Organization Information

Organization Name:	Athol Memorial Hospital
Address:	2033 Main Street
City, State, Zip:	Athol, Massachusetts 01331
Website:	www.atholhospital.org
Contact Name:	Mary Giannetti
Contact Title:	Director of Resource Development
Contact Department (Optional):	Philanthropy
Phone:	(978) 630-5797
Fax (Optional):	(978) 630-6830
E-Mail:	mary.giannetti@heywood.org
Contact Address: (Optional, if different from above)	Heywood Hospital 242 Green Street
City, State, Zip: (Optional, if different from above)	Gardner, Massachusetts 01440

Organization Type:	Hospital
For-Profit Status:	Not-For-Profit
Health System:	Not Specified
Community Health Network Area (CHNA):	Fitchburg/Gardner Community Health Network(CHNA 9),
Regions Served:	Athol, Erving, New Salem, Orange, Petersham, Phillipston, Royalston, Warwick, Wendell,

Mission and Key Planning/Assessment Documents

Community Benefits Mission Statement:
Athol Hospital is committed to improving the health of our community, with special consideration of disadvantaged populations, by working collaboratively with community partners to increase prevention efforts, address social determinants of health, and improve access to care.

Target Populations:

Name of Target Population	Basis for Selection
Athol Hospital is committed to addressing health disparities that exist in our region. We target community benefit programs for racial and ethnic minorities, older adults, veterans, youth and adolescents and individuals and families with low socioeconomic and low social determinants.	2018 Heywood Healthcare (Athol Hospital and Heywood Hospital) Community Health Needs Assessment quantitative and qualitative data.

Publication of Target Populations:
Marketing Collateral, Website

Community Health Needs Assessment:

Date Last Assessment Completed:

2018

Data Sources:

Community Focus Groups, Community Health Network Area, Consumer Groups, Hospital, Interviews, MA Population Health Information Tool (PHIT), Public Health Personnel, Surveys,

CHNA Document: FINAL 2018 HEYWOOD CHA.PDF

Implementation Strategy:

Implementation Strategy Document: 2018-HEYWOOD-HEALTHCARE-COMMUNITY-HEALTH-IMPROVEME

Key Accomplishments of Reporting Year:

Social Determinants of Health: Assisted 72 community members to overcome barriers and address psycho-social needs by providing information and referrals on issues related to housing, food, transportation, behavioral, and substance abuse. Provided financial and health insurance information and enrollment assistance to 2671 individuals at the Athol Campus, reducing financial barriers to accessing healthcare. Assisted 90 patients with transportation, and as a result, they were able to follow up with their healthcare and prevented missed appointments.

Interpersonal Violence and Injuries: Convened the Regional Behavioral Health Collaborative (RBHC), a multi-sector partnership of school, emergency responders, social service organizations, medical, and behavioral health providers. The RBHC organized the implementation of Handle With Care (HWC)- an initiative to address and minimize the adverse effects of childhood trauma. The RBHC hosted trainings to increase the partnership's knowledge of the HWC model, adverse childhood experiences, and how to provide trauma-informed care.

Mental Health and Substance Use: Offered MENders support group for men who struggle with depression providing peer exchange and coping skills to over 270 men for managing symptoms associated with mental illness and substance use. Community Health Workers, located in the Athol Royalston and Mahar Regional School Districts, provided school-based care coordination and behavioral health supports. 64 youth with 1,108 mental health counseling sessions via tele-behavioral health and aided with 94 referrals to community-based services such as food, fuel, and housing assistance.

Wellness and Chronic Disease: Partnered with the Athol Public School District to distribute 4,400 backpacks with nutritious food for the weekend distributed weekly to 110 low- income youth and their families. Offered Free Blood Pressure screenings at Petersham Farmers Market and provided information to manage symptoms associated with high blood pressure. Diabetes Support Group held monthly to assist community members living with diabetes.

Plans for Next Reporting Year:

Athol Hospital remains committed to addressing health disparities and the health needs of our region. A focus of the community health needs assessment (CHNA) is to understand the needs of under-resourced populations (low-income individuals and families, school children, elderly, minority, veterans, and the disabled) and to identify and prioritize health issues and related socio-economic determinants of health). In addition to doing the CHNA, Athol Hospital will monitor hospital data. It actively engages with the hospital leadership team and Community Benefits Advisory Committee to continuously monitor and assess any changing or emerging community and healthcare needs. The community health improvement plans for 2020 remains focused on under-resourced populations (low-income individuals and families, school children, elderly, minority, veterans, and the disabled) and prioritizes social determinants of health, mental health and substance misuse, wellness and chronic disease, and interpersonal violence and injuries. We also plan to address emergent issues related to the COVID-19 pandemic and to support the region to prepare for and prevent the spread of the virus. The Community Health Improvement Plan (CHIP) will align with the hospitals strategic plan and coordinated with the existing work of partner organizations. An ongoing review of the Community Benefits Advisory Committee members will ensure representation from the CHIP's target population and priority focus areas.

Self-Assessment Form: Hospital Self-Assessment Update Form - Years 2 and 3

Community Benefits Programs

MENders	
Program Type	Community-Clinical Linkages
Program is part of a grant or funding provided to an outside organization	No
Program Description	Education provided to the community on recognizing signs and symptoms of suicide crisis and substance use and how to respond. Self-care techniques offered to individuals suffering from mental health and substance abuse disorders.

Program Hashtags	Community Education, Support Group,
Program Contact Information	Timothy Sweeney

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
A Men's support group that promotes healthy living and offering coping skills for managing symptoms associated with mental illness and substance use.	The MENders support program met 78 times with participation from 273 men. Through this support group, men became connected to resources, gained confidence and learned coping skills to manage their behavioral health better and/or addiction issues.	Outcome Goal	Year 2019 of 1

EOHHS Focus Issues	Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities	Social Environment,
Health Issues	Health Behaviors/Mental Health-Depression, Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Stress Management, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Athol, Erving, New Salem, Orange, Petersham, Phillipston, Royalston, Warwick, Wendell, • **Environments Served:** Rural, • **Gender:** Male, Transgender, • **Age Group:** Adults, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Domestic Violence History, Incarceration History, LGBT Status, Veteran Status,

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

Sharps Disposal Program

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	Educate the community on substance use prevention and resources. Topics included recognizing the signs and symptoms of substance abuse, safe storage, and handling of medications and sharps and needles. Self-care techniques and support provided for individuals suffering from mental health and substance abuse disorders. Offer community members with a safe way to dispose of them.
Program Hashtags	Community Education, Prevention,
Program Contact Information	Daniel French

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Athol Hospital offers a sharps disposal program at no cost to help community members safely dispose of used medical "sharps" such as needles, syringes, and lancets, reducing risk to families and waste management and landfill staff.	Laboratory distributed 150 biohazard sharps containers from community members and received 130 back for disposal with waste stream steri cycle. This program provided a community benefit by reducing the possible injury or exposure to disease from medical sharps used at home; especially the most vulnerable groups at the greatest risk including sanitation and sewage treatment workers, janitors and housekeepers, and children.	Outcome Goal	Year 2019 of 1

EOHHS Focus Issues	Substance Use Disorders,
DoN Health Priorities	Built Environment,
Health Issues	Infectious Disease-Hepatitis, Injury-Home Injuries, Social Determinants of Health-Public Safety, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Athol, Erving, New Salem, Orange, Petersham, Phillipston, Royalston, Warwick, Wendell, • **Environments Served:** Rural, • **Gender:** All, • **Age Group:** Adults, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

Chronic Disease Management

Program Type	Community-Clinical Linkages
Program is part of a grant or funding provided to an outside organization	No
Program Description	Participation in community health fairs and events to educate the community about heart disease and diabetes and offer blood pressure screenings to help residents identify and monitor risk factors. Home Visits to provide self-care techniques, medication management, and support provided for individuals suffering from chronic conditions.
Program Hashtags	Community Education, Health Screening, Prevention,
Program Contact Information	Nancy Mallory; Laurie Babcock 2033 Main St Athol, MA 01331

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Participate in community health and wellness events targeting elderly and those with chronic conditions. Provide health education and screenings on risk factors for heart health and stroke prevention.	Offered Free Blood Pressure screenings at Petersham Farmers Market throughout the summer. Provided information to manage symptoms associated with high blood pressure.	Outcome Goal	Year 2019 of 1
Cancer Support Group - provides support for patients and their families through participation in a group discussion with people with similar life experiences.	Support Group offered monthly serving approximately 65 individuals. Participants benefited from information and referral, education, and peer support around coping with Cancer.	Outcome Goal	Year 2019 of 1
Diabetes Support Group- provides support and self-care techniques for participants to manage symptoms related to their diabetes.	Diabetes support group met monthly and - provided an opportunity for people with diabetes to come together to receive continuing support and exchange of ideas, networking and education as It pertains to diabetes	Outcome Goal	Year 2019 of 1

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities	Not Specified
Health Issues	Cancer-Breast, Cancer-Cervical, Cancer-Colorectal, Cancer-Lung, Cancer-Multiple Myeloma, Cancer-Other, Cancer-Ovarian, Cancer-Prostate, Cancer-Skin, Chronic Disease-Diabetes, Chronic Disease-Hypertension, Chronic Disease-Overweight and Obesity, Chronic Disease-Stroke,
Target Populations	• **Regions Served:** Athol, Erving, New Salem, Orange, Petersham,

Phillipston, Royalston, Warwick,
- **Environments Served:** Rural,
- **Gender:** All,
- **Age Group:** Adult, Adult-Elder,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Athol Orange Housing Authority	http://www.atholorangehousing.com/
Athol YMCA	http://ymcaathol.org/
Petersham Farmers Market	http://www.petershamcommon.com/fridaymarket.htm
North Quabbin Garlic and Arts Festival	https://garlicandarts.org/
Erving Council on Aging Community and Senior Center	https://www.erving-ma.gov/council-aging-senior-center
Royalston Council on Aging	http://www.royalston-ma.gov/?page_id=149
Phillipston Council on Aging	http://www.phillipston-ma.gov/council-on-aging

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Care Transition Program

Program Type	Infrastructure to Support CB Collaboration
Program is part of a grant or funding provided to an outside organization	No
Program Description	The Care Transition Program is to improve the communication of information as the patient moves to another care setting. The focus of the Transition of Care coalition is to identify opportunities that improve service, quality, compliance and reimbursement.
Program Hashtags	Community Health Center Partnership, Health Professional/Staff Training,
Program Contact Information	Barbara Nealon

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Care Transition Program- The transition of care committee was established in 2013 membership includes hospital system staff, medical staff, agencies and facilities that are used as referral sources in the continuum/transitions of care. The benefits of the Care Transition program are to improve patient outcomes, decrease acute hospitalizations, improve communication, facilitate medication reconciliation, develop a fiscally sound inter agency system, and assist in meeting regulatory requirements.	In 2019 the membership of this committee expanded to include not only skilled nursing facilities, and home health agencies but also behavioral health, developmental disability and addiction partners to better serve our patients. The committee met quarterly. Outcomes achieved included: 1) Enhanced the clarity of discharge information to improve care processes and empower the patient to take an active role in health management; 2) Reduced fragmentation of care and unnecessary hospital readmissions; 3) developed hospital and community system intervention to improve communication and transition of care.	Process Goal	Year 2019 of 1

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities	Not Specified
Health Issues	Other-Senior Health Challenges/Care Coordination,

Target Populations	• **Regions Served:** Athol, Erving, New Salem, Orange, Petersham, Phillipston, Royalston, Warwick, Wendell, • **Environments Served:** Rural, • **Gender:** All, • **Age Group:** Adults, Elderly, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
LUK- LUK is a not-for-profit social service agency located in central Massachusetts dedicated to improving the lives of youth and their families. We offer a full spectrum of programs addressing mental and behavioral health, trauma, addiction and substance abuse prevention, and homelessness.	https://www.luk.org/
Transitions: Home health and private care	http://transitionshomehealth.net/
Sterling Villages provides short term rehabilitation, long term care, wound care, respite care, hospice care	https://www.sterling-village.com/
Gardner Rehabilitation and Nursing Center- Provides transitional care, skilled rehabilitation, speech therapy,physical therapy, occupational therapy, post-acute nursing services, long-term care.	http://www.gardnerrehab.com/

Life Path- Agency Services Access Point Home Care Agency	https://lifepathma.org/
Montachusett Home Care- Agency Services Access Point Home Care Agency	http://montachusetthomecare.org/
Option Care Health- home infusion services	optioncarehealth.com
Fallon Health Health insurance plans for older adults and medicare eligible patients.	https://www.fchp.org/
Genesis Healthcare- provides short-term post-acute, rehabilitation, skilled nursing and long-term care services.	http://www.genesishcc.com/
Broadview Assisted Living Community	https://broadviewassistedliving.com/
Next Step Home Healthcare nursing and rehab facility	nextstephc.com
Open Sky Community Services includes: Developmental and Intellectual Disabilities, Mental Health Services, Adult Family Care, Shared Living, Brain Injury, Care Management and Coordination, Counseling Center, Housing and Homelessness Services, Trauma Response Services	https://www.openskycs.org/
Care Central	https://www.carecentralvnahospice.org/

VNA & Hospice	
Epic Wellness- home healthcare services	https://epicwellnessllc.com/
Clinical & Support Options provides family support programs, mental health & addiction recovery programs, housing and homelessness supports, community based, and crisis programs.	https://www.csoinc.org/
Sunrise Senior Living- assisted living	https://www.google.com/aclk?sa=l&ai=DChcSEwjupd_3vu7qAhUa7LUKHesxBHoYABAAGgJxbg&sig=AOD64_1GM5KJuT_UFmT5ykr_Zy8xPq-hZw&q=&ved=2ahUKEwiAqtX3vu7qAhUhheAKHReTBsoQ0Qx6BAgcEAE&adurl=
Umass Memorial Medical Center	https://www.umassmemorialhealthcare.org/umass-memorial-medical-center
UMass Memorial Health Alliance Clinton Hospital	https://www.umassmemorialhealthcare.org/healthalliance-clinton-hospital
Nashoba Valley Medical Center	https://www.nashobamed.org/

Nutrition- Weekend Backpack Program and Summer Farm Shares

Program Type	Community-Clinical Linkages
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	In conjunction with area schools and community partners, provide education to youth and families on wellness and healthy behaviors. Support a backpack food program to foster good health in and out of school time by supplementing low-income at risk students with food on the weekend.
Program Hashtags	Prevention,
Program Contact Information	Theresa Thompson; Mary Giannetti

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
A backpack of kid-friendly and healthy food items is given out on Friday for the weekend when kids are likely to be most hungry. The food is discreetly and conveniently distributed at the school.	110 low income third and fourth-grade students that attend the Athol Public Elementary School benefited from the Weekend Backpack program. A total of 4,400 food bags were distributed throughout the school year. In addition to helping children with having enough food on the weekend and not coming to school hungry on Monday, the school administration expressed it building a connection between the families and the school.	Outcome Goal	Year 2019 of 1
Farm shares of locally grown			

produce provided for low income, food-insecure households. This program increases healthy food access while supporting local/ regional farms.	Quabbin Harvest Food Co-op provided Senior Summer Farm Shares to 39 elder households 16 in Orange and 23 in Athol.	Outcome Goal	Year 2019 of 1

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities	Social Environment,
Health Issues	Social Determinants of Health-Access to Healthy Food,
Target Populations	• **Regions Served:** Athol, • **Environments Served:** Rural, • **Gender:** All, • **Age Group:** Adults, Children, Elderly, Teenagers, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Athol Roylston Regional School District	www.arrsd.org
Athol Orange Rotary Club	https://atholorangerotary.org/
Quabbin Food Harvest COOP Market: mission is to provide healthy food at an affordable price, while building community, supporting local agriculture and respecting the natural environment.	https://quabbinharvest.coop/
Orange Senior Center and Council on Aging	https://www.townoforange.org/
Seeds of Solidarity: non-profit organization based in Orange MA that innovates programs to awaken the power among people of all agesâ€"from toddlers to teens to people who are incarceratedâ€" to Grow Food Everywhere to transform hunger to health, and create resilient lives and communities.	https://seedsofsolidarity.org/

Handle With Care

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	In conjunction with area schools, law enforcement, medical and behavioral health providers, and social service agencies support youth affected by trauma and child maltreatment.
Program Hashtags	Community Education, Health Professional/Staff Training, Prevention,
Program Contact Information	Michael Ellis

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Handle With Care is an initiative to			

address and minimize child trauma and its adverse effects. HWC will develop a process for identifying, communicating, and providing appropriate trauma-informed supports for the student and family. The initiative will promote partnerships between schools, first responders, healthcare, and community organizations. The HWC partnerships aim to ensure that children exposed to trauma in their home, school, or community receive appropriate interventions and support to help them achieve academically and grow personally.	Convened the Regional Behavioral Health Collaborative (RBHC), a multi-sector partnership of school, emergency responders, social service organizations, medical, and behavioral health providers met quarterly to develop the Handle with Care Initiative. The RBHC hosted trainings to increase the partnership's knowledge of the HWC model, adverse childhood experiences, and how to provide trauma-informed care.	Process Goal	Year 2019 of 1

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Social Environment, Violence,
Health Issues	Social Determinants of Health-Domestic Violence, Social Determinants of Health-Violence and Trauma,
Target Populations	• **Regions Served:** Athol, Orange, Phillipston, Royalston, • **Environments Served:** Rural, • **Gender:** All, • **Age Group:** Children, Teenagers, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Domestic Violence History,

Partners:

Partner Name and Description	Partner Website
Athol Roylston School District	www.arrsd.org
Orange School District	https://www.orange-elem.org/
Athol Police Department	www.athol-ma.gov
Orange Police Department	townoforange.org
Regional Behavioral Health Collaborative	Not Specified

School-based Care Coordiation and Tele-behavioral Health Services

Program Type	Community-Clinical Linkages
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	In conjunction with Athol and Mahar School Districts provide school-based behavioral health and social supports for high-risk, school-aged youth and their families.
Program Hashtags	Prevention,
Program Contact Information	Selena Johnson; Maureen Donovan

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame

School-based Care Coordination Program (SBCC) is to support students and family's psycho-social-emotional needs. A community health worker embedded in the school assists youth with appropriate mental health counseling and connects families with community-based services.	A community Health Worker supported students enrolled in the Athol elementary and middle schools. The CHW linked 150 youth with appropriate mental health counseling and assisted 103 families with accessing community-based services such as food, fuel, and housing assistance. Benefits of the SBCC program include: Stronger family, school & community relationship; Healthier family dynamics, reduced social determinants of health factors; and Improved organizational culture reducing risks and creating a safe, high-quality environment for students and employees.	Outcome Goal	Year 2019 of 1
School-based tele-behavioral health program offered in collaboration with the school district connects youth to behavioral health counseling via telehealth while at school. This program eliminates barriers to access services while reducing time away from learning.	One thousand one hundred eight behavioral health sessions were provided via video conferencing for 64 at-risk students enrolled in the Mahar and Athol Royalston School Districts. Ninety-four referrals supported these students to community-based services.	Outcome Goal	Year 2019 of 1

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Education, Social Environment,
Health Issues	Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Stress Management, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Education/Learning, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Nutrition, Social Determinants of Health-Violence and Trauma,
Target Populations	• **Regions Served:** Athol, New Salem, Orange, Petersham, Phillipston, • **Environments Served:** Rural, • **Gender:** All, • **Age Group:** Adults, Children, Teenagers, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Athol Roylston School District	www.arrsd.org
Ralph C Mahar School District	https://www.rcmahar.org/

Social Determinants of Health- Access to Health Care and Community Services

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	No
Program Description	Provide psychosocial supports and financial counseling for individuals and families to address needs and overcome barriers to accessing healthcare. Direct support included health coverage enrollments and information and referral.
Program Hashtags	Community Education,
Program Contact Information	Barbara Nealon, Director of Social Services Melissa Wrigley Director Patient Financial Services 2033 Main St Athol, MA

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide uninsured or under-			

insured patients with information and enrollment assistance with health care	2,671 individuals received counseling on health insurance coverage and financial assistance.	Outcome Goal	Year 2019 of 1
Arrange for transportation for individuals who do not have transportation and it would be a financial burden to go to their medical appointments.	90 patients assisted with transportation for a total cost of $3,428. As a result, patients were able to follow up with their healthcare and prevented missed appointments.	Outcome Goal	Year 2019 of 1
Assist vulnerable individuals with information and referrals to community programs that could address their needs.	Assisted 72 community members who either phoned in or walked-in with psycho-social services to overcome barriers to accessing needed health care. Provided information and referrals on issues related to housing, food, transportation, behavioral health, substance abuse.	Outcome Goal	Year 2019 of 1

EOHHS Focus Issues	N/A,
DoN Health Priorities	Education, Housing, Social Environment,
Health Issues	Access to Health Care, Other-Senior Health Challenges/Care Coordination, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Uninsured/Underinsured,
Target Populations	• **Regions Served:** Athol, Erving, New Salem, Orange, Petersham, Phillipston, Royalston, Warwick, • **Environments Served:** Rural, • **Gender:** All, • **Age Group:** Adult, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Disability Status,

Partners:

Partner Name and Description	Partner Website
GAAMHA transit offers full service door-to-door transportation to individuals of all ages, private and public businesses. We accommodate most needs including those that are handicapped, physically challenged, elderly and the visually and hearing challenged.	https://www.gaamha.com/transportation/

Social Determinants- Career Development

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	Athol Hospital provides opportunities for students to gain experiential learning at the hospital. These learning experiences serve two different purposes: to help educate young adults on current health issues and to allow participants to explore different career options. This activity further supports Athol Hospital's efforts to improve local socio-economic factors and to increase availability of trained healthcare workforce.
Program Hashtags	Mentorship/Career Training/Internship,
Program Contact Information	Gay Lilja-Houghton

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Rehabilitation Services serves as			

a clinical education site for college students to gain experience in an array of acute inpatient and outpatient physical and occupational therapy services.	Staff provided 1054 hours of on-site training for six college students. Internship experience is required for students to graduate with a BS in Exercise Science.	Outcome Goal	Year 2019 of 1
Club Med a summer exploratory program to introduce high school students to the field of medicine.	10 area high school students received 200 hours of mentorship by the nursing staff. Students explored career opportunities and gained knowledge in the following areas: First Aid education, Emergency Department, Surgery, Swing Bed, Infections Disease.	Outcome Goal	Year 2019 of 1
Nursing Clinical Placements offered for college students to gain experience in an array of acute inpatient nursing services.	Staff provided 160 hours of on-site educational training on the medical-surgical unit for students	Outcome Goal	Year 2019 of 1

EOHHS Focus Issues	N/A,
DoN Health Priorities	Education, Employment,
Health Issues	Social Determinants of Health-Education/Learning,
Target Populations	• **Regions Served:** Other-Central MA, • **Environments Served:** Rural, • **Gender:** All, • **Age Group:** Adult, Adult-Young, Child-Teen, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Mount Wachusett Community College	https://mwcc.edu/
Fitchburg State University	https://www.fitchburgstate.edu/
Athol Royalston School District	www.arrsd.org
Ralph C Mahar Regional School District	https://www.rcmahar.org/

Social Determinants of Health- Community Building Initiatives

Program Type	Infrastructure to Support CB Collaboration
Program is part of a grant or funding provided to an outside organization	No
Program Description	Athol hospital staff actively participates in and take leadership roles on a number of organization boards and committees. The objective is to collaboratively plan and implement strategies to reduce identified health needs and gaps in services.
Program Hashtags	Not Specified
Program Contact Information	Tina Griffin, COO, VP Patient Care Services 2033 Main St Athol, MA 01331

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
The Multicultural Task Force- This task force with community participation focuses on addressing health disparities and social determinants of health-focused for underrepresented populations	The Multicultural Task Force organized and participated in community events to raise awareness on issues related to diversity and health, including the Stand Against Racism and Martin Luther King Event.	Process Goal	Year 2019 of 1

The Montachusett Suicide Prevention Task Force - Spearheaded by HH, this multi-sector Task Force serves the City of Gardner and the surrounding 22 towns. In its fourth year, its mission is to prevent suicide by providing education and resources to help those who struggle with depression, survivors of suicide, and those who have lost loved ones to suicide.	Approx 30 members participated in 11 meetings for resource sharing and educational events. Organized the annual Ride Of Your Life Suicide Prevention Event, which also included community media and billboards to raise awareness education on resources.	Process Goal	Year 2019 of 1
Staff participation in community-based coalitions and committees.	Athol staff participate with the following groups: North Quabbin Community Coalition, Valuing our Children, Franklin Hampshire North Quabbin Opiate Prevention Task Force, Greater Gardner Religious Council, Life Path Board of Directors, Community Foundation of North Central MA, and the Regional Behavioral Health Collaborative. Issues addressed by these committees include mental health and substance abuse, nutrition, Elder and Caregivers services, and child health and wellness.	Process Goal	Year 2019 of 1

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities	Not Specified
Health Issues	Health Behaviors/Mental Health-Mental Health, Maternal/Child Health-Parenting Skills, Other-Cultural Competency, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Nutrition, Social Determinants of Health-Racism and Discrimination, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Athol, Erving, New Salem, Orange, Petersham, Phillipston, Royalston, Warwick, Wendell, • **Environments Served:** Rural, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
North Quabbin Community Coaltion: A community-wide alliance committed to improving the quality of life for all those living and working in the North Quabbin region.	https://www.nqcc.org/
Valuing Our Children: Serving the North Quabbin VOC offers family support and advocacy, parent education, father and grandparent resources.	www.valuingourchildren.org
Franklin Hampshire North Quabbin Opiate Task Force	https://www.opioidtaskforce.org/
Greater Gardner Religious Council brings together area clergy from the surrounding towns together to network monthly and work on those issues identified as community needs and/or opportunities for growth	https://www.atholhospital.org/services/social-services/spiritual-services
Life Path- Aging Service Access	https://lifepathma.org/

Point and home care agency	
Community Foundation of North Central MA	https://www.cfncm.org/
Regional Behavioral Health Collaborative	Not Specified

Expenditures

Total CB Program Expenditure	**$521,921.00**

CB Expenditures by Program Type	Total Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
Direct Clinical Services	$0.00	$0.00
Community-Clinical Linkages	$193,716.00	$58,985.00
Total Population or Community-Wide Interventions	$255,722.00	$1,345.00
Access/Coverage Supports	$480.00	$0.00
Infrastructure to Support CB Collaborations Across Institutions	$72,003.00	$3,065.00

CB Expenditures by Health Need	Total Amount
Chronic Disease with a Focus on Cancer, Heart Disease, and Diabetes	$21,019.00
Mental Health/Mental Illness	$146,050.00
Housing/Homelessness	$0.00
Substance Use	$5,280.00
Additional Health Needs Identified by the Community	$349,572.00

Other Leveraged Resources	$47,600.00

Net Charity Care Expenditures	Total Amount
HSN Assessment	$335,209.00
HSN Denied Claims	$0.00
Free/Discount Care	$194,589.00
Total Net Charity Care	$529,798.00

Total CB Expenditures:	$1,099,319.00

Additional Information	Total Amount
Net Patient Service Revenue:	$29,180,079.00
CB Expenditure as Percentage of Net Patient Services Revenue:	3.77%
Approved CB Program Budget for FY2020:	$250,000.00

(*Excluding expenditures that cannot be projected at the time of the report.)

Comments (Optional): Not Specified

Optional Information

Hospital Publication Describing CB Initiatives: Download/View Report

Bad Debt: $1,956,654.00

Bad Debt Certification: Certified

Optional Supplement: Not Specified