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 advancing our community's well-being by intentionally addressing race, sexual orientation, and gender identity inequities and 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. The hospital's Community Health Improvement Plan identifies ares of health needs and priority populations including racial/Ethnic minorities and indigenous population, recent imigrants and non-englich speakers, low income populations, older adults, children/adolescents, veterans, homeless, and LGBTQIA+	2021Community Health Needs Assessment quantitative and qualitative data

Publication of Target Populations:
Marketing Collateral, Annual Report, Website

Community Health Needs Assessment:

Date Last Assessment Completed:

September 2021

Data Sources:

Community Focus Groups, Community Health Network Area, Consumer Groups, Hospital, Interviews, MA Population Health Information Tool (PHIT), Other, Public Health Personnel, Surveys, Other Quantiative Sources:
â€¢ US Census/American Community Survey (ACS)
â€¢ Mass Department of Workforce Development (DWD)
â€¢ Youth Behavior Risk Survey (YRBS)
â€¢ Mass Department of Mental Health (DMH)
â€¢ Behavioral Risk Factor Surveillance Survey (BRFSS)

CHNA Document: HEYWOOD AND ATHOL HOSPITAL CHNA 2021 - FINAL REPORT 1.31.22.PDF

Implementation Strategy:

Implementation Strategy Document: HEYWOOD AND ATHOL HOSPITAL 2022-2024 COMMUNITY HEA

Key Accomplishments of Reporting Year:

COVID-19 COMMUNITY RESPONSE:
- Provided daily messaging to the community using multi-media, including print and social media. Communications were translated into multiple languages for the deaf and hearing impaired.
- Convened local boards of health weekly to foster coordination of resources and community testing services.
- Operated a regional covid 19 testing site six days/week to ensure community access to PCR testing and decrease Covid-19 prevalence.

- Hosted six (6) COVID clinics to administer vaccines to the public

INTERPERSONAL VIOLENCE/ TRAUMA
- Handle With Care- This initiative addresses and minimizes child trauma and its adverse effects. Starting in 2019, it has grown into the North Central, and North Quabbin Handle with Care Collaborative. It is a partnership between ten police departments, six regional school districts, youth-serving, and early education providers, and the Worcester County District Attorney. The HWC Collaborative has trained over1,150 school, police, and early childhood personnel on Trauma-informed Care and Adverse Childhood Experiences. These organizations have adopted trauma-informed care practices from these trainings and are better equipped to respond to childhood trauma.

MENTAL HEALTH and SUBSTANCE USE
- MENders A Men's peer support group promoting healthy living and offering coping skills for managing symptoms associated with mental illness and substance use had a steady influx of new participants. It met 129 times and served 1,339 MENders is constantly referred to as â€œlife-changingâ€ and a â€œlife-saver.â€ It has helped to normalize the conversation about mental health among men.
- School-based Tele behavioral Health program- In conjunction with Athol and Mahar School Districts, the school-based tele behavioral health program expanded to include evidence-based substance use prevention and treatment. The program provided 1,225clinical sessions via video conferencing for 66 at-risk students and 273 referrals to community-based services.

ACCESS TO HEALTH INSURANCE AND FINANCIAL ASSISTANCE
- Provided Financial and health insurance information and enrollment assistance to 2,305 individuals reducing financial barriers to accessing healthcare.

Plans for Next Reporting Year:

The CHIP will serve as a foundation for the next three years (2022-2024) and describes how Heywood Healthcare plans to address significant community health needs. Many strategies are a continuation of previous CHIPâ€™s. Heywood Healthcare (Athol Hospital and Heywood Hospital) continues to build and maintain relationships with partner organizations in the community to ensure that community health improvement work is carried out collaboratively.
The following is an overview of the priority health area and some of the strategies we plan for each.

INTERPERSONAL VIOLENCE/ TRAUMA
- Convene Suicide Prevention Task Force is a multi-sector, regional task force providing education and resources to help those who struggle with depression, survivors of suicide, and those who have lost loved ones to suicide.
- Expand Handle With Care (HWC) collaborations and coordination with the Emergency Department and pediatric offices. Test alternative methods for communication between first responders and schools and data tracking systems.

MENTAL HEALTH and SUBSTANCE USE
- Continue to use peer recovery coaches to connect individuals struggling with mental health and substance use issues to peer recovery support services and effective prevention programs.
- Expand the School-based Tele Behavioral Health program to include the middle schools in Gardner and Athol.

WELLNESS and CHRONIC DISEASE
- Implement Food as Medicine collaborations to link individuals with community food resources, i.e., Farmacy prescriptions and subsidies to support fruit and vegetable shares and purchase of healthy food items
- Support food system partnerships and planning with the North Central MA Local Food Works and Quabbin Food Connector to increase access to healthy foods and strengthen our local and regional food economy.
- Collaborating with the school district nurses and the ACES and Murdock SBHC, utilize innovative tele med diagnostics to expand and increase access to school-based health services.

SOCIAL DETERMINANTS
- Provide psychosocial support for individuals and families to address needs and overcome barriers. Direct support includes health coverage enrollments, transportation, legal services, and information and referral.
- Provide high school/college students and incumbent workers with opportunities to explore and gain skills for employment in health care
- Continue and expand HEAL (HOPE, EMPOWER, ACCESS, LIVE) model focused on three interdependent areas: Economic Empowerment, Equitable Food Access, and Social Inclusion to address the root causes of health disparities.
- Collaborate on the North Central Mass Anchor Collaborative to work with community-based organizations to address systemic inequities and strengthen the local economy. Anchor collaborative will work in three areas: 1. Local skill development, hiring, retention, and advancement strategies; 2 Local purchasing and investment; 3. Diversity, equity, and inclusion in the institutions and local community.

Self-Assessment Form: Hospital Self-Assessment Form - Year 1

Community Benefits Programs

COVID 19 Public Health Education and Prevention

Program Type	Direct Clinical Services
Program is part of a grant or funding provided to an outside organization	No
Program Description	Community education and coordination of community based services and resources focused on mitigating the spread of the virus and helping individuals manage symptoms and the impact of COVID 19.
Program Hashtags	Not Specified
Program Contact Information	Dawn Casavant, Tina Griffin

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Educate the community about the	1. Provided daily messaging to the community using multi-media to include print and social media. Communications were translated in multiple languages and for the deaf and hearing impaired. and working closely with community-based partners to help relay accurate and up-to-date information.		

COVID 19 virus and collaborate with partners to identify resources to assist individuals with preventing the spread and managing symptoms from the virus.	2. Convened local boards of health weekly to foster coordination of res0urces and community testing services. 3. Operated a regional covid 19 testing site six days/week to ensure community access to pcr testing and to decrease Covid-19 prevelance. 4. Hosted six (6) COVID clinics to administer vaccines to the public	Outcome Goal	Year 2020 of 2

EOHHS Focus Issues	N/A,
DoN Health Priorities	Not Specified
Health Issues	Infectious Diseaseâ€"COVID-19,
Target Populations	• **Regions Served:** Athol, Erving, New Salem, Orange, Petersham, Phillipston, Royalston, Warwick, Wendell, • **Environments Served:** Rural, • **Gender:** All, • **Age Group:** Adults, Children, Elderly, Teenagers, • **Race/Ethnicity:** All, • **Language:** Spanish, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified
Not Specified	Not Specified
Athol Board of Health	https://www.athol-ma.gov/health-department
Erving Board of Health	https://www.erving-ma.gov/board-health
New Salem Board of Health	https://newsalemma.org/board-of-health/
Orange Board of Health	https://www.townoforange.org/board-health
Petersham Board of Health	//www.townofpetersham.org/
Royalston Board of Health	https://www.royalston-ma.gov/health-department
Phillipston Board of Health	https://www.phillipston-ma.gov/board-of-health
Warwick Board of Health	http://www.warwickma.org/selectboard.html#boh
Wendell Board of Health	https://www.wendellmass.us/governance/board-of-health.html

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	Not Specified
Program Contact Information	Timothy Sweeney

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
A Men's peer support group promoting healthy living and offers coping skills for managing symptoms associated with mental illness and substance use.	The MENders program has seen a steady influx of new participants. Weâ€™ve increased the number of meetings (from 103 last year to 129) and increased the number of men served (from 748 last year to 1339.) While some of that demand may have been driven by unprecedented global circumstances, MENders has proven its value and that there continues to be a need for a safe, stigma-free space for people who identify as male to share, care, learn, grow, and connect. The MENders groups has helped normalize conversations about mental health and a safe space for sharing stories with candor and vulnerability. MENders is constantly referred to as â€œlife-changingâ€ and as a â€œlife-saver.â€ Men in the groups have sought professional help (some for the first time in their lives) pursued and attained recovery from addictions, accessed emergency services, and learned to thrive.	Outcome Goal	Year 2021 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:** Not Specified

	• **Gender:** Male, Transgender, • **Age Group:** Adults, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Veteran Status,

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

School-based Tele-behavioral Health Services, Care Coordination, and Youth Substance Use Prevention and Treatment Services

Program Type	Community-Clinical Linkages
Program is part of a grant or funding provided to an outside organization	No
Program Description	In conjunction with Athol and Mahar School Districts provide school-based behavioral health, substance use prevention and treatment and social supports for high-risk, school-aged youth and their families.
Program Hashtags	Health Screening, Prevention,
Program Contact Information	Maureen Donovan

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
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 accessing services while reducing time away from learning.	Tele-behavioral health clinicians provided 1,225clinical sessions via video conferencing for 66 at-risk students enrolled in the Ralph Mahar and Athol School Districts. School-based community health workers provided students and families with 273 referrals to community-based services. Issues most commonly faced by families and exacerbated by the pandemic were food insecurity, fuel assistance, and housing instability.	Outcome Goal	Year 2021 of 1
Expansion of School-based tele behavioral Health services to address co-occuring SUD and mental health disorders.	1. Three of our telebhavioral health clinicians became trained in A-CRA, an evidenced based youth substance use treatment program. Clinicians began providing this treatment via tele services in September 2021. In this one month 2 students were enrolled in the program. 2. Along with A-CRA we also provide and AMP program which connects at-risk youth with mentors to assist them with future plans and meeting goals which will move them away from their substance use behaviors. Eight (8) students were enrolled in the first two months that the program started.	Outcome Goal	Year 2021 of 1

EOHHS Focus Issues	Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities	Not Specified
Health Issues	Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Stress Management, Social Determinants of Health-Access to Health Care, 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-Homelessness, Social Determinants of Health-Income and Poverty, Substance Addiction-Alcohol Use, Substance Addiction-Opioid Use, Substance Addiction-Smoking/Tobacco Use, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Athol, New Salem, Orange, Petersham, Phillipston, • **Environments Served:** Not Specified • **Gender:** All, • **Age Group:** Adults, Teenagers, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** LGBT Status,

Partners:

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

Handle With Care- an initiative to address and minimize child trauma and its adverse effects.

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	Health Professional/Staff Training, Prevention,
Program Contact Information	Selena Johnson

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Handle With Care (HWC) supports children exposed to trauma through improved communication and collaboration between law enforcement, schools/child care agencies, and mental health providers and connects children and families to community and mental health services. HWC promotes school-community partnerships to ensure that children exposed to trauma in their home, school, or community receive appropriate interventions and support to foster personal and academic success.	1. Heywood Healthcare (Athol Hospital and Heywood Hospital) and area partners launched HWC, an initiative to mitigate child trauma and its adverse effects in 2019. Systems have been developed to identify students impacted by a traumatic event and then communicate with the schools, initiating appropriate trauma-sensitive care practices. 2. The initiative has grown into the North Central and North Quabbin Handle with Care Collaborative and is a partnership between ten police Departments and six regional school districts, youth serving and early education providers, and the Worcester County District Attorney, 3. The HWC Collaborative has trained over1,150 school, police, and early childhood personnel on Trauma informed Care and Adverse Childhood Experiences. These organizations have adopted trauma-informed care practices from these trainings and are better equipped to respond to child trauma.	Process Goal	Year 2019 of 3

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, Petersham, Phillipston, Royalston, • **Environments Served:** Not Specified • **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
Petersham Police Department	https://petershampolice.org/

Local Farm Shares for Seniors

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	Seeds of Solidarity in collaboration with the Orange Senior Center and North Quabbin Harvest 25 Elder Households will receive a CSA share during the summer. Produce will be from local farmers.
Program Hashtags	Not Specified
Program Contact Information	Mary Giannetti

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide 25 weekly household farm shares.	Quabbin Harvest Food Corp, with produce from seeds of solidarity and local farmers, provided Senior Summer Farm Shares to 39 elder housieholds in Orange and Athol. Recipes and cokking tips were provided with tips on how to prepare the produce.	Outcome Goal	Year 2021 of 1

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

Partners:

Partner Name and Description	Partner Website
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/
Quabbin Food Harvest- North Quabbin Harvest- Community owned grocery store for the North Quabbin region of MA	https://quabbinharvest.coop/
Orange Senior Center- local senior center in Orange, MA	https://www.orangeseniorcenter.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	Not Specified
Program Contact Information	Barbara Nealon, Director of Social Services and Teri Harrington 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	Provided 2305 individuals with counseling on Health Insurance Coverage and Financial Assistance to overcome barriers to accessing needed healthcare. 103 Health insurance applications were completed providing 152 individuals with health insurance benefits.	Outcome Goal	Year 2021 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.	6 patients assisted with transportation for a total cost of $410.00. As a result patients were able to follow up with their healthcare and prevented missed appointments.	Outcome Goal	Year 2021 of 1

EOHHS Focus Issues	N/A,
DoN Health Priorities	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:** Not Specified • **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/
Woods Ambulance and Medivan Services	https://woodsambulance.com/

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	Not Specified
Program Contact Information	Michelle Germain

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Athol Hospital serves as a clinical education site for college students to gain experience in an array of acute inpatient and outpatient health care fields.	Nursing clinical placements offered for college students to gain experience in an acute inpatient nursing service. Staff provided 160 hours of on-site educational training on the medical surgical unit for nursing students.	Outcome Goal	Year 2021 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:** Not Specified • **Gender:** All, • **Age Group:** Adult, Adult-Young, • **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/

Social Determinants of Health and Behavioral 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	Barbara Nealon; Mary Giannetti

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
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 fifth 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.	Approximately 30 members participated in quarterly virtual meetings. The Montachusett Suicide Task Force meetings include training and information sharing for members Activities of the task froce include: AWARENESS EVENTS A motorcycle "Ride of Your Life Event" to provide community education and raise awarenes on suicide prevention resources. COMMUNITY EDUCATION: The task force provides Mental Health First Aid and Question Persuade.. two evidence based suicide prevention/mental health trainings, for community. SUPPORT GROUPS: Suicide Loss Survivor Groups, MENders- Non clinical support programs led by peers	Process Goal	Year 2021 of 1
The Multicultural Task Force- Diversity and Inclusion (DEI) team- This task force with community participation is focused on addressing health disparities and social determinants of health focused on under-represented populations	The Multicultural DEI inclusion task force met monthly virtually given the COVID 19 pandemic. The interagency team includes staff that serve our target populations, patient members of the Patient Family Advisory Committee, and community members representing diverse gender identities, race/ethnicities, veterans and other underrepresented populations. Given that COVID 19 adversly impacted these populations, the committee reviewed data stratified by subpopulations, and strategies identified how to better serve these populations to reduce the health disparities and social determinants of health.	Process Goal	Year 2021 of 1
GAIT (Gardner Area Interagency Team) Administered by Heywood, this well-established coalition has been working together for over 35 years to improve access to health and social services for the communities' most compromised populations. GAIT consists of over 50 members representing school departments, elected officials, health and human service providers, mental health providers, home care services and	Nine meetings were held virtually with a consistent and diverse representation of 30 community organizations. The meetings provided opportunities for networking, resource sharing, and collaboration on addressing community health needs.	Process Goal	Year 2021 of 1

businesses.			

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Mental Illness and Mental Health,
DoN Health Priorities	Not Specified
Health Issues	Health Behaviors/Mental Health-Depression, Health Behaviors/Mental Health-Mental Health, Other-Cultural Competency, Social Determinants of Health-Access to Transportation, 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:** Adults, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
The North Central Massachusetts Minority Coalition is a strategic alliance between the regionâ€™s five minority-led agencies (Spanish American Center, Hmongâ€“Lao Foundation, Three Pyramids Inc.).	https://www.theminoritycoalition.org/
The Gardner Are interagency Team (GAIT) Team is committed to the coordination and improvement of health and human services in the Greater Gardner Area.	https://www.heywood.org/education/calendar/gardner-area-interagency-team
Montachusett Suicide Prevention Task Force	http://www.suicidepreventiontaskforce.org/meetings/membership

Expenditures

Total CB Program Expenditure **$527,942.00**

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	$195,555.00	$0.00
Total Population or Community-Wide Interventions	$306,505.00	$196,156.00
Access/Coverage Supports	$249.00	$0.00
Infrastructure to Support CB Collaborations Across Institutions	$25,633.00	$0.00

CB Expenditures by Health Need	Total Amount
Chronic Disease with a Focus on Cancer, Heart Disease, and Diabetes	$32,598.00
Mental Health/Mental Illness	$207,935.00
Housing/Homelessness	$0.00
Substance Use	$5,280.00
Additional Health Needs Identified by the Community	$282,129.00

Other Leveraged Resources	$0.00

Net Charity Care Expenditures	Total Amount
HSN Assessment	$330,314.00
HSN Denied Claims	$0.00
Free/Discount Care	$154,167.00
Total Net Charity Care	$484,481.00

Total CB Expenditures:	$1,012,423.00

Additional Information	Total Amount
Net Patient Service Revenue:	$33,741,262.00
CB Expenditure as Percentage of Net Patient Services Revenue:	3.00%
Approved CB Program Budget for	$500,000.00

FY2022:
(*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: Not Specified

Bad Debt Certification: Certified

Optional Supplement:

The Health Equity Partnership (CHNA9) recently launched the North Central Mass Anchor Collaborative. Heywood Healthcare (Athol Hospital and Heywood Hospitals) and five other anchor institution (UMass Memorial Health - Health Alliance-Clinton Hospital.Community Health Connections,Fitchburg State University,Gardner Public Schools, and LUK, Inc.) make up the North Central MA (NCM)Anchor Collaborative. The anchor collaborative formed with a committment to build an inclusive economy. The institutions are the larger employers, purchasers, and influencers in the region. Given this, we recognize that collectively we have the power to stabilize and rebuild the local economy. As part of these efforts, the NCMA Anchor Collaborative organizations have been engaged in analyzing our current policies and practices relating to equity and community development. The Collaborative is looking at what we can do individually and collectively to affect policy, systems, and environmental change within the institutions and the broader community. As a group, the collaborative organizations have focused on workforce development and how we can create jobs, increase incomes, and invest in communities to invest in themselves. Internally Heywood Hospital has several initiatives that align with the anchor collaborative mission. They include: 1. WORKFORCE DEVELOPMENT- Develop local skill through equitable hiring, retention, and advancement strategies; LOCAL FOOD WORKS- Support the local food economy, infrastructure, and farmers through local purchasing and investment; RESIDENT EMPOWERMENT-Provide backbone support and being thought leaders to coalitions (Multicultural DEI Task Force and HEAL Winchendon) that are focused on the shared values of diversity, equity, and inclusion in the local community and shifting the power structures and structural inequities.