FY18 Community Benefit Report Athol Hospital

Organization Information

Organization Address and Contact Information

Organization Name: Athol Memorial Hospital
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Web Site: www.atholhospital.org
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Organization Type and Additional Attributes

Organization Type: Hospital
For-Profit Status: Not-For-Profit
Health System: Heywood Healthcare
Community Health Network Area (CHNA):
Regions Served: Athol, Erving, New Salem, Orange, Petersham, Phillipston, Royalston, Warwick, and Wendell.

CB Mission

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
Committed to addressing health disparities that exist in our region and improving access to care and wellness for populations adversely affected by social determinants of health especially populations living in poverty, ethnic and linguistic minorities, youth, veterans, and elders and their caregivers. Priority Health Issues identified are Mental Health and Substance Abuse; Suicide Prevention; Chronic Health Conditions and related risk factors; Nutrition needs including obesity and food insecurity.	2015 Community Health Needs Assessment quantitative and qualitative data

Publication of Target Populations: Marketing Collateral, Website

Hospital/HMO Web Page Publicizing Target pop.: **www.atholhospital.org**

Key Accomplishments of Reporting Year:

- Partnered with the Athol Schools to address food insecurity by providing 1600 backpacks filled with food for the weekend to assist to 50 low- income youth and their families.
- Provided health information about heart disease and offered free blood pressure screenings to over 50 individuals.
- Promoted wellness by providing flu prevention education in community settings and free flu vaccinations to 33 individuals.
- Distributed 150 biohazard containers and offered free disposal of sharps and needles reducing risk to families and waste management and landfill staff.
- Offered wellness instruction and self-care techniques to 82 individuals to cope and manage symptoms associated with Cancer and chronic conditions and end of life care.
- Provided 3003 individuals with health insurance counseling and financial assistance. Completed 593 health insurance applications.
- Assisted 89 patients with transportation and as a result was able to follow up with their healthcare and prevented missed appointments.
- Offered free psychosocial support to 63 community members looking for information and referrals on issues related to housing, food, transportation, behavioral and substance abuse.
- Provided 1,026 hours of mentorship to 5 students pursuing careers in healthcare.
- Actively participate on community boards and committees including, the North Quabbin Community Coalition, Athol YMCA Diabetes Prevention Advisory Board, Valuing our Children, Franklin Hampshire North Quabbin Opiate Prevention Task Force, Life Path, Greater Gardner Religious Council, and the Regional Behavioral Health Collaborative, to collaboratively address community health needs and gaps in services.

Plans for Next Reporting Year: In 2018, Athol Hospital conducted a comprehensive community health needs assessment (CHNA). Athol Hospital remains committed to addressing health disparities and the health needs of our region. A focus of the health assessment 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 early 2019 the final assessment will be presented to the groups and individuals that contributed to the assessment findings. The CHNA findings and feedback garnered from the presentations will inform the Hospital's community benefit target population, priority areas, and implementation strategies. The Community Health Improvement Plan (CHIP) will align with the Hospitals strategic plan and coordinated with the CHNA9 regional community health improvement planning process. Membership of the Community Benefits Leadership Team and Advisory Committee will be reviewed to ensure representation from the CHIP's target population and priority focus areas.

Community Benefits Process

Community Benefits Leadership/Team: Athol Hospital's community benefit leadership team is a 13 member Community Investment Committee (CIC), comprised of internal hospital leaders, community members, CHNA 9, and external stakeholders representing the minority community, schools, and local

businesses. Meetings are staffed by the VP of External Affairs. The Community Health Needs Assessment and related Community Benefit Plan goals and activities are shared with the Board of Trustees for approval.

Community Benefits Team Meetings: Formal Meetings of the CIC are held quarterly. Periodic meetings are held between the Community Benefits Manager and the program leads. Updates are provided at the Hospital's senior leadership meetings with feedback incorporated for program expansion and improvement. Members of the management team actively participate in various community agency boards, coalitions, and committees, which assist in identifying community needs and facilitate new ideas and community collaborations to address the issues.

Community Partners: Athol Hospital's approach to Community Benefits is to actively participate on and collaborate with cross-sector coalitions, healthcare and behavioral health providers, community, and faith-based organizations and businesses to develop and implement our plan, goals, and strategies. Partners include: North Quabbin Community Coalition; Valuing our Children; Franklin Hampshire North Quabbin Opiate Prevention Task Force; The Regional Behavioral Health Collaborative; Athol and Royalston Boards of Health; Suicide Prevention Task Force; Athol YMCA; Athol Public School District; Athol, Erving, and Winchendon Senior Center; Life Path; Phillipston Congregational Church; Salvation Army.

Community Health Needs Assessment: The health needs and targeted population for Athol Hospital's 2018 Community Benefit initiatives were identified through a 2015 Community Health Needs Assessment conducted in partnership with the North Quabbin Community Coalition. Additionally, the Hospital's Board of Trustees was integral in the development and support of identified initiatives.

Date Last Assessment Completed and Current Status: During 2018 Athol Hospital conducted a comprehensive Community Health Needs Assessment (CHNA) including the greater Athol and North Quabbin area served by Athol Hospital. Throughout the assessment, special attention was paid to "communities within communities", health disparities and health equity. Information and perceptions from under-represented racial/ethnic, socioeconomic and geographic groups were collected from Surveys, Focus Groups, and Healthcare Professional Interviews to supplement the quantitative data gathered. The Community Benefits Advisory Committee made up of department heads from Athol and Heywood Hospitals, the North Quabbin Community Coalition, the CHNA-9 Group, and other relevant community partners provided input into the process and assisted with analyzing and reviewing the report. The board approved Community Health Assessment is posted on the hospital's website at https://www.atholhospital.org/about/community-benefit. Hospital staff is presenting the CHNA findings with community members, stakeholders, and partners and soliciting input in response to the CHNA to help inform the development of a Community Health Improvement Plan (CHIP). The CHIP will align hospital efforts with other work being done in the region, leverage cross-sector resources and expertise in the community, and maximize the impact on improving population health.

Consultants/Other Organizations: The CHNA was a collaborative effort conducted by Heywood Healthcare's Heywood Hospital and Athol Hospital; the Montachusett Regional Planning Commission (MRPC); UMASS Memorial Health Alliance Clinton Hospital; The Community Health Network Area 9 of North Central MA (CHNA 9) Group; and John Snow, Inc. Staff at MRPC were responsible for conducting research and analysis efforts. Other organizations and individuals also contributed to the assessment,

including: North Quabbin Recovery Planning Group; Jail to Community Task Force; Children's Health and Wellness; Multicultural Task Force; Gardner Area Interagency Team; Substance Abuse Task Force; Greater Gardner Religious Council; Schwartz Center Rounds; Greater Gardner Chamber of Commerce; Heywood Senior Team ; Regional Behavioral Health Collaborative; Gardner MENders Support Group; Montachusett Suicide Prevention Task Force; North Quabbin Community Coalition; Community Health Connections Board; Montachusett Public Health Network; and CHNA-9 CHIP Breakfast .

Data Sources:
Quantitative data for the 2018 CHNA came from Massachusetts Community Health Information Profile (MassCHIP) data from the Massachusetts Department of Public Health (MassDPH); the Youth Risk Behavior Survey (YRBS) data; U.S. Census data (including data from the American Community Survey); and other Commonwealth and Federal Government organizations and agencies.

Qualitative data was gathered through 17 Focus Groups and 12 Healthcare Professional Interviews hosted by MRPC with individuals representing many diverse communities and populations that live in Athol Hospital's catchment area. A survey was also made available online through SurveyMonkey.com and was distributed to 29 locations across the Service Area in hard copy form. Overall, 952 surveys were filled out with a completion rate of about 62.7% (596 completed surveys).

Community Benefits Programs

Priority Area: Wellness

Program Type: Direct Service; Prevention
Statewide Priority: Promoting Wellness in Vulnerable Populations
Brief Description or Objective: Provide Free influenza immunizations in the community to at-risk populations.
Target Population:
Regions Served- Greater Athol Hospital Service Area
Health Indicator- Immunization
Sex- All ***Age Group-*** adults and elders ***Ethnic Group-*** All ***Language-*** All

Goal Description	Goal Status
Offer free influenza shots and flu prevention education in the community to help lower the occurrence of the flu.	Participated in Influenza Clinics at St Mary's Monastery in Petersham, and public clinics for community members, volunteers, and contractors providing 33 flu shots.

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Priority Area: Wellness- Substance Use

Program Type: Prevention
Statewide Priority: Promoting Wellness of Vulnerable Populations

Brief Description or Objective: 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.

Target Population: ***Regions Served-*** Greater Athol Hospital Service Area
Health Indicator- Substance Use, Public Saftey
Sex- All ***Age Group-*** **All** ***Ethnic Group-*** All ***Language-***All

Goal Description	Goal Status
Sharps Disposal Program- 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.
MENders- Men's support group promoting healthy living and offering coping skills for managing symptoms associated with mental illness and substance use.	34 men participated in the MENders support program that met 77 times at three different sites. Through this support group, men became connected to resources; gained confidence and learned coping skills to better manage their behavioral health and/or addiction issues.
Opioid Overdose Prevention Education	Participated in health fairs at Athol High School, Athol Police Department and the North Quabbin Community Coalition providing resources on naloxone administration, opioid prevention, and materials for parents.

Contact Information:

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Priority Area: Chronic Disease Management

Program Type: Direct Service
Statewide Priority: Chronic Disease Management in Disadvantaged Populations

Brief Description or Objective: 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.
Target Population: ***Regions Served***- Greater Athol Hospital Service Area
Health Indicator- Cardiac Disease; Stroke; Diabetes
Sex- **All** ***Age Group***- adults and elders ***Ethnic Group***- All ***Language***-All

Goal Description	Goal Status
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.	Provided health education and free blood pressure screenings for approx. 50 individuals at community events including the Petersham Farmers Market, Erving, Royalston, and Phillipston Senior Center, Lakeside Apartments, the Athol YMCA, and the North Quabbin Garlic Festival.
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 50 individuals. Participants benefited from information and referral, education, and peer support around coping with Cancer.
Transitional Care by Outreach RN	The Nurse conducted provided 32 follow-up home visits or phone calls providing a wellness check, health education, and assistance with referrals for services

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Priority Area: Nutrition

Program Type: School Partnership
Statewide Priority: Promoting Wellness of Vulnerable Populations, Reducing Health Disparities
Brief Description or Objective: In conjunction with area schools and community partners, supported 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.
Target Population: ***Regions Served***- Athol
Health Indicator- Nutrition
Sex- All ***Age Group***- school aged children ***Ethnic Group***- All ***Language***-All

Goal Description	Goal Status
Weekend Backpack Food Program: 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.	50 low income third and fourth-grade students that attend the Athol Public Elementary School benefited from the backpack program. 1,600 bags were distributed. 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.
Munch and Move Community Event	300 families participated in a Free Healthy Community dinner and hands-on healthy snack demonstration.

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Priority Area: Social Determinants of Health

Program Type: Direct Services
Statewide Priority: Supporting Health Care Reform
Brief Description or Objective: Provide financial counseling, psychosocial support, and transportation for individuals and families to address needs and overcome barriers to accessing healthcare. Direct support included health coverage enrollments, information, and referral, transportation.
Target Population: ***Regions Served-*** Greater Athol Hospital Service Area
Health Indicator- Social Determinants of Health
Sex- All ***Age Group-*** **All** ***Ethnic Group-*** **All** ***Language-*****All**

Goal Description	Goal Status
Provide uninsured or underinsured patients with information and enrollment assistance with health care	Provided 3,303 individuals with counseling on health insurance coverage and financial assistance. Completed 593 health insurance applications.
Arrange for transportation for individuals who do not have transportation and it would be a financial burden to go to their medical appointments.	89 patients assisted with transportation for a total cost of $3,961. As a result, patients were able to follow up with their healthcare and prevented missed appointments.
Assist vulnerable individuals with information and referrals to community programs that could address their needs.	Assisted 63 community members which either phoned in or walked in, with psychosocial services to overcome barriers to accessing needed health care. Many of the individuals served were elder caretakers, veterans, individuals with HIV or homeless. Provided information and referrals on

	issues related to housing, food, transportation, behavioral health, substance abuse.

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Priority Area: Social Determinants- Career Development

Program Type: Mentorship/Career Training/Internship
Statewide Priority: Promoting Wellness of Vulnerable Populations/ Reducing Health Disparity/ Supporting Health Care Reform
Brief Description or Objective: 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, which further supports Athol Hospitals efforts to improve local socio-economic factors and to increase the availability of trained health care workforce.

Target Population:

Regions Served- Greater Heywood Service Area
Health Indicator- Social Determinants of Health- Education, Employment, Income
Sex- All ***Age Group-*** Teens and Young Adults ***Ethnic Group-*** All ***Language-***All

Goal Description	Goal Status
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 400 hours of on-site training for college student during a 240-hour internship required for graduation with a BS in Exercise Science.
Club Med a summer exploratory program to introduce high school students to the field of medicine.	10 area high school students explored career opportunities and gained knowledge in the following areas: First Aid education, Emergency Department, Surgery, Swing Bed, Infections Disease, Public Health, Behavioral health and Substance Misuse, Radiology. At the end of the program students were given the opportunity to volunteer at the hospital in the area of interest.

Priority Area: Social Determinants of Health

Program Type: Community Participation/ Community Building Initiative
Statewide Priority: Promoting Wellness of Vulnerable Populations; supporting health care reform
Brief Description or Objective: 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.
Target Population: ***Regions Served*****-** Greater Athol Hospital Service Area
Health Indicator**-** Social Determinants of Health, Mental Health, Substance Abuse; Nutrition
Sex**-** All ***Age Group*****-** All ***Ethnic Group*****-** All ***Language*****-**All

Goal Description	Goal Status
Participation in community-based coalitions and committees.	Athol staff actively participated on the North Quabbin Community Coalition, Athol YMCA Diabetes Prevention Advisory Board, Valuing our Children, Franklin Hampshire North Quabbin Opiate Prevention Task Force, Greater Gardner Religious Council, Life Path Board of Directors, 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.

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