Organization Information

Organization Name:	South Shore Hospital
Address:	55 Fogg Road
City, State, Zip:	South Weymouth, Massachusetts 02190
Website:	www.southshorehospital.org
Contact Name:	Elizabeth Cullen
Contact Title:	Director, Community Benefits and Strategic Initiatives
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Contact Address: (Optional, if different from above)	55 Fogg Road
City, State, Zip: (Optional, if different from above)	South Weymouth, Massachusetts 02190

Organization Type:	Hospital
For-Profit Status:	Not-For-Profit
Health System:	Not Specified
Community Health Network Area (CHNA):	Blue Hills Community Health Alliance (Greater Quincy)(CHNA 20), Greater Brockton Health Alliance(CHNA 22), South Shore Community Partners in Prevention (Plymouth)(CHNA 23),
Regions Served:	Abington, Avon, Braintree, Bridgewater, Brockton, Canton, Carver, Cohasset, Duxbury, East Bridgewater, Easton, Halifax, Hanover, Hanson, Hingham, Holbrook, Hull, Kingston, Lakeville, Mansfield, Marshfield, Middleborough, Milton, Norton, Norwell, Pembroke, Plymouth, Plympton, Quincy, Randolph, Rockland, Scituate, Sharon, Stoughton, Taunton, West Bridgewater, Weymouth, Whitman,

Mission and Key Planning/Assessment Documents

Community Benefits Mission Statement:

The South Shore Health Mission Statement: Your Health. Our Passion. One Community
Vision: We will be the first place our community turns to for health and wellness.
Values: We put the patient first
We act with courage and compassion.
We are ONE team.
We never stop learning, never stop improving.
We know our employees are the best thing about our organization.
We are the community we serve.
We love our work.

Target Populations:

Name of Target Population	Basis for Selection
Individuals Impacted by Chronic & Complex Conditions	Stakeholders identified need for care management, navigation, and care coordination for these populations. Transportation, fragmented care and lack of health literacy were common themes during the South Shore Health CHNA.
Those requiring assistance obtaining health insurance or guidance in navigating health system	Statewide health priority

Community members impacted by Behavioral Health	Statewide Priority
Those at risk of experiencing disparities in care due to income, education, disabilities, race, ethnicity, language or other criteria	Area of focus for South Shore Health Community Benefits, eliminating Health and Racial Inequities Statewide health priority
1) Under served Brazilian/Asian Population in the Region, 2) Youth at Risk (high risk behaviors) 3) Population with chronic disease such as Cardiovascular disease or diabetes, especially those with challenges relating to access to care such as transportation and language barriers.	Findings in the Community Health Needs Assessment completed in 2021: A large and mostly hidden population including a Brazilian subgroup with health care disparities evident making access to care a challenge. South Shore Health serves a large and growing Asian population, many older adults with English secondary other languages (ESOL). Chronic diseases such as cardiovascular disease and diabetes are prominent in the region as identified in the Community Health Needs Assessment of 2021.
Those at risk related to Access to Care, including language barriers, transportation and Behavioral Health Initiatives, disproportionately impacting people of color, immigrants, refugees & non English speaker	The South Shore Health 2021 Community Health Needs Assessment, statewide health priority
People & Families with Limited Economic Means	Area of focus for Community Benefits, eliminating Health and Racial Inequities, those at risk of experiencing disparities in care due to income, education, disabilities, race, ethnicity, language or other criteria, often not eligible for public programs such as WIC, Medicaid, SNAP, Head Start, The Ride yet often making difficult decisions regarding housing, medications and food. Statewide health priority
Those at risk related to Access to Care, including language barriers, transportation and Behavioral Health Initiatives	The 2021 South Shore Health Community Health Needs Assessment and Statewide Priorities. People of Color, Older Adults Non English speakers, Children & Adolescents, People and Families with limited economic means and chronic complex medical conditions are all impacted by Access to Care challenges.
Immigrants, Refugees, & Non English Speakers	Area of focus for Community Benefits, eliminating Health and Racial Inequities reducing barriers to care. Including those requiring assistance with health insurance and navigating the health care system. Statewide health priority
Particularly vulnerable population: elderly and at-risk youth	The 2021 Community Health Needs Assessment Older Adults and Children & Adolescents as priority populations. Older adults and children & adolescents were greatly impacted during the Pandemic which exacerbated the many challenges already faced by both populations.

Publication of Target Populations:
Website

Community Health Needs Assessment:

Date Last Assessment Completed:

South Shore Health's most recent CHNA was completed in September 2024.

Note that this Community Benefit AGO report is referencing programs under the 2022-2024 Implementation Strategy attached below.

Data Sources:

Community Focus Groups, Community Health Network Area, Consumer Groups, Hospital, Interviews, Surveys,

CHNA Document: Not Specified

Implementation Strategy:

Implementation Strategy Document: Not Specified

Key Accomplishments of Reporting Year:

The following key highlights focus on the work South Shore Health has done in in FY2024 in response to the health needs and target populations identified in the 2021 Community Health Needs Assessment and addressed in the 2022-2024 Implementation Strategy, as well as a brief summary of our latest Community Health Needs Assessment conducted in 2024.

1) Serving the community during regional hospital closures and transitions
In 2024, South Shore Health remained a steadfast community asset in the midst of regional health care instability as several health centers closed or transitioned to new leadership. Starting in 2020 with the closure of Quincy Medical Center and Norwood Hospital, continuing through 2023 with the temporary closure of Signature Brockton Hospital (through August of 2024) and the closure of Compass Medical Primary Care and into 2024 with the closure of Steward Carney Hospital, the region has lost over 500 hospital beds. These closures, compounded by the instability of Steward Good Samaritan's transition to new leadership, have contributed to increased volume at South Shore Health. South Shore Health has sustained ED volumes of 35% of total ED Volume in the region, has seen an increase of over 500 births, and has the third busiest Cardiac Catheterization Lab in Massachusetts. South Shore Health also provided IV supplies to other area hospitals during the nationwide shortage of IV products in September 2024.

2) Conducting tri-annual Community Health Needs Assessment and developing Implementation Strategy
In 2024, South Shore Health conducted its tri-annual Community Health Needs Assessment (CHNA). Over the course of several months, South Shore Health analyzed demographic and health outcome data across the cities and towns in the Community Benefit Service area, conducted 21 key informant interviews, and engaged the community through a community health survey with over six hundred respondents, five focus groups and one listening session. Through this comprehensive approach, and a series of Steering Committee and Community Benefit Advisory Committee meetings, the following health needs emerged as priorities for the next three years: Mental Health, Substance Use, Chronic Complex Conditions and Access to Care. The CHNA also emphasizes the role of social determinants of healthâ€”such as housing, transportation, food insecurity, and economic stabilityâ€”in shaping health outcomes. Health equity is a cross-cutting issue across all priority areas.

3) Reducing barriers to care, reducing health disparities and improving social determinants of health
South Shore Healthâ€™s Mobile Integrated Health (MIH) program brings care into the community by providing personalized, high touch care that is also supported by technology. Paramedics improve access to care for patients by providing certain services, such as lab work IV fluids and other medications, wound care, nebulizer treatments, COVID-19 tests and vaccines in patientâ€™s homes. Barriers to care are also reduced due to the interpersonal relationships that are developed between SSH paramedics and the patients receiving care. In FY24, MIH paramedics completed 4,325 in person visits to 2,502 unique patients.

South Shore Health expanded its work in improving transportation to reduce barriers to care. In January 2024, South Shore Health dedicated a vehicle to transport behavioral health patients discharged from the hospital to an inpatient psychiatric facility. Since January, this vehicle transported 750 patients and traveled 60,377 miles, improving the experience for patients through comfortable and dignified transportation, and the community freeing up an ambulance to make more local trips in the time that would have been used traveling to a behavioral health facility. South Shore Health continues to partner with Modivcare Connect, a transportation and ride sharing program to ensure patients have transportation home after an inpatient stay. In FY24, this solution provided a total distance of 29,171.74 miles with an average of 9 rides per day, and an average distance of 8.5 miles per ride. Lastly, in 2024, our clinical partner, DFCI dedicated an ambulance to transport cancer patients to their appointments at the South Shore Cancer Center, reducing transportation barriers of a very vulnerable population.

South Shore Health recognizes the importance of improving access to healthy food and supports and participates in programs such as â€œMass in Motion,â€□ the Weymouth Food Pantry, the South Shore Regional Food Pantry and Wellspringâ€™s food pantry and food delivery van to ensure those in need of health food have access to it and can ideally improve health outcomes in the long run due to this improved access.

South Shore Health continued its focus on social determinants of health in 2024. Patients admitted to the hospital are screened for health-related social needs, and if a patient screens positive for a health-related social needs, a referral to social work is made to connect the patient with necessary resources. South Shore Health periodically reviews this screening data, along with quality metrics, and patient demographic data to better understand the needs of its patients and has made strides in identifying health disparities and implementing strategies to address them. In addition to this screening process, South Shore Health has robust partnerships with community multi-service groups including the Weymouth Food Pantry and South Shore Food Pantry, the South Shore Health Collaborative Network, Wellspring, and Father Billâ€™s and Mainspring. South Shore Health meets with these groups

on a quarterly basis to better understand the social determinant of health needs in the community. The South Shore Health Community Resource Directory, in partnership with Find Help, is available for public use on our website and has had 2,021 views in FY24, connecting our patients and community with information on the resources they need.

4) Improving health literacy and communication: In 2024, South Shore Health continued to welcome new patients into our health system and has been proactive in addressing the corresponding increase in need for interpreter services and other support services. The total calls to our interpreters increased 62% from 2023 to 2024. Additionally, South Shore Hospital issued 25 additional iPads to improve access to our services, translated additional materials into our top languages including our patient rights and responsibilities document, medical records request form and educational materials. South Shore Health added two additional language lines in Spanish and Portuguese, and also formed an Interpreter Services Working Group to identify ways to enhance our language services offerings. Our top interpreted languages for the past year include Arabic, Chinese, Haitian Creole, Portuguese, Spanish, and Vietnamese and we had a 7% increase in the number of languages provided by interpreters.

South Shore Health also closely partners with Greater Plymouth Community Health Network Alliance (CHNA 23) and serves on its Steering Committee. Greater Plymouth Community Health Network Alliance is especially focused on health literacy and reflects this focus in planning its monthly community meetings and annual health literacy community awards. Health literacy topics planned together with this group in 2024 included inclusive language in health care settings, navigating hospitalizations, and health care decisions month.

5) Improving mental health:
The South Shore Behavioral Health Initiative concluded its fifth and final year in 2024. This community lead coalition met 1-2 times per year to discuss ways of improving behavioral health and partnering together to take action. Each of the two community agencies that received funding for these initiatives have provided services to over 531 clients through FY24. Additionally, the hub model has expanded to focus on very high-risk patients, collaborating with South Shore Health and community and town partners to ensure these patients receive the care they need in the right setting. Each program grantee has worked to successfully sustain their respective programs and moving forward these will be integrated into existing operations of the two grantees. The two grants were awarded with the South Shore Health Critical Care Expansion Project DoN CHI funds to Police Assisted Addiction and Recovery Initiative (PAARI) and Bay State Community Services.

South Shore Health Occupational Therapy and Behavioral Health collaborated with community partners to develop a Sensory Informed Care plan of care for neurodiverse individuals in 2023 and continued to expand on this work in 2024 by securing a grant to adapt two pediatric patient rooms into sensory informed rooms.

6) Addressing Substance Use: South Shore Health provides community based Narcan and leave behind Narcan and provides training on how to administer Narcan for many local communities and the community health workers of Aspire Health Alliance.
In FY24, 246 units of take home Narcan were distributed.

In 2024 South Shore Health received a seven-year grant from the Bureau of Substance Addition Services to focus on substance use treatment. South Shore Health will use the grant to provide additional treatment options including an intensive outpatient program to address SUD issues and relapse prevention and access to methadone treatment at SSH during the first 72 hours post-induction. Additionally, two Community Health Workers will focus on greater outreach into BIPOC communities within our community. South Shore Health also partners with Manet Community Health Center to ensure wrap around services are provide to those in treatment.

South Shore Health presented information on the Grayken Center for Treatment at South Shore Health to the Greater Plymouth Community Health Network Alliance, to expand the regions awareness of the low barrier, rapid-access programs offered for community members with substance use disorder.

South Shore Health continues to collaborate with town and community members to continue the important work on SUD harm reduction that was done under the HEAL grant which ended in 2023. Each month, South Shore Health participate sin the collaborative, promoting prevention, harm reduction and connecting those in need to appropriate treatment.

7)Addressing Chronic Complex Conditions: Community education continues to be a successful strategy in improving health for those with chronic complex conditions. A few key highlights of South Shore Healthâ€™s work in this area include hosting both educational programs and community support groups for individuals with cancer and those who have had a stroke, and a robust cardiac rehab program and community exercise program that provide support groups, reduce social isolation, and foster community connections for those with chronic pulmonary and cardiac conditions. Palliative care community presentations inform community members on this important service, and how to access it. The Annual Senior Safety fair provided more than 50 seniors information on managing prescriptions, trauma prevention, and home and community-based services. Trauma prevention trainings like Fall prevention, car seat safety and Stop the Bleed are free and offered monthly. Lastly, several presentations informing community members on best practices in navigating a hospitalization and how to advocate for themselves during a stressful time were especially beneficial for those with complex chronic conditions.

Plans for Next Reporting Year:

South Shore Health will finalize its Implementation Strategy for 2025-2027, which follows the 2024 Community Health Needs Assessment. Thus far, key objectives emerging from strategy development include reducing barriers to social determinants of health, enhancing community outreach and education, expanding workforce development initiatives, strengthening existing and explore new community partnerships, and promoting health equity.

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

Community Benefits Programs

Building Healthy Communities Program

Program Type Total Population or Community-Wide Interventions

Program is part of a grant or funding provided to an outside organization No

Program Description A Healthy Community is where people come together to make their community better for themselves, their families, their friends, their neighbors, and others. A Healthy Community creates ongoing dialogue, generates leadership opportunities for all, embraces diversity, connects people and resources, fosters a sense of community, and shapes its future. South Shore Health is actively involved in building healthier communities. Our Building Healthier Communities Program includes: * Participating in the South Shore Regional Shelter Task Force, which brings together officials from area towns to plan and simulate how to work together in the event of a man-made or natural disaster, pandemic or other catastrophic event, * Using both a hospital-based and a mobile simulation lab, our experts provide realistic emergency services training and certification for regional first responders *Collaborating with our home community of Weymouth through several public health initiatives such as medical direction for the Weymouth Health Department, participation in Weymouth's 'Mass in Motion grant program, and sponsoring the Healthy Wey initiative to promote healthy living and working environments, * Addressing the critical community challenge of substance abuse through the provision of Narcan to first responders in order to save the lives of patients experiencing a life threatening overdose to opening a Bridge Clinic and the Grayken Center for Treatment that offers support, various treatments and treatment with MAT and support for people struggling with SUD. * Providing free flu shots to colleagues * Providing free Courtesy Van transportation for patients who have exhausted other options and need a ride to South Shore Hospital services, and working with our regional CHNAs -- including the Blue Hills Community Health Alliance (CHNA 20), the Greater Brockton Community Health Alliance (CHNA 22) and the Greater Plymouth Community Health Alliance (CHNA 23) - to expand the impact of these groups as a leading voice and resource to improve the region's health and well-being. * Using Modivcare Connect, a ride share program, offering transportation for patients back home after an acute hospitalization *Working with South Shore Elder Services, Council on Aging's and other community partners focused on working with seniors in our community.

Program Hashtags Not Specified

Program Contact Information Elizabeth Cullen

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Goal of building health communities programs is to engage the community, be a trusted resource and support initiatives that are breaking down barriers to health care and empowering the community.	Ongoing	Process Goal	Year 6 of 6

EOHHS Focus Issues Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders,

DoN Health Priorities Built Environment, Education, Housing, Social Environment,

Health Issues

Health Behaviors/Mental Health-Depression, Health Behaviors/Mental Health-Immunization, Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Physical Activity, Health Behaviors/Mental Health-Stress Management, Infectious Disease-COVID-19, Maternal/Child Health-Reproductive and Maternal Health, Other-Cultural Competency, Other-Senior Health Challenges/Care Coordination, 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-Domestic Violence, Social Determinants of Health-Education/Learning, Social Determinants of Health-Homelessness, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Nutrition, Social Determinants of Health-Public Safety, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Violence and Trauma,

Target Populations

- **Regions Served:** Abington, Avon, Braintree, Bridgewater, Brockton, Canton, Carver, Cohasset, Duxbury, East Bridgewater, Easton, Halifax, Hanover, Hanson, Hingham, Hull, Kingston, Marshfield, Milton, Norwell, Norwood, Pembroke, Plymouth, Plympton, Quincy, Randolph, Rockland, Scituate, Sharon, West Bridgewater, Weymouth, Whitman,
- **Environments Served:** Not Specified
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Additional Target Population Status:** Disability Status,

Partners:

Partner Name and Description	Partner Website
Town of Weymouth, South Shore Elder Services, Blue Hills Community Health Alliance (CHNA 20), the Greater Brockton Community Health Alliance (CHNA 22) and Greater Plymouth Community Health Alliance (CHNA 23)	southshorehealth.org, www.sselder.org, https://www.weymouth.ma.us/health-wellness, http://www.greaterbrocktonhealthalliance.org, https://chna23.org, https://www.bluehillscha.org/

Community Support & Community Engagement

Program Type

Total Population or Community-Wide Interventions

Program is part of a grant or funding provided to an outside organization

No

Program Description

As a large provider of health care and a major employer in our region, it is important for South Shore Hospital to be engaged in our larger community and to support efforts to make our region a healthier, safer, and more vibrant place to live and work. In an effort to fulfill this objective we provide financial sponsorship and direct personal participation as many organizations and initiatives are committed to the same goal. Among the financial and personal resources that we commit to strengthening our community are the following organizations:
* Manet Community Health Center
* Quincy Asian Resources (QARI)
* The Town of Weymouth through a voluntary Payment In Lieu Of Taxes (PILOT) in the amount of $949,977 in FY24
* South Shore Chamber of Commerce
* QCAP
*Father Bill's & Main Spring, providing the support and tools to fight homelessness
*DOVE, providing support in the community combating domestic violence and abuse
* Plymouth County Outreach (PCO)
* Bay State Community Health Services
* Wellspring Multi-Service Center
*South Shore Peer Recovery

In addition to providing financial support to key organizations, participation in community coalitions and events include serving as members of the South Shore Continuum of Care (focused on homelessness prevention) and South Shore Collaborative Network (nonprofits working together to improve needs of vulnerable populations) and providing resources at many local health fair including Weymouth Health and Wellness Fair, Cohasset Health and Rec Fair, Behavioral Health awareness events, Wollaston Community Center/Asian American Service Association Senior Fair and many others.

Program Hashtags Not Specified

Program Contact Information Elizabeth Cullen

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Continue our community support and engagement, especially with organizations addressing key community health needs.	Ongoing	Process Goal	Year 1 of 1

EOHHS Focus Issues Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders,

DoN Health Priorities Education, Employment, Housing, Social Environment, Violence,

Health Issues Other-Cultural Competency, 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-Domestic Violence, Social Determinants of Health-Education/Learning, Social Determinants of Health-Homelessness, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Nutrition, Social Determinants of Health-Public Safety, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of Health-Violence and Trauma, Substance Addiction-Alcohol Use,

Target Populations

- **Regions Served:** Abington, Avon, Braintree, Bridgewater, Brockton, Cohasset, Duxbury, East Bridgewater, Easton, Halifax, Hanover, Hanson, Hingham, Holbrook, Hull, Kingston, Marshfield, Middleborough, Milton, Norwell, Pembroke, Plymouth, Quincy, Randolph, Rockland, Scituate, Sharon, West Bridgewater, Weymouth,
- **Environments Served:** Not Specified
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Father Bills & Mainspring: Housing and Emergency Shelter Wellspring Multiservice Center: Multiservice Social Services DOVE: Domestic Violence Prevention and Emergency Housing Quincy Community Action Program: Multiservice Social Service Agency Bay State Community Health: Multiservice Social Service Agency Town of Weymouth: Municipality Manet Community Health Center: Federally funded CHC Weymouth Food Pantry: Town and Region food pantry and distribution center	helpfbms.org, wellspringmultiservice.org, www.dovema.org, www.qcap.org, www.manetchc.org, www.weymouthfoodpantry.org, www.baystatecs.org, www.qariusa.org, https://southshorepeerrecovery.org/

QARI South Shore Peer Recovery	

Chronic Disease Management: Diabetes/Cardiovascular Disease Community Outreach Program

Program Type Community-Clinical Linkages

Program is part of a grant or funding provided to an outside organization No

Program Description *Provided free community health education to familiarize attendees with diabetes prevention and heart health
*Provided free community blood pressure screenings to older adults
*Support QARI, who provides culturally competent diabetes programs

Program Hashtags Not Specified

Program Contact Information Elizabeth Cullen

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Goal is outreach to a vulnerable population, with use of technology for virtual outreach as needed.	Completed	Process Goal	Year 6 of 6

EOHHS Focus Issues Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,

DoN Health Priorities Education, Housing, Social Environment,

Health Issues Other-Senior Health Challenges/Care Coordination, 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, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Nutrition, Social Determinants of Health-Public Safety,

Target Populations

- **Regions Served:** Abington, Avon, Bridgewater, Brockton, Carver, Duxbury, East Bridgewater, Hanover, Hanson, Hingham, Holbrook, Hull, Milton, Norwell, Pembroke, Plymouth, Plympton, Quincy, Randolph, Rockland, Scituate, West Bridgewater, Weymouth, Whitman,
- **Environments Served:** Not Specified
- **Gender:** All,
- **Age Group:** Adults, Elderly,
- **Race/Ethnicity:** All,
- **Language:** Cape Verdean Creole, Chinese, English, Haitian Creole, Korean, Portuguese, Russian, Spanish,
- **Additional Target Population Status:** Domestic Violence History,

Partners:

Partner Name and Description	Partner Website
Partners in the community include: * Town of Weymouth * South Shore VNA * Quincy Asian Resources Inc.	https://www.qariusa.org/

Chronic Disease Management Cardiovascular Disease

Program Type Total Population or Community-Wide Interventions

Program is part of a grant or funding provided to an outside organization No

Program Description South Shore Health's Cardiovascular Center is dedicated to the prevention and treatment of heart disease, stroke, and peripheral vascular conditions. In addition to the core clinical services, our Cardiovascular Center will continued to provide free health education, workshops, and screenings to help reduce the incidence and severity of cardiovascular disease. In FY24, the Center's community benefits initiatives to address cardiovascular disease included: * Hosting free community health education programs to familiarize participants with cardiovascular disease and stroke prevention and management techniques. * Partnering with the South Shore YMCA to offer a cardiac rehabilitation maintenance exercise program for individuals with stable heart disease who have completed a course of cardiac rehabilitation. Participants will have the opportunity to exercise in a supervised outpatient group setting. * Offering a pulmonary rehabilitation maintenance program for individuals with stable pulmonary disease who have completed a course in pulmonary rehabilitation. Participants have the opportunity to exercise in a supervised outpatient group setting. *Offering a monthly cardiac support group. * Enhanced the availability of information about diabetes prevention and management on our website and at community events.

Program Hashtags Not Specified

Program Contact Information Elizabeth Cullen

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
The cardiovascular disease management program is designed to engage the community in preventative health activities and early recognition of potential problems.	Ongiong	Process Goal	Year 6 of 6

EOHHS Focus Issues Not Specified

DoN Health Priorities Not Specified

Health Issues Chronic Disease-Cardiac Disease, Chronic Disease-Diabetes, Chronic Disease-Hypertension, Chronic Disease-Pulmonary Disease,

Target Populations

- **Regions Served:** Abington, Avon, Braintree, Bridgewater, Brockton, Canton, Cohasset, Duxbury, East Bridgewater, Hanover, Hanson, Hingham, Holbrook, Hull, Kingston, Mansfield, Marlborough, Marshfield, Norwell, Plymouth, Plympton, Quincy, Randolph, Rockland, Scituate, West Bridgewater, Weymouth, Whitman,
- **Environments Served:** Not Specified
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** Not Specified
- **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Town of Weymouth	weymouth.ma.us

Chronic Disease Management: Cancer Care Community Outreach Program

Program Type Total Population or Community-Wide Interventions

Program is part of a grant or funding provided to an outside organization No

Program Description South Shore Health has a clinical affiliation with Dana-Farber Cancer Institute and Brigham and Women's Hospital to bring world-leading cancer care and treatment to the people of our region. Our Cancer Care Community Outreach Program involves 1) hosting free health

education programs for anyone in the community to familiarize participants with cancer prevention as well as early detection and management techniques and what to expect from chemotherapy, (2) hosting free support groups for anyone in the community who is coping with prostate cancer, and (3) staffing a cancer resource center for anyone in the community who would benefit from free access to its books, brochures, computers, and other resources. Outreach to the Asian population in nearby communities has led to a collaboration with local senior centers to provide transportation for community members with appointments or treatments, addressing access to care challenges. Community presentations and screenings were offered throughout FY24

Program Hashtags Not Specified

Program Contact Information Jennifer Croes

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
The goal is to provide outreach to surrounding communities, provide care locally by partnering with transportation services, and supporting the most vulnerable patients.	Ongoing	Process Goal	Year 7 of 10

EOHHS Focus Issues Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,

DoN Health Priorities Education,

Health Issues Cancer-Breast, Cancer-Cervical, Cancer-Colorectal, Cancer-Lung, Cancer-Multiple Myeloma, Cancer-Other, Cancer-Ovarian, Cancer-Prostate, Cancer-Skin, Other-Cultural Competency,

Target Populations

- **Regions Served:** Abington, Avon, Braintree, Bridgewater, Brockton, Canton, Cohasset, Duxbury, East Bridgewater, Easton, Halifax, Hanover, Hanson, Hingham, Holbrook, Hull, Marlborough, Middleborough, Milton, Norwell, Pembroke, Plymouth, Plympton, Quincy, Randolph, Rockland, Scituate, West Bridgewater, Weymouth, Whitman,
- **Environments Served:** Not Specified
- **Gender:** All,
- **Age Group:** Adults, Elderly,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Additional Target Population Status:** Disability Status,

Partners:

Partner Name and Description	Partner Website
Dana Farber Brigham Cancer Center in clinical affiliation with South Shore Health	www.dana-farber.org

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Community Health Education

Program Type Total Population or Community-Wide Interventions

Program is part of a grant or funding provided to an outside organization No

Program Description A series of programs have been developed for community education and patient empowerment, including but not limited to, musculoskeletal health, nutrition, palliative care and health care decisions, health care safety topics like Stop the Bleed and Car seat safety inspections, maternal health, and substance use disorders and access to treatment.

Program Hashtags Not Specified

Program Contact Information Elizabeth Cullen

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide education to community on a number of topics including musculoskeletal health, health care safety, substance use and treatment options, women's health, nutrition and others.	Completed	Process Goal	Year 6 of 6

EOHHS Focus Issues Mental Illness and Mental Health,

DoN Health Priorities Education,

Health Issues Health Behaviors/Mental Health-Mental Health, Maternal/Child Health-Reproductive and Maternal Health, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Education/Learning, Social Determinants of Health-Nutrition, Social Determinants of Health-Public Safety, Substance Addiction-Substance Use,

Target Populations

- **Regions Served:** Abington, Avon, Braintree, Bridgewater, Brockton, Carver, Cohasset, Duxbury, East Bridgewater, Halifax, Hanover, Hingham, Holbrook, Kingston, Mansfield, Marshfield, Norwell, Pembroke, Plymouth, Plympton, Quincy, Randolph, Rockland, Scituate, West Bridgewater, Weymouth,
- **Environments Served:** Not Specified
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** Not Specified
- **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

At-Risk Seniors: Healthy Aging

Program Type Direct Clinical Services

Program is part of a grant or funding provided to an outside organization No

Program Description South Shore Hospital recognizes that those over 60 are vulnerable to injury, illness and preventable complications caused by chronic diseases. According to the Massachusetts Department of Public Health Community Health Information Profile, older adults in our region exhibit many behavioral risk factors, including alcohol consumption, smoking, and physical inactivity. There also is prevalence among older adults in our region to be overweight, have oral health problems, and mental health conditions. This program includes:
* Providing injury-prevention information in the community, with a focus on strategies to avoid traumatic injuries from falls - a leading cause of death among those ages 65 and older - through the Matter of Balance and Better Balance Programs
* Offering community education and exercise programs for improved balance, gait, muscle and fall prevention.
* Offering a therapeutic pool program to any individual with arthritis to increase motion and strength, in collaboration with the SSYMCA, to continue therapeutic programs are at a low or reduced cost further enhancing injury prevention and disease management.
* Community programs designed for seniors are given throughout the year at Senior Centers in our Community. Through these community education programs topics include Nutrition, Management Diabetes, Fall Prevention and ongoing blood pressure screenings.
* Working with the Town of Weymouth on the Age Friendly Communities initiative and working with the Mass In Motion program
*Providing the First Day Home program, which supports patients in ensuring their homes are

safe from fall hazards and that they have food and their prescribed medication after discharge from the hospital.

Program Hashtags Not Specified

Program Contact Information Elizabeth Cullen

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
The goal to reach seniors, engage this population in healthy habits, and continue to follow up with health care providers will continue. Outreach through classes, community education, and services continues.	Ongoing	Process Goal	Year 6 of 6
Promote Healthy Aging lifestyles: Quality	Ongoing	Process Goal	Year 7 of 10

EOHHS Focus Issues Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,

DoN Health Priorities Education,

Health Issues Chronic Disease-Alzheimer's Disease, Chronic Disease-Arthritis, Chronic Disease-Asthma/Allergies, Chronic Disease-Cardiac Disease, Chronic Disease-Chronic Pain, Chronic Disease-Diabetes, Chronic Disease-Hypertension, Chronic Disease-Osteoporosis, Chronic Disease-Pulmonary Disease, Chronic Disease-Stroke, Health Behaviors/Mental Health-Depression, Infectious Disease-COVID-19, Injury-Home Injuries, Other-Hospice, Other-Senior Health Challenges/Care Coordination, Social Determinants of Health-Access to Health Care,

Target Populations

- **Regions Served:** Abington, Avon, Braintree, Bridgewater, Brockton, Canton, Carver, Cohasset, Duxbury, East Bridgewater, Easton, Halifax, Hanover, Hanson, Hingham, Holbrook, Hull, Marshfield, Middleborough, Milton, Norwell, Pembroke, Plymouth, Plympton, Quincy, Randolph, Rockland, Scituate, Sharon, Stoughton, West Bridgewater, Weymouth,
- **Environments Served:** Not Specified
- **Gender:** All,
- **Age Group:** Adults, Elderly,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Additional Target Population Status:** Disability Status,

Partners:

Partner Name and Description	Partner Website
Town of Weymouth, South Shore Elder Services, Old Colony Elder Services, Councils on Aging	weymouth.ma.us, www.sselder.org, www.ocesma.org

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Enhancing Access to Care: Insurance Coverage and System Navigation Assistance

Program Type Access/Coverage Supports

Program is part of a grant or funding provided to an outside organization No

Program Description South Shore Health's Patient Access Team assists both patients and community members research and obtain health insurance. Appointments are open to the community to assist with enrollment. Financial information is provided through a team of counselors in a language patients, family members, and others in the community understand. The program is free and open to community members. The patient access financial team is open and willing to work with the community, researching the most accessible and relevant insurance information available.

Program Hashtags Not Specified

Program Contact Information Cheryl Coveny

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide patients and community members with information about obtaining health and insurance and navigating the health care system.	Ongoing	Process Goal	Year 18 of 30

EOHHS Focus Issues Not Specified

DoN Health Priorities Education,

Health Issues Social Determinants of Health-Access to Health Care,

Target Populations

- **Regions Served:** Abington, Avon, Braintree, Bridgewater, Brockton, Canton, Carver, Cohasset, Duxbury, East Bridgewater, Halifax, Hanover, Hanson, Hingham, Holbrook, Hull, Kingston, Mansfield, Marshfield, Norwell, Pembroke, Plymouth, Plympton, Quincy, Randolph, Rockland, Scituate, West Bridgewater, Weymouth,
- **Environments Served:** Not Specified
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** Not Specified
- **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
South Shore Health	https://www.southshorehealth.org/patient-resources/billing-insurance

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Mobiile Integrated Health

Program Type Direct Clinical Services

Program is part of a grant or funding provided to an outside organization No

Program Description South Shore Healthâ€™s Mobile Integrated Health (MIH) program brings care into the community by providing personalized, high touch care that is also supported by technology. Paramedics improve access to care for patients by providing certain services, such as lab work IV fluids and other medications, wound care, nebulizer treatments, COVID-19 tests and vaccines in patientâ€™s homes. Barriers to care are also reduced due to the interpersonal relationships that are developed between SSH paramedics and the patients receiving care.

Program Hashtags Not Specified

Program Contact Information Not Specified

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Expand program to serve more patients each year.	Completed. FY24, MIH paramedics completed 4,325 in person visits to 2,502 unique patients, up from 4,219 visits to 1342 patients in FY23.	Process Goal	Year 1 of 1

EOHHS Focus Issues Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,

DoN Health Priorities Not Specified

Health Issues Chronic Disease-Cardiac Disease, Chronic Disease-Diabetes, Chronic Disease-Hypertension, Chronic Disease-Pulmonary Disease, Health Behaviors/Mental Health-Mental Health, Injury-Other, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Public Safety, Substance Addiction-Substance Use,

Target Populations

- **Regions Served:** Not Specified
- **Environments Served:** Not Specified
- **Gender:** All,
- **Age Group:** Adults, Elderly,
- **Race/Ethnicity:** All,
- **Language:** Not Specified
- **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

Substance Use Treatment and Community Outreach Expansion

Program Type Direct Clinical Services

Program is part of a grant or funding provided to an outside organization No

Program Description In 2024 South Shore Health received a seven-year grant from the Bureau of Substance Addition Services to focus on substance use treatment. South Shore Health will use the grant to provide additional treatment options including an intensive outpatient program to address SUD issues and relapse prevention and access to methadone treatment at SSH during the first 72 hours post-induction. Additionally, two Community Health Workers will focus on greater outreach into BIPOC communities within our community. South Shore Health also partners with Manet Community Health Center to ensure wrap around services are provide to those in treatment.

Program Hashtags Not Specified

Program Contact Information Not Specified

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Plan Community Health worker outreach role in prep for program expansion in 2025.	Ongoing	Process Goal	Year 1 of 1

EOHHS Focus Issues Mental Illness and Mental Health, Substance Use Disorders,

DoN Health Priorities Education,

Health Issues Health Behaviors/Mental Health-Mental Health, Substance Addiction-Alcohol Use, Substance Addiction-Opioid Use, Substance Addiction-Smoking/Tobacco Use, Substance Addiction-Substance Use,

Target Populations

- **Regions Served:** Not Specified
- **Environments Served:** Not Specified
- **Gender:** Not Specified
- **Age Group:** Not Specified
- **Race/Ethnicity:** Not Specified
- **Language:** Not Specified
- **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website

Manet Community Health Center Weymouth Food Pantry	https://www.manetchc.org/https://www.weymouthfoodpantry.org/

Expenditures

Total CB Program Expenditure **$3,142,612.83**

CB Expenditures by Program Type	Total Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
Direct Clinical Services	$969,653.35	Not Specified
Community-Clinical Linkages	$897,485.78	Not Specified
Total Population or Community-Wide Interventions	$460,614.00	Not Specified
Access/Coverage Supports	$251,541.40	Not Specified
Infrastructure to Support CB Collaborations Across Institutions	$563,318.30	Not Specified

CB Expenditures by Health Need	Total Amount
Chronic Disease with a Focus on Cancer, Heart Disease, and Diabetes	$722,870.21
Mental Health/Mental Illness	$665,903.22
Housing/Homelessness	$621,448.26
Substance Use	$687,177.59
Additional Health Needs Identified by the Community	$445,213.55

Other Leveraged Resources	$869,832.00

Net Charity Care Expenditures	Total Amount
HSN Assessment	$2,231,117.00
HSN Denied Claims	Not Specified
Free/Discount Care	$245,110.00
Total Net Charity Care	$2,476,227.00

Total CB Expenditures:	$6,488,671.83

Additional Information	Total Amount
Net Patient Service Revenue:	$815,143,319.00
CB Expenditure as Percentage of Net Patient Services Revenue:	0.80%
Approved CB Program Budget for FY2025: (*Excluding expenditures that cannot be projected at the time of the report.)	Not Specified
Comments (Optional):	Note that the HSN Assessment is $2M lower than in previous years.

Optional Information

Hospital Publication Describing CB Initiatives:	Download/View Report
Bad Debt:	$24,056,732.00
Bad Debt Certification:	Certified
	In addition to the programs outlined in this report, South Shore Health works closely with the Town of Weymouth and surrounding community to meet the needs of its employees. South Shore Health offers an ELL program open to all employees and has a number of workforce development initiatives with the community. These initiatives include career exploration opportunities, Transitions to Work, a program planned in FY24 to offer individuals with disabilities job experience to build their resumes and professional experience, and a grant with Regis College to train employees on advanced positions including pharmacy tech and medical assistant. South Shore Health also works with local area high schools for a medical assistant co-op experience and lastly, offered a free Behavioral Health Tech certificate training for colleagues in partnership with Mass Bay Community College, to better equip colleagues to work inclusively in fields of mental health and wellness.
Optional Supplement:	SSH collaborates between the public health dept., town emergency management, and other governmental, community and health care agencies to support the Emergency Assistance Shelter in Rockland and ensure those living there have access to needed health care and other support services. SSH also recognizes the importance of improving access to healthy food and supports and participates in programs with the Weymouth Food Pantry, the South Shore Regional Food Pantry and Wellspringâ€™s food pantry and food delivery van to ensure those in need of health food have access to it and can ideally improve health outcomes in the long run due to this improved access. SSH understands and embraces its responsibility as a community leader and anchor to provide care to the community without barriers or stigma and institute preventative programs and collaborations reducing barriers and social determinants of health.