Hallmark Health System

Community Health Implementation Plan 2017-2019

Prepared by the Institute for Community Health

Building sustainable community health, together
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Behavioral Health: Reduce stigma and support ongoing community collaborations to address behavioral health.

Cancer: Encourage early detection and intervention to reduce cancer incidence.

Cardiovascular Disease: Provide education and training to reduce the incidence and long-term impacts of heart attacks and stroke.

Diabetes: Educate and screen the population to reduce incidence and impact of diabetes.

Infectious Disease: Educate the community on emerging infectious diseases.

Access to Care: Overcome barriers to healthcare by considering social determinants in our programming.

Vulnerable Populations: Provide resources and support to vulnerable individuals and families.

Secondary health priorities: preventable injuries and poisonings; respiratory disease; obesity; violence and sexual assault prevention; disaster readiness and emergency planning.
About Hallmark Health

Hallmark Health System, Inc. (HHS) was founded in 1997, when four community hospitals in Boston’s northern suburbs joined together to form a local nonprofit health system—a coordinated approach to providing hospital, ambulatory and community-based services that were innovative, engaged and committed to improving the health of all who live and work in its service area.

Today, Hallmark Health encompasses Melrose-Wakefield Hospital in Melrose and Lawrence Memorial Hospital of Medford; Hallmark Health Medical Center in Reading; Hallmark Health Cancer Center, Center for Radiation Oncology, and Center for MRI, all in Stoneham; Hallmark Health VNA and Hospice; Hallmark Health Medical Associates; Lawrence Memorial/Regis College Nursing and Radiography programs; alliances for specialized services including wound care, sleep, and bariatric care; and more than 700 affiliated physicians north of Boston.

To bring the best specialty care to residents in the region, Hallmark Health is affiliated with:

- **Joslin Diabetes Center** for diabetes care, with clinical locations at both Melrose-Wakefield Hospital and Lawrence Memorial Hospital of Medford
- **Massachusetts General Hospital** for cardiac care, including procedures performed at the Cardiac & Endovascular Center at Melrose-Wakefield Hospital
- **UMass Memorial Medical Center** for ICU care, as one of only 10 Massachusetts hospitals to offer e-ICU services, at Melrose-Wakefield Hospital
- **Tufts Medical Center** for neonatology, supporting the Maternal/Child Health program at Melrose-Wakefield Hospital, including the Special Care Nursery

The Massachusetts Department of Public Health has designated Melrose-Wakefield Hospital and Lawrence Memorial Hospital as Primary Stroke Service hospitals, ready to provide emergency diagnostic and therapeutic services 24 hours a day, seven days a week, to acute stroke patients. Melrose-Wakefield Hospital is designated a “Baby Friendly” hospital, a program of the World Health
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Organization (WHO) and United Nations Children’s Fund (UNICEF). Baby-Friendly birthing facilities create environments for parents and infants to get the best start in life from the very start, supporting breastfeeding and best practice infant care strategies.

In April 2014, Hallmark Health achieved MAGNET® status, a reflection of its nursing professionalism, teamwork and excellence in patient care. In 2016, the Vermont Oxford Network, a national nonprofit collaboration of health professionals working to change the landscape of neonatal care, named Melrose-Wakefield Hospital one of only 28 Centers of Excellence across the country in Education and Training for Substance-Exposed Infants.

Hallmark Health’s inpatient and ambulatory clinical services reflect excellence in **five key service lines:**

- Orthopedics and Sports Medicine
- Cardiology and Endovascular Medicine
- Gastrointestinal Medicine
- Maternal and Newborn Medicine
- Hematology and Oncology Services

Hallmark Health’s **Community Services** division oversees programs that impact both medical and social determinants of health, supported by a mix of federal, state and private funding. These include:

- North Suburban Women, Infants, and Children (WIC) Nutrition Program
- Healthy Families Program and Massachusetts Home Visiting Initiative (HF/MHVI)
- North Suburban Child and Family Resource Network (NSCFRN)
- Dutton Adult Day Health Center
- Aging in Balance Elder Outreach
- Community Health Education
- Lifeline Program
Community Benefits

MISSION STATEMENT
Hallmark Health System, Inc. is committed to building and sustaining a strong, vibrant and healthy community. Hallmark Health dedicates appropriate resources to collaborations with community partners and the utilization of community members’ input toward improving health services. Hallmark Health pledges to act as a resource and to work with the community during emergencies; to improve access to care; to identify, monitor, and address the unique health care needs within its core communities; and to promote healthier lifestyles for residents through health education and prevention activities.

COMMUNITY BENEFITS STRUCTURE
The Community Services Department of Hallmark Health reports to the Senior Vice President for Home Care and Community Programs. The Director, Community Services oversees the Manager, Community Benefits and Community Services Operations, a Community Outreach Worker, and the operational and regulatory functions of eight departments in the division. These include: Community Health Education, North Suburban Child and Family Resource Network (NSCFRN), North Suburban Women, Infants and Children (WIC) Nutrition Program, Healthy Families and the MA Home Visiting Initiative (HF/MHVI), Aging in Balance-Elder Outreach Program, Lifeline Program, and Robert Dutton M.D. Adult Day Health Center. Other community services and community benefits are provided throughout the system, but report outcomes and impacts, and receive guidance and support from the Community Services Department.

COMMUNITY BENEFITS SERVICE AREA
The HHS community benefits service area consists of 6 core communities: Malden, Medford, Melrose, Reading, Stoneham and Wakefield. It also consists of 3 secondary communities: Everett, North Reading, and Saugus. The core communities are so designated because HHS has actual physical clinical facilities in those communities. Secondary communities are so called because HHS does not have a physical presence in these communities, but does actively collaborate with other organizations to provide services as well as work on coordinated responses regionally inclusive of these cities and towns.
After the CHNA was completed, the HHS Community Benefits Advisory Council and leaders from the health system reviewed the information gathered, sought community input, and made decisions about how the health system will utilize the available resources to address the needs identified. The 2017 Community Health Implementation Plan (CHIP) includes some initiatives led solely by Hallmark Health, although the health system has made collaboration a priority, wherever possible, to engage local stakeholders and residents and ensure their critical feedback informs its efforts.

Hallmark Health will make every effort to use the limited funds available to effectively continue support for programs with high impact, such as those funded by state grants and serving vulnerable populations. Other programming will be implemented through partnerships with other like-minded organizations, as donations, grants, and other funds are secured to ensure their sustainability.

While the system will touch on most of the health priorities identified in the 2016 Community Health Needs Assessment (CHNA), the CHIP will be limited in the breadth of programming and will not be fully funded to address all aspects of the identified needs. In each year of the three year CHIP the resources available will be reevaluated and allocated as resources allow.
2016 Hallmark Health System Community Health Needs Assessment

Every three years as a not-for-profit health system, Hallmark Health System (HHS) is required to complete a Community Health Needs Assessment (CHNA). HHS completed its second formal CHNA process in August 2016 in collaboration with the Institute for Community Health, a not-for-profit organization based in Malden, MA. Using a mixed methods approach, ICH assessed a variety of health topics and social factors, using a mix of primary and secondary data. The complete assessment is available at hallmarkhealth.org and in hard copy at several locations.

Based on this process, priority health concerns were identified.

Primary health priorities:
- Substance use disorders
- Behavioral health
- Cancer
- Cardiovascular disease
- Diabetes
- Infectious disease
- Access to care including barriers due to language, transportation, housing and food insecurity
- Vulnerable populations

Secondary health priorities:
- Preventable injuries and poisonings
- Respiratory disease
- Obesity
- Violence and sexual assault prevention
- Disaster readiness and emergency preparation
Health Priorities

Primary Priority: Substance Use Disorders

Summary of Need
Substance use disorders were a major concern across all types of data reviewed.

Specific concerns in the HHS community benefits service area as compared to the state:
- Adult opioid-related emergency department visits, hospitalizations and deaths were higher, as were opioid-related emergency visits for 15-19 year olds
- Rates of alcohol/substance use-related emergency department visits were higher for both 15-19 year olds and adults, as were hospitalizations for 15-19 year olds
- Stakeholders identified substance use as their top concern through surveys and community forums

Goal
Build awareness and support efforts in the community around primary prevention, overdose reduction, and recovery-based interventions to reduce the impact of substance use disorders.

Key Strategies
- Provide support to local and regional substance abuse prevention coalitions
- Host the Middlesex County District Attorney’s regional Eastern Middlesex Opioid Task Force
- Co-chair the Care Collaborative, comprised of agencies serving mothers and infants with substance use disorders
- Support the regional tobacco prevention efforts in the community
- Provide weekly space to an Alcoholics Anonymous (AA) support group in a handicapped accessible location
- Continue to offer programming such as COACHH (Collaborative Outreach and Adaptive Care at Hallmark Health), HF/MHVI (Healthy Families Program and Massachusetts Home Visiting Initiative), and Grandparents Raising Grandchildren in Harmony, reaching multiple generations within families impacted by substance use disorders

1 Note that all data described in the ‘Summary of Need’ sections are from Hallmark Health System’s 2016 Community Health Needs Assessment. See the assessment document for detailed data and a list of data sources.
Community Health Implementation Plan

Primary Priority: Behavioral Health

Summary of Need
Behavioral health was also noted to be a major concern across all types of data.

Specific concerns in the HHS community benefits service area as compared to the state:
• Rates of mental disorder-related mortality were higher
• In adults 65 and older, the rates for both mental disorder-related emergency department visits and hospitalizations were higher
• 5 of the 6 towns that collected data on depression in high school aged youth had rates higher than the state
• Behavioral health was identified as the second-highest priority among stakeholder survey participants and was noted as an important issue by community forum participants

Goal
Reduce stigma and support ongoing collaborative efforts in the community to address behavioral health, both independent of and co-occurring with substance use disorders.

Key Strategies
• Offer sliding scale supplemental support for individuals unable to afford mental health services
• Reduce the stigma of mental illness through education and support to families
• Provide a variety of support programs for elders, children, and adults suffering after the loss of a family member or friend
• Act as the fiscal agent for the Moving Beyond Depression program
• Continue to integrate behavioral health needs into primary and chronic disease models of care, including community-based programming and coalition efforts (The Care Collaborative, HF/MHVI, COACHH), as well as with external partners, to support individuals and families impacted by behavioral health challenges

Prepared by the Institute for Community Health
Primary Priority: Cancer

Summary of Need
Although the rate of cancer as a whole for the community benefits service area is comparable to MA, when looking at specific cancers and at individual towns areas of concern were noted.

Specific concerns in the HHS community benefits service area as compared to the state:
- The rate of colorectal cancer is higher
- The mortality rates for colorectal cancer and lung cancer are higher
- Lung cancer is the third highest cause of death, which is comparable to the state
- Six towns have higher breast cancer incidence rates vs. the state. Three have higher breast cancer mortality rates

Goal
Reduce overall incidence of multiple cancers through implementation of environmental improvements, education on healthy behaviors, and encouragement of early detection and intervention, and support efforts to improve quality of life for survivors.

Key Strategies
- Promote healthy living and green technology as root cause prevention measures
- Provide a variety of screenings according to the American Cancer Association standards
- Offer opportunities for cancer patients and their families to receive support to address the challenges of living with the disease
- Continue to promote the ongoing health of patients in recovery
- Through a collaborative effort, provide chronic disease self-management programming in the area and resources and referrals to Live Strong Programs at the local YMCAs
Primary Priority: Cardiovascular Disease

Summary of Need
Specific concerns in the HHS community benefits service area as compared to the state:

- Major cardiovascular disease-related emergency visits are higher
- Rates of acute heart attack mortality are also higher
- Circulatory system diseases are the top cause of mortality, and 3rd highest reason for hospitalization (comparable to the state)
- Rates of major cardiovascular disease hospitalization for adults 65+ are higher
- While not among the most frequently-identified concerns in surveys and community forums, cardiovascular disease did arise in the context of lifestyle factors such as diet, exercise, and obesity

Goal
Reduce the incidence and long-term impacts of cardiovascular disease and stroke through education and training of community members and first responders.

Key Strategies
- Train high school students in a train-the-trainer CPR model, preparing them to train their families and friends
- Provide Emergency Medical Technician (EMT) training focused on stroke and cardiovascular disease education
- Offer heart healthy education to community residents
- Continue to train the community to recognize and respond quickly to the signs of stroke
Primary Priority: Diabetes

Summary of Need
Specific concerns in the HHS community benefits service area as compared to the state:

- Diabetes is the highest cause of hospitalization (vs. 2nd highest cause in the state)
- For adults ages 65 and older, the rates of diabetes-related emergency department visits and hospitalizations are both higher
- Youth ages 15-19 also had a higher rate of diabetes-related emergency department visits
- Diabetes was mentioned as a concern by some of the stakeholders in surveys and forums, as were the contributing factors of unhealthy diets, lack of exercise, and obesity

Goal
Reduce the overall incidence and impact of diabetes for multiple populations in the region through education, screening, and the sharing of resources and referrals.

Key Strategies

- Provide diabetes education and screening throughout the region, especially focused on the underserved
- Offer monthly support groups to area residents with diabetes
- Provide comprehensive diabetes education for newly diagnosed and long term diabetics
- Through a collaborative effort, provide chronic disease self-management programs in the area and resources and referrals to pre-diabetes prevention programs at local YMCAs
Primary Priority: Infectious Disease

Summary of Need
Specific concerns in the HHS community benefits service area:
- HIV/AIDS, Hepatitis C, Chlamydia and Tuberculosis rates were higher than the state for some towns
- Concerns noted in stakeholder surveys were related to the threat of emerging diseases (such as Ebola and Zika) and the need for coordinated efforts in community education and health messaging

Goal
Act as a resource for information to the community around known and emerging infectious diseases, including the role of travel and immigration and its impact on disease models and prevention, and management of infectious diseases within the region.

Key Strategies
- Maintain a clinic for Tuberculosis (TB) to assist local public health officials in supporting individuals with TB in the region
- Produce Health Minute You-Tube videos in collaboration with Wakefield Cable Access TV
- Provide support to local flu clinics
- Promote the travel clinic at Lawrence Memorial Hospital as a resource for issues related to global health and disease management
- Conduct ongoing Continuing Medical Education programs, available for community members to participate in free of charge
- Continue to address emerging diseases through Disaster Readiness, and Emergency Planning efforts (see page 18)

2 Note that no service area-wide data was available for infectious disease.
Primary Priority: Access to Care

Summary of Need
Overcoming barriers to routinely accessing healthcare emerged as a common concern in the stakeholder surveys and forums. Some barriers frequently mentioned included language barriers, transportation difficulties, economic insecurity/poverty, housing insecurity, and food insecurity.

Specific concerns in HHS community benefits service area:
- Serving the needs of vulnerable populations, including immigrants, older adults, and people/families living in poverty, for whom barriers impact the ability to engage and receive health services, and adversely affect care outcomes
- Maintenance of health insurance coverage continues to be an issue
- Economic instability is a concern for immigrants due to immigration status and low English proficiency
- Housing insecurity is a particular concern due to the high cost of living in the area
- Rates of food insecure households varied in the service area by community, with Reading having the lowest rate and Malden the highest

Goal
Consider the impact of social determinant factors on health in program planning, development and implementation, and explore opportunities for cross-sector collaboration to address these factors, including those outside the scope of traditional health care.

Key Strategies
- Assist several hundred residents annually with applications or re-applications for health insurance, as well as consultations related to health coverage and related financial challenges and issues
- Participate on local boards of directors for agencies serving the underserved
- Assist families with access to family assistance programs such as those through WIC, HF/MHVI, and COACHH
- Continue to work with local schools and colleges to promote the education and training of professional health care workers; especially diverse candidates
- Host a Mobile Food Market monthly in partnership with the Greater Boston Food Bank and area volunteers
Primary Priority: Vulnerable Populations

Summary of Need
Vulnerable populations in the HHS community benefits service area were identified by participants in the stakeholder surveys and community forums.

Specific populations of concern in the HHS community benefits catchment area included:
- Older adults
- Immigrants
- People living in poverty
- Children and families

Goal
Provide concrete supports, resources and referrals to individuals and families within vulnerable populations. These will include both resources focused on reducing health disparities, as well as efforts to promote health equity across the community regardless of socio-economic and other factors.

Key Strategies
- Train youth to provide calls to home-bound elders in the Lifeline Buddy Program
- Monitor health conditions and offer education to elders in the Aging in Balance Program
- Convene annual necessities drives for veterans, children, and low-income residents
- Provide nutrition education and vouchers to low-income eligible recipients through the WIC program
- Offer Adult Day Health services at the Dutton Center ADH for frail elders and Department of Mental Health and Department of Developmental Services participants
- Provide lightly-used children's clothing and equipment, parenting education, and resources and referrals to families in need at the Mothers Helping Mothers Closet. This should allow families additional resources for food and other necessities
Secondary Priorities

Preventable Injuries and Poisonings

Goal: Provide information and training to decrease preventable injuries and poisonings.

Key Strategies:
- Continue to offer the Concussive Injury Prevention Program for school-age children
- Maintain sports medicine trainers in local high schools at a reduced fee to help reduce sports injuries
- Provide education and training for residents with chronic back problems and risk of further injury
- Promote CPR, First Aid, and Safe Sitter babysitting training programs in the community

Obesity

Goal: Offer programs and services to prevent obesity that promote both weight loss and healthy living.

Key Strategies:
- Provide a minimum of one community-based weight management class annually
- Offer multiple healthy eating and active living programs in the community
- Host three Baby Cafés in the service area
- Support the Medford SNAP Program for elders
- Promote wellness through local Mass in Motion Programs and direct-service organizations such as the Greater Boston Food Bank

Respiratory Disease

Goal: Offer programs and services to address prevention of respiratory diseases prevalent in the community.

Key Strategies:
- Provide resources for long-term smokers to be able to successfully quit
- Act as the facilitator for the regional TB clinic overseen by the Massachusetts Department of Public Health
- Continue to promote vaccines as a prevention strategy for adults, elders, and children
Violence and Sexual Assault Prevention

Goal: Provide information and training to support prevention and decrease incidence and impact of domestic violence and sexual assault in the community.

Key Strategies:
- Support local initiatives addressing domestic violence through board and task force participation
- Provide space to Melrose Alliance Against Violence for a monthly group for domestic violence survivors
- Offer office space in-kind to Portal to Hope
- Facilitate bi-annual round table on domestic violence and intimate partner violence and provide other trainings to employees and community members

Disaster Readiness and Emergency Planning

Goal: To support resiliency and preparation in the community during and after cataclysmic events, including natural disasters, pandemic illness, and terrorism threats.

Key Strategies:
- Provide support to Hallmark Health communities preparing for seasonal flu
- Act as a resource to the community during emergencies or acts of terror
- Ensure local blood supply is available during emergencies and for regular needs
- Sponsor seven community teams to provide support to local communities and bring back information from stakeholders/residents on emerging community needs
Vision of the Future

As of January 1, 2017, Hallmark Health became a third, equal and founding member of Wellforce, a collaboration of value-driven, academic medical and community health care providers in Massachusetts which includes Circle Health in Lowell and Tufts Medical Center in Boston. This affiliation provides tremendous opportunities for Hallmark Health to collaborate with these new partners on best practice strategies that seek to reduce health disparities identified by each organization within its service area. As a member of Wellforce, Hallmark Health maintains oversight and responsibility for this Community Health Implementation Plan and its programs addressing health needs, and will amend this plan as funding or collaboration permits to enhance, broaden, and deepen the scope of its community benefits programming.
Appendices

Appendix A: Overview of Programs and Initiatives Addressing the 2016 Community Health Priorities

Below is a full list of all programs and initiatives planned to address the priorities.

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<th>Program/Activities</th>
<th>Substance Use Disorders</th>
<th>Behavioral Health</th>
<th>Cancer</th>
<th>Cardiovascular Disease</th>
<th>Diabetes</th>
<th>Infectious Diseases</th>
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## Community Health Implementation Plan

**Prepared by the Institute for Community Health**

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Appendix B: Glossary

**Key Abbreviations Used**

AA/NA/OA=Alcoholics Anonymous/Narcotics Anonymous/Overeaters Anonymous
ALS/BLS=Advanced Life Support/Basic Life Support
CFCE=Malden Coordinated Family and Community Engagement program
CHIP= Community health implementation plan
CHNA= Community health needs assessment
COACH= Collaborative Outreach and Adaptive Care at Hallmark Health
CPR=Cardiopulmonary resuscitation
DV=Domestic Violence
EMS=Emergency Medical Services
EMT=Emergency Medical Technician
HF/MHVI= Healthy Families Program and Massachusetts Home Visiting Initiative
HHS=Hallmark Health System
ICU= Intensive care unit
MA=Massachusetts
MRI=Magnetic resonance imaging
NSCFRN= North Suburban Child and Family Resource Network
TB=Tuberculosis
VNA= Visiting Nurse Association
WIC= Women, Infants and Children Nutrition Program

**Program Service Areas**

Each of the Hallmark Health grant-funded programs provide services to residents in their contracted communities. For WIC, the service area includes Burlington, Everett, Malden, Medford, Melrose, North Reading, Reading, Stoneham, Wakefield, Wilmington, Winchester, and Woburn. For the NSCFRN the communities served are Lynnfield, North Reading, Reading, Melrose, Stoneham, Wakefield, and Winchester. Healthy Families/MHVI is contracted to serve families in Everett, Malden, Medford, North Reading, Reading, Stoneham, and Wakefield. In addition, Lifeline covers all nine Hallmark Health priority communities and many other surrounding communities.
Appendix C: Key Partners

- Action for Boston Community Development, Inc. (ABCD)
- American Cancer Society
- Asian American Civic Association
- American Diabetes Association
- American Heart Association
- American Lung Association
- American Red Cross
- Association for Community Health Improvement
- Baby Café USA
- Baby Friendly America
- Boys and Girls Clubs of Middlesex County
- Boston Bruins Foundation
- Bread of Life Malden
- Burbank YMCA of Reading
- Cambridge Health Alliance
- Catholic Charities
- Children’s Trust Massachusetts
- Chinese Culture Connection
- CMS Innovation Forum
- Commonwealth Corporation
- Community Health Network Areas (CHNA) 15 & 16
- Community Family Human Services, Inc.
- Community Servings
- Cross Cultural Communications, Inc.
- Early Intervention Programs (Several)
- East Boston Neighborhood Health Center
- Eliot Community Human Services
- EMARC (Eastern Middlesex Association of Retarded Citizens)
- Elder Services of the North Shore
- Everett Coordinated Family Community Engagement Grant
- Families First
- Friends of the Middlesex Fells Reservation
- Friends of Oak Grove
- Greater Boston Food Bank
- Greater Lynn Senior Services
- Health Care for All
- Health Care Without Harm
- Housing Families, Inc.
- Immigrant Learning Center of Malden
- Institute for Community Health (ICH)
- Jackson Healthcare – Hospital Charitable Service Awards
- Jewish Children and Family Services
- Joint Committee for Children’s Health Care in Everett
- Joslin Diabetes Center
- Junior Aid Association of Malden
- La Comunidad, Inc.
- Life Care Center of Stoneham
- Local Arts Councils
- Local Boards of Health
- Local Chambers of Commerce
- Local Civic Groups (such as Rotary and Kiwanis)
- Local Councils on Aging
- Local faith-based organizations
- Local Public Schools
- Malden Coordinated Family and Community Engagement Grant
- Malden's Promise Coalition
- MA Executive Office of Elder Affairs
- Tri-City Homelessness Task Force
- Malden YMCA
Community Health Implementation Plan

MA Department of Children and Families (DCF)
MA Department of Conservation & Recreation (DCR)
MA Department of Early Education and Care (EEC)
Massachusetts Department of Public Health (DPH)
Massachusetts Department of Transitional Assistance (DTA)
Mass in Motion Coalitions for Everett, Malden, Medford, and Melrose-Wakefield
Massachusetts General Hospital
Massachusetts Health Policy Commission
Massachusetts Hospital Association
Medford Family Network
Medford Health Matters
Medford Substance Abuse Task Force
Melrose Human Rights Council
Melrose Alliance Against Violence
Melrose Birth to Five Coalition
Melrose Community Coalition
Melrose Family YMCA
Melrose Human Rights Commission
Melrose Substance Abuse Prevention Coalition
Merrimack Valley Elder Services
Middlesex Recovery, PC
Middlesex County District Attorney’s Office
Middlesex County Sheriff’s Department
Mount Auburn Hospital
MotherWoman
Mystic Valley Elder Services
Mystic Valley Public Health Coalition:
  - Mystic Valley MA Opioid Abuse Prevention Collaborative
  - Mystic Valley Tobacco and Alcohol Program
  - Substance Abuse Prevention Collaborative
Northeastern University
Oak Grove Improvement Organization
Partners HealthCare, Inc.
Portal to Hope, Inc.
Reading Substance Abuse Prevention Coalition (RCASA)
Regional EMS Providers
Regis College and other area colleges and universities
Respond, Inc.
South Bay Mental Health Center
Somerville Cambridge Elder Services
Staples, Inc.
Stoneham Alliance Against Violence
Stoneham Substance Abuse Coalition
Tailored for Success
The Stoneham Theater
Tri-City Hunger Network
Tufts Medical Center
Tufts University
The Salvation Army
The Sharewood Project
UMass Memorial Health System
Wakefield Alliance Against Violence
WAKE-UP: Wakefield Unified Prevention
West Medford Community Center
Winchester Hospital/Lahey Health
YouthHarbors Program (JRI)
YWCA of Malden
Zonta Clubs of Medford and Malden
Zoo New England-Stone Zoo
The Hallmark Health System (HHS) CHIP has been in operation since it was approved by the HHS Board of Trustees in January 2017. As required by the IRS and the state of Massachusetts through the Attorney General’s Office, the comprehensive plan identifies the programs and services the system expects to provide to the community as community benefits during a three year period comprised of fiscal years 2017 through 2019. Community benefits at HHS has historically been a system-wide approach to addressing community health needs with services and programs provided in a de-centralized model of care integrated across many clinical, ambulatory, and community departments.

From the fourth quarter of fiscal 2017 and into the first quarter of fiscal 2018, it became apparent that due to significant financial challenges facing the organization, the community benefits expected to be delivered to the community would need to be reduced.

From page 7 of the CHIP:

“After the CHNA was completed, the HHS Community Benefits Advisory Council and leaders from the health system reviewed the information gathered, sought community input, and made decisions about how the health system will utilize the available resources to address the needs identified. The 2017 Community Health Implementation Plan (CHIP) includes some initiatives led solely by Hallmark Health, although the health system has made collaboration a priority, wherever possible, to engage local stakeholders and residents and ensure their critical feedback informs its efforts.

Hallmark Health will make every effort to use the limited funds available to effectively continue support for programs with high impact, such as those funded by state grants and serving vulnerable populations. Other programming will be implemented through partnerships with other like-minded organizations, as donations, grants, and other funds are secured to ensure their sustainability.

While the system will touch on most of the health priorities identified in the 2016 Community Health Needs Assessment (CHNA), the CHIP will be limited in the breadth of programming and will not be fully funded to address all aspects of the identified needs. In each year of the three year CHIP the resources available will be reevaluated and allocated as resources allow.”
Annually, Hallmark Health will make the necessary adjustments to the levels of programs and services offered based on changes in available resources.

To this end, the Hallmark Health Board Governance Committee met on February 12, 2018 to discuss the proposed amendments to the CHIP and recommend those changes to the full Board of Trustees. The Board of Trustees approved changes to the plan unanimously on February 22, 2018. Those changes are listed below.

Primary Priority- Substance Use Disorders- page 9
- Co-chair the Care Collaborative. This group is expected to meet less frequently and with reduced membership. HHS Social Services representatives will decrease their role on the committee to allow for an increase in direct patient care services.
- The Collaborative Outreach and Accountable Care at Hallmark Health (COACHH) Program will end services in February 2018 when funding ends.

Primary Priority- Behavioral Health- page 10
- Reduce stigma of mental illness through education and support to families. Less programming will be offered due to budget reductions.
- The Moving Beyond Depression Program is no longer funded by the state.
- New program: Alzheimer’s Caregiver Education in collaboration with Tufts Health Plan has been offered in early 2018. The planning for the program began in fiscal 2017.
- New program: Behavioral Health Integration Program (BHIP) is being offered in employed physician offices in collaboration with NEQCA. It is yet to be determined if this program or other behavioral health programs will have losses that will be captured as subsidized services.

Primary Priority- Cancer- page 11
- With the Cancer Center becoming licensed under Tufts Medical Center, screening and educational programs will be the shared responsibility of Tufts Medical Center and Hallmark Health.

Primary Priority- Cardiovascular Disease- page 12
- While funding for the school kits is available, the train-the-trainer CPR program has not provided services since the fall of 2017 when the Program Coordinator position was eliminated. Public Affairs/Marketing, in collaboration with Community Services, has reinstated the program in the spring of 2018, but attendance will be lower than in prior years due to the later start-up.
- Other educational components have not been assigned as yet such as EMT training, heart healthy education, and stroke education.

Primary Priority- Diabetes- page 13
- The Diabetes Program was moved to Hallmark Health Medical Associates in May of FY17. Due to changes in the Massachusetts Department of Public Health licensing for
blood screenings, the screening component of the program has been temporarily suspended with the goal to reinstate it when alternate screening methods have been approved.

- A potential partnership is being discussed to better screen and refer the Asian elder population in the Malden area for diabetes services.

**Primary Priority - Infectious Disease - page 14**
- The HHS TB Clinic was closed by MA DPH in June 2017. The HHS license is active through 2018. The program was reinstated in January 2018, but to date there has been little activity in the program.

**Secondary Priority - Obesity - page 17**
- It may not be possible to continue to support the Medford SNAP program due to reduced funding.
- Community-based weight management programs are not being offered at this time.
- New programs
  - A summer food program was added for school children in 2017 at the Summer Fun Program in Medford.
  - HHS has taken a leadership role on the new Medford Food Insecurity Task Force.
  - HHS is also represented on the Food Insecurity Task Force of the Greater Boston Food Bank.

**Secondary Priority - Disaster Readiness and Emergency Planning - page 18**
- Active Shooter training and drills have had limited information reported to capture the work of the program.

**Other Program Impacts:**
- Aging In Balance (AIB) Senior Health Program - page 20. The program’s hours have been reduced to address other community needs.
- Community Health Education - page 20 and page 21. Osteoporosis, Falls Prevention, and Lung Cancer talks have been limited due to diminished resources.
- Community Services - page 21. Route 99 shelter visits ended in August 2017 as most families have been placed in other more desirable housing sites.
- New Programs - pages 21 and 22. Increased funding has been received for parenting groups and HHS has expanded its role with the Malden Public Schools for the Coordinated Family and Community Engagement (CFCE) grant.

**Additional Recommendations:**
- While it is noted on page 19 of the CHIP that Hallmark Health became a third, equal and founding member of Wellforce on January 1, 2017; there is information on page 4 of the CHIP that has changed such as the following:
o Hallmark Health is no longer affiliated with Joslin Diabetes Center for diabetes care
o Hallmark Health is no longer affiliated with Massachusetts General Hospital for cardiac care.