch's Place recently (April 1, 2023) increased its capacity from 30 individuals nightly to 40 in order to better meet the need for emergency shelter in the community. Mitch's Place targets both those who need temporary emergency shelter on a short-term basis as well as chronically homeless men and women. The individuals seeking shelter at Mitch's Place are extremely low-income and most struggle with chronic health problems, substance abuse, and/or mental illness.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	The primary goal is to save lives by providing critically-needed overnight emergency shelter, meals, housing search assistance, and referrals to support services to 40 homeless individuals nightly and approximately 250 individuals annually.	
Goal Status	Of the 225 guests served at Mitch's Place between October 1, 2022, and September 30, 2023, 79% of the guests (178) stayed 30 days or less and 9% (20) stayed between 30 and 60 days. Only 5 (2%) of the guests served during this period met the criteria for chronically homeless. These ratios have been consistent over the years. Mitch's Place expanded its capacity from 30 to 40 beds nightly effective April 1, 2023. This program expansion responded to the growing number of unsheltered men and women identified during the 2023 homeless count in Haverhill. From 2022 to 2023, this number increased from 12 to 22 individuals, an 83% increase.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: First Parish Newbury Food Pantry** **Health Issue: Additional Needs (Access to Healthy Foods)**

Brief Description or Objective	The First Parish Newbury Food Pantry provides free food to those in need, including residents of Newburyport, Salisbury, Amesbury, and other surrounding cities/towns. The organization serves approximately 600 guests each week, the majority of which live in Newburyport (45%). More than half the households served don't have transportation and depend on the organization's food delivery. The organization has pantries in all the schools in the Triton School District, which includes Salisbury Elementary School and Triton High School, serving Salisbury residents.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to healthy food for persons who are food insecure.	
Goal Status	In FY23, the pantry served 401 households on a regular basis. Of the 1,041 individuals in these households, 48% were adults (18-64 years old); 30% were seniors (65 years old and older); and 22% were children (under 18 years old).	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Our Neighbors' Table Wednesday Meal** **Health Issue: Additional Needs (Access to Healthy Foods)**		
Brief Description or Objective	Our Neighbors' Table (ONT)'s Wednesday Meal is a community-wide dining experience offering a three-course meal. The Wednesday Meal is open to anyone, with no income or geographic limitations, and no pre-registration is required. The Meal program is frequently how people learn of Our Neighbors' Table, often leading them to enroll as guests in their market programs and connect with other food resources. ONT also provides home deliveries of the Wednesday Meal to those who are homebound and distributes extra prepared meals in the market on Thursday as an extra convenience for ONT guests. The Wednesday Meal provides a hot meal to 300– 500+ unique people each month. For many, the friendly face and kind words exchanged when they pick up their meal may be crucial for their mental health. The guests know that they can count on ONT every week for a delicious hot meal and service with dignity.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	The main goal of the Wednesday Meal program is to reduce hunger by providing a nutritious prepared meal every Wednesday. Outcomes include:	

	Increased food-security for those who visit the meal and learn of ONT's grocery programs or other food assistance available to them. Reduction in stress levels knowing there is a dependable, hot meal every Wednesday. A social connection with community members and volunteers.
Goal Status	In FY23, the Wednesday Meal program served 4,490 unique guests. Of these guests, approximately 64% were adults (ages 18-64 years), 28% were older adults (age 65 years or over), and 4% were children. ONT served approximately 350+ meals per week throughout the organization. In June 2023, the Wednesday meal resumed in-person dining which was paused since the COVID-19 onset. In-person dining allows for increased interactions for guests with program staff, volunteers, and other dining guests. Take-out meals are still available also.

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

Priority Health Need: Social Determinants of Health **Program Name: YMCA Haverhill Freight Farm** **Health Issue: Additional Needs (Access to Healthy Foods)**	
Brief Description or Objective	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. The YMCA partnered with the Haverhill Public Schools to house the farm at Gateway Academy, a public middle and high school. Students from the school and the YMCA afterschool program help to grow, tend, and harvest produce. The Freight Farm grows a variety of vegetables, including lettuce, bok choy, and spinach, that are distributed to Gateway students, YMCA participants, and shared with local food pantries/homeless shelters.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	The farm will be fully operational by August 2023, operating at full capacity within 5 months. The farm will provide produce to students and individuals identified as food insecure, as well as local food pantries.

	The farm will provide STEM and nutrition education opportunities to students. The farm will educate the community about freight farming, nutrition, and farming.
Goal Status	The farm was fully operational by July 2023 and has been at 100% capacity since October 2023. The program produced an average of 107 units of vegetables each week for distribution. The program served 1,040 people. Of these persons, 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; and shared produce with Somebody Cares New England Food Pantry and Emmaus' Family Shelter. Approximately 33 students aged 10-13 years old and 10 students aged 5-9 years old participated in STEM and nutritional activities. There were five community education events/opportunities offered, reaching approximately 154 people.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Infrastructure to support Community Benefits collaborations across BILH hospitals** **Health Issue: All**	
Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital worked together to plan, implement, and evaluate Community Benefits programs. Community Benefits staff continued to understand state and federal regulations, build community engagement and evaluation capacity, and collaborate on implementing similar programs. BILH continues to refine the Community Benefits (CB) database, as part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention ☐Access/Coverage Supports ☒Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2023, BILH Community Benefits and Community Relations staff will participate in workshops to build community engagement skills and expertise.

	By September 30, 2023, continue to refine a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits data to more accurately capture and quantify CB/CR activities and expenditures. By September 30, 2023, all BILH Hospitals will launch a Community Connections newsletter on a quarterly basis to communicate community benefits activities to community partners, residents, and vested parties.
Goal Status	All 10 BILH Community Benefits hospitals participated in 4 community engagement workshops. All FY23 regulatory reporting data were entered into the Community Benefits Database. The ability for community organizations to apply for grants was added in FY23. Anna Jaques Hospital launched and sent its first newsletter to a mailing list of 138 organizations and people.

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

Priority Health Need: Mental Health and Substance Use **Program Name: Behavioral Health Crisis Consultation** **Health Issue: Mental Health**	
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 ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to clinical and non-clinical support services for those with mental health and substance use issues, by providing behavioral health services in the hospital. 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.

Goal Status	The team provided 974 screens in FY23.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Beth Israel Lahey Health Collaborative Care Model** **Health Issue: Mental Health**		
Brief Description or Objective	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 psychiatrist may advise the primary care provider on medications that may be helpful.	
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	To increase access to behavioral health services.	
Goal Status	AJH offered this collaborative care model in 3 locations in FY23: Amesbury (2) and Haverhill (1). 159 patients were served.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Family Services of the Merrimack Valley's Samaritans Program** **Health Issue: Mental Health**		
Brief Description or Objective	Family Services' Samaritans of the Merrimack Valley aims to reduce the incidence of suicide in the Merrimack Valley and throughout Massachusetts by providing a host of prevention and after-care services including postvention services, trainings and seminars, support groups, and a helpline. Through expanded crisis helplines, survivor support services, community education and training, the program serves over 2,000 individuals each year affected by suicide across the state, the majority of whom reside in Essex County.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Reduce incidence of suicide and increase community awareness, education, programming, and resources around mental health.	

Goal Status	4,600 individuals were served through helplines totaling 23,000 calls. On average, 80% are repeat callers. 495 individuals participated in training and supportive programs.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Link House: Children and Teen Center for Help "CATCH" Program** **Health Issue: Mental Health/Mental Illness; Substance Use**		
Brief Description or Objective	Link House, Inc. recently created CATCH (Children and Teen Center for Help) to address growing unmet needs around mental health and substance-use for school-aged children and teens in the community. The funds from this grant focused especially on child and teens, ages five to eighteen years old, and their immediate families who may be in need of receiving treatment and/or psychoeducation related to acute or chronic mental health concerns, in addition to treatment, education, and/or relapse prevention skills.	
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	CATCH will provide access to approximately 75 new underserved patients seeking mental health and substance use treatment, who might not have been seen for services elsewhere.	
Goal Status	146 patients received therapy of which 143 were under age 18; and three were ages 18-24 years old.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Pettengill House, Inc. Substance Abuse/Mental Health Initiative** **Health Issue: Mental Health**		
Brief Description or Objective	Behavioral Event and Substance Support Team (BESST) is a direct collective response to address system barriers and meet growing community need. BESST creates a streamlined process for collaboration across every level of care to enhance quality and continuity of care for those struggling with substance misuse/behavioral health. Through a person-centered coordinated team approach, BESST aims to bridge gaps by breaking down barriers, providing education, reducing stigma, and coordinating wraparound supports to improve stabilization and well-being for at-risk community members struggling with substance misuse and behavioral health. The identified goals of BESST are to improve quality of care and client well-being, enhance continuity of care across	

	all levels, increase equitable access to care within our communities, share information and resources among providers, and increase accountability and streamline delivery of services and resources.
Program Type	☐ Direct Clinical Services ☒Community Clinical Linkages ☐Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Pettengill House aims to continue implementing key services and initiatives to address crisis level substance/behavioral health need in the nine communities comprising the agency's catchment area. By the end of the grant period, Pettengill House aims to have achieved the following goals: Screen 50 individuals who are seeking SUDs/BH support. Assist 30 individuals with accessing SUDs/BH care and treatment across the spectrum of care. Provide services to 175 individuals who are experiencing SUDs/BH challenges to support improved stabilization and recovery. Provide Family Support Services to 30 family members of individuals seeking SUDs/BH support.
Goal Status	BESST assessed 361 individuals; provided outreach and contact to 335 individuals; emotional support to 113 individuals; and support services to 111 individuals. BESST provided direct service to 481 unique individuals (clients); and reached 611 unique individuals through both direct and indirect service (clients and family members). BESST provided substance use disorder and/or behavioral health services to 579 clients, including comprehensive case management to 186 clients, family support to 94 people, recovery support to 66 clients. With increased staffing and funding, the program was able to respond to the increased mental health and substance related needs of our communities. Referrals increased 48.6% and corresponding services, referrals, interventions, and assessments offered to BESST clients reached an all-time high.

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

Priority Health Need: Mental Health and Substance Use
Program Name: Greater Newburyport Village Membership Assistance Program
Health Issue: Mental Health

Brief Description or Objective	The mission of the Greater Newburyport Village is to promote living well and independently through community engagement and neighborly support. To support members' life choices during this remarkable time of life, the Village offers shared social, cultural, and educational experiences. The Village's Good Neighbor Volunteers provide neighborly help at home and rides to appointments/events. In addition, the Village follows up with non-participating members, who may be suffering from isolation. The Greater Newburyport Village recognizes that not all people in their service area can afford to pay the dues required for membership in the Village. Their Membership Assistance Program assists those with financial needs. Anyone applying for membership may request this assistance.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	To help seniors to successfully navigate the transitions of aging, including assistance with home tasks, technology, transportation, cultural enrichment, and socialization. The Village aims to be inclusive of all people who may benefit from membership. They aim that 25% of their members are low resourced, with minimal income and financial assets.
Goal Status	During FY23, 20% of their members were enrolled in the Membership Assistance program. 100% of these members were female.
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Essex County Outreach** **Health Issue: Mental Health**	
Brief Description or Objective	Essex County Outreach is a collaboration of the 34 law enforcement agencies, including the sheriff's department working together with social service, public health, recovery coaches, and other community partners to provide resources and better access to recovery and treatment for individuals and their families for: Substance Use Disorder Mental and Behavioral Health diagnosis At- risk referrals Harm Reduction Strategies Additional supports to families and children impacted by SUDs Supports for those that have lost a loved one to SUDs After identifying the need(s), the goal is for a follow up to be completed ideally within 72 hours to the residence with a plain clothes police officer, recovery coach with lived experience, and provider to navigate to the appropriate services

	if accepted. Additionally, ECO provides resources to families and loved ones, including post fatal overdose visits.
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)	The FY 2023 ECO program prioritizes the following strategies that have emerged as gaps in resources: (1) program coordinator/administrative support (2) funding for police overtime for post-overdose follow-up visits and training (3) child advocacy services and increase resources for children either with own SUDs/Behavioral Health or living in homes where referrals made (4) housing and transportation resources to support clients in all stages of recovery (5) expansion of access to harm reduction/client support kits. AJH supported assistance for transportation.
Goal Status	104 unique persons were assisted by ECO in FY23.

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

Priority Health Need: Mental Health and Substance Use **Program Name: Patient Care Navigator at Anna Jaques Hospital** **Health Issue: Mental Health**	
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 ☐Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐Total Population or Community Wide Intervention
Program Goal(s)	Support patient sobriety by setting individualized treatment goals such as securing mental health counseling, obtaining stable housing, discontinuing marijuana use, or following up with Early Intervention, or connecting with local resources, recovery support services, or mental health providers to help achieve their goals.

Goal Status	Served 300 women either in recovery and seeking additional support, who have suffered from trauma or abuse, or who have been diagnosed with mental health disorders. The Birth Center served a total of 596 women in FY23, therefore over 50% of patients were deemed "high risk" due to anxiety/depression, substance use, or other social determinants of health. This is an increase from FY22 and almost double the number of patients in FY21.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Disease **Program Name: North of Boston Cancer Resource** **Health Issue: Chronic Disease**		
Brief Description or Objective	The North of Boston Cancer Resource (NBCR) Speaker Series is designed to educate and offer support to people affected by cancer. They serve people affected by cancer from diagnosis, through treatment and beyond. Services include oncology massage, manual lymph drainage, acupuncture, reiki, personal training, yoga therapy, guided imagery, health coaching and nutrition counseling. Through the *Gift Certificate/Voucher Program* they fund supportive services from their resource guide to recipients. Through their monthly *Speaker Series*, NBCR provides information and that promotes empowerment through knowledge and self-care.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to programs and resources to support people and families impacted by cancer.	
Goal Status	NBCR hosted 271 people through events in its Speaker Series. NBCR supported 160 sessions of complementary care for those impacted by cancer, including 76 sessions of oncology massage and 45 sessions of acupuncture. NBCR supported 50 $50 gift cards to assist with purchasing groceries.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Disease **Program Name: Anna Jaques Hospital "Baby and Me" Classes** **Health Issue: Chronic Disease**		
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 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 ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Support new parents and their infants with parenting information, 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 reopened in-person in January 2023. The participation has slowly increased over the year and the program is now seeing approximately five parents per week.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Disease **Program Name: Breast Care Navigator at Anna Jaques Hospital** **Health Issue: Chronic Disease**	
Brief Description or Objective	The Breast Care Navigator at the Gerrish Breast Care Center is a Nurse Practitioner with extensive oncology-specific clinical knowledge. The Navigator offers individualized support and assistance to patients and their caregivers to help them make informed decisions about their care and to overcome barriers to optimal care. The Navigator contributes to the Hospital's mission by providing cancer patients with coordinated care through a holistic and collaborative approach that includes communication and coordination with the patient's family and/or caregivers, along with a multidisciplinary team consisting of physicians, nurse practitioners, oncology nurses, and social workers. The Navigator works in collaboration with the clinical team to develop clinical pathways for appropriate care and acts as the contact clinical person for patient-related concerns.

Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Increase support and access to services to patients through their cancer journey, from health care services through to survivorship programs.	
Goal Status	In FY23, the Breast Care Navigator provided support services and care coordination to 266 women scheduled for image-guided breast biopsies and 100 Gerrish Breast Care Center (GBCC) patients and families undergoing breast surgery for both benign and malignant conditions.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Disease **Program Name: YWCA Newburyport Encore and After Encore Program** **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 ☐Community Clinical Linkages ☐☒ Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	The goal of the Encore program is to empower women to reclaim their physical activities and resume exercise in an inviting and social environment.
Goal Status	The program had 36 participants in FY23, of which 94% were women. The program welcomed an average of 2-3 new participants per week. 70% of the attendees participated more than once per week. The YWCA uses a series of 4 metrics (test, questionnaire, scale and an assessment) to assess aggregate outcomes at both week 1 and week 12, and then incrementally throughout the program. Factoring in the participants who regularly attended the Encore/After Encore program (more than once per week): 85% of the participants experienced an increase in functional movements, range of motion, strength, balance, and overall mental state per the metrics above. 15% who attended once a week or less maintained and/or saw a marginal decrease in functionality.

Time Frame Year: Year 1	Time Frame Duration: Year 1	Goal Type: Process Goal

Priority Health Need: Complex and Chronic Disease Program Name: YMCA North Shore/Haverhill Cornerstone Program Health Issue: Chronic Disease		
Brief Description or Objective	Cornerstone is a collaborative health and wellness program providing support to cancer patients, cancer survivors, and their immediate families. A free one-year YMCA membership is provided to the family, as well as a week of summer camp programming at no cost. In addition, there are special events and access to the LIVESTRONG at the YMCA Program.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Support programs and resources that promote survivorship for people impacted by cancer by providing memberships and summer camp for families.	
Goal Status	The Haverhill YMCA extended 41 Cornerstone memberships to support healthy living to families dealing with cancer. The Haverhill YMCA provided eight children of Cornerstone families with a week of summer camp in 2023, providing a sense of normalcy.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Disease Program Name: Haverhill Farmers' Market Health Issue: Chronic Disease		
Brief Description or Objective	AJH sponsors the Haverhill Farmers Market, which promotes healthy eating and supports local business, sustainability, and community spirit by providing fresh, local produce and 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 ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to fresh produce and healthy food options.	

Goal Status	The Haverhill Farmers' Market hosted markets weekly from June through October 2023. Farmers' markets are crucial in providing fresh local produce and healthy food options. The market moved location this season, however Merrimack Valley Transit provides free bus transportation from downtown to the new location.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Disease **Program Name: North Shore YMCA: Enhance Fitness** **Health Issue: Chronic Disease**		
Brief Description or Objective	EnhanceFitness is a proven community-based senior fitness and arthritis management program. It helps older adults become more active, energized, and empowered for independent living. EnhanceFitness has been nationally recognized by the Centers for Disease Control and Prevention, US Department of Health and Human Services, US Department on Aging, and the National Council on Aging. EnhanceFitness welcomes older adults at all fitness levels. The program is especially beneficial for older adults living with arthritis.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	The Haverhill YMCA will serve up to 25 seniors in each of the two 16-week sessions of the 2023 EnhanceFitness® program, with 25% of participants being considered economically disadvantaged. At least 52% of participants will report that they have maintained or increased their feeling of general overall health thanks to their participation in the 16-week EnhanceFitness® program. At least 61% of participants will report that the EnhanceFitness® program has improved their physical abilities over the 16-week session.	
Goal Status	The program ran two sessions this year, in which 60% of the participants were considered economically disadvantaged. 90% of the participants either maintained or increased their feeling of overall health over the 16-week period. Over 75% of the participants have improved their physical abilities over the 16-week session.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Beth Israel Lahey Health

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$4,906,465	$0
Community-Clinical Linkages	$45,036	$5,000
Total Population or Community Wide Interventions	$135,717	$52,850
Access/Coverage Supports	$189,311	$33,370
Infrastructure to Support CB Collaborations	$8,897	$0
Total Expenditures by Program Type	$5,285,426	$91,220
CB Expenditures by Health Need		
Chronic Disease	$2,366,017	
Mental Health/Mental Illness	$2,444,165	
Substance Use Disorders	$216,712	
Housing Stability/Homelessness	$10,140	
Additional Health Needs Identified by the Community	$248,392	
Total by Health Need	$5,285,426	
Leveraged Resources	$705,613	
Total CB Programming	$5,991,039	
Net Charity Care Expenditures		
HSN Assessment	$734,425	
Free/Discounted Care	$0	
HSN Denied Claims	$269,674	
Total Net Charity Care	$1,004,099	
Total CB Expenditures	$6,995,138	

Additional Information	
Net Patient Services Revenue	$143,852,674
CB Expenditure as % of Net Patient Services Revenue	5%
Approved CB Budget for FY24 (*Excluding expenditures that cannot be projected at the time of the report)	$6,995,138
Bad Debt	$2,262,622
Bad Debt Certification	Yes

Optional Supplement	
Comments	

SECTION VI: CONTACT INFORMATION

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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – 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:
    - Pam Palombo, RN, Newburyport Public Health Nurse stepped off the committee in FY23.
    - Anna Jaques Hospital added several internal senior leaders including:
        - Dr. Glenn Focht, President
        - Michael McCarthy, Vice President of Philanthropy
        - Sandra Levin, Vice President Support Services, Chief Quality Officer and Patient Safety Officer

II. **Community Engagement**

- Organizations Engaged in CHNA and/or Implementation Strategy

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.

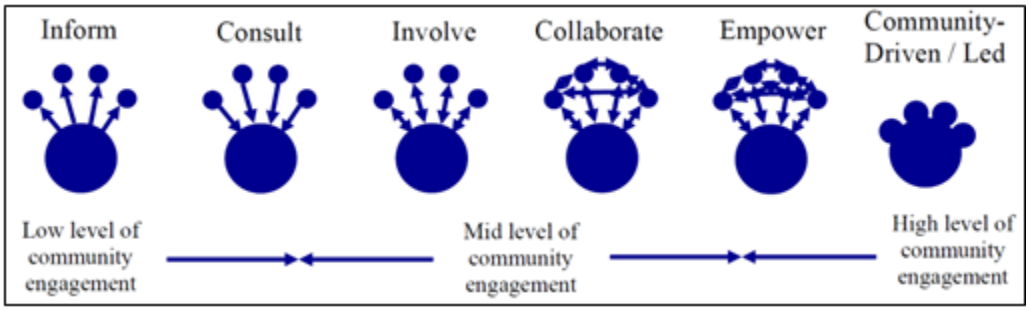
Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
YMCA Haverhill	Tracy Fuller, Executive Director	Health; Housing; Food Insecurity	To increase health equity in Gateway Municipalities, 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. The YMCA collaborated with the City of Haverhill and the Haverhill Public Schools to locate the farm at Haverhill's Gateway Academy, a public middle and

			high school. The farm became operational this year and has provided produce to 1,040 persons, 90% of which are under age 18. Students assisted with planting, tending, and harvesting vegetables.
Pettengill House	Tiffany Nigro, Executive Director	Mental Health; Substance Use	AJH collaborates Pettengill House and their BESST program on an ongoing and frequent basis. Most often, regularly and weekly the Pettengill/BESST team coordinator and/or social work case manager are invited to the adult psychiatric services unit to meet with patients who have expressed interest in referral and may need some additional care coordination or interim support services while waiting to navigate or enroll at their next level of support. Often times, referrals will also include need for stabilization supports and may include referrals to social and benefit programs, housing stabilization resources, basic needs resources such as food, clothing, etc. In addition, on a regular basis, as needed, the Pettengill BESST team and other social workers work collaboratively with the emergency department, ICU, and cancer unit.
Northern Essex Elder Transport (NEET)	Dori Sawyer, Administrator	Access to Care; Transportation	AJH funded NEET for the first time in FY23 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. NEET collaborates with the Councils on Aging in all five communities within AJH's CBSA. In FY23, NEET volunteers drove 68,454 miles, a 30% increase from the year prior. They assisted 436 unique individuals with transportation to medical care resulting in 3,643 free rides.

- Level of Engagement Across CHNA and Implementation Strategy

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



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

A. **Implementation Strategy**

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

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)

Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Collaborate	Yes	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Involve	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:

In FY24, Anna Jaques Hospital will form two allocation committees including community members to determine funding for two requests for proposals.

- Opportunity for Public Feedback

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

AJH held a public meeting in conjunction with its CBAC on October 4, 2023 from 1-2:30PM at Anna Jaques Hospital 25 Highland Ave in Newburyport, MA. AJH welcomed a new hospital president in September 2023 and he attended the public meeting to present and meet the community.

III. **Updates on Regional Collaboration**

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

AJH is part of the Beth Israel Lahey Health (BILH) system community health planning process. In 2019, BILH formed a system-wide Community Benefits Committee (CBC). This Committee provides strategic direction for all 10 BILH hospitals and its affiliates and seeks to ensure that strategies are in place to meet the health care needs of at-risk, underserved, uninsured, and government payer patient populations in the communities. Guided by the

CBC, hospitals' Community Benefits staff meet regularly to review regulatory requirements and share community health programming best practices. Together, hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact.

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

N/A