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Organization Information

Organization Address and Contact Information

Organization Name:	Harvard Pilgrim Health Care
Address (1):	93 Worcester Street, Suite 100
City, State, Zip:	Wellesley, Massachusetts 02481
Web Site:	www.harvardpilgrim.org
Contact Name:	Michael Devlin
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Contact Address (1): (If different from above)	93 Worcester Street, Suite 100
City, State, Zip:	Wellesley, Massachusetts 02481

Organization Type and Additional Attributes

Organization Type:	HMO
For-Profit Status:	Not-For-Profit
Health System:	Not Specified
Community Health Network Area (CHNA):	all, Alliance for Community Health (Boston/Chelsea/Revere/Winthrop)(CHNA 19), Blue Hills Community Health Alliance (Greater Quincy)(CHNA 20), Cape and Islands Community Health Network(CHNA 27), Community Health Connection (Springfield)(CHNA 4), Community Health Network North (Beverly/Gloucester)(CHNA 13), Community Health Network of Berkshire County(CHNA 1), Community Health Network of Greater Metro West (Framingham)(CHNA 7), Community Health Network of Southern Worcester County(CHNA 5), Community Partners for Health (Milford)(CHNA 6), Fitchburg/Gardner Community Health Network(CHNA 9), Four Communities (Holyoke, Chicoppe, Ludlow, Westfield)(CHNA 21), Greater Attleboro-Taunton Health & Education Response(CHNA 24), Greater Brockton Health Alliance(CHNA 22), Greater Cambridge/Somerville Community Health Network(CHNA 17), Greater Haverhill Community Health Network(CHNA 12), Greater Lawrence Community Health Network(CHNA 11), Greater Lowell Community Health Network(CHNA 10), Greater New Bedford Community Health Network(CHNA 26), Greater Woburn/Concord/Littleton Community Health Network(CHNA 15), North Shore Community Health Network(CHNA 14), North Suburban Health Alliance (Medford/Malden/Melrose)(CHNA 16), Partners for a Healthier Community (Fall River)(CHNA 25), Partnership for Health in Hampshire County (Northampton)(CHNA 3), South Shore Community Partners in Prevention (Plymouth)(CHNA 23), Upper Valley Health Web Franklin County (CHNA 2), West Suburban Health Network (Newton/Waltham)(CHNA 18), Worcester Wellness Coalition(CHNA 8),
Regions Served:	All Massachusetts,

CB Mission

Community Benefits Mission Statement

The Harvard Pilgrim Health Care Foundation supports Harvard Pilgrim Health Careâ€™s mission to improve the quality and value of health care for the people and communities we serve by providing the tools, training and leadership to build healthy communities throughout Massachusetts, Connecticut, Maine, and New Hampshire.

Target Populations

Name of Target Population	Basis for Selection
All	Needs assessment

Publication of Target Populations
Marketing Collateral, Website

Hospital/HMO Web Page Publicizing Target Pop.
www.harvardpilgrim.org/foundation

Key Accomplishments of Reporting Year
Healthy Food Fund grantmaking initiative

â€¢ According to the Foundation's Massachusetts-based evaluators (DAISA Enterprises), the Foundationâ€™s $3.7 million investment in local healthy food organizations over three years has translated into $9.6 million of healthy food infused into the communities of highest need in MA, CT, ME and NH since 2015.
â€¢ Other important results since 2015 include:
o a 686% increase in food sales on mobile markets and at farmers markets;
o a 169% increase in food that was distributed for free to organizations such as food banks, pantries and soup kitchens; and
o a 331% increase in places where people can buy or pick up food.
â€¢ A second, more accessible mobile market for its differently-abled customers was launched, with Foundation support, to Mill City Grows in Lowell â€“ as well as a winter farmers market at a Senior Center.
â€¢ The Massachusetts Urban Farming Conference in Boston and Nourishing the North Shoreâ€™s Volunteer Appreciation event featured Foundation staff as speakers.
â€¢ Coastline Elder Services presented their Foundation-supported work at â€œHungry for Health,â€ the Southcoast Food Security Forum at UMass Dartmouth which was attended by students, local experts, and food security activists.
â€¢ The Foundation-supported Healthy Food Fund project in MA saw enormous sales growth for a second summer because of the Healthy Incentives Program (HIP). This program has been a triple win; a win for our projects, a win for consumers and a win for farmers.
â€¢ The Foundation is leading an effort with the MA Department of Transitional Assistance to raise additional funds for HIP for people using SNAP (food stamp) benefits. HIP provides $1 for each dollar a SNAP customer spends on locally farmed fruits and vegetables. Funded originally via federal Farm Bill allocations, HIP has proven to raise substantially MA farm revenues as well as the amount of fresh produce purchased by low income families.
â€¢ The Magical Mystery (Food) Tour presentation about the Foundationâ€™s Healthy Aging projects was a huge, multi-media hit at the national Grantmakers in Aging conference in Memphis. The Tour featured the Foundationâ€™s Healthy Aging projects and food demonstrations from Mattapan, MA; Manchester, NH; and Portland and Auburn, ME. We debuted this video.
â€¢ Mike Devlin presented sessions on evaluation and mobile farmers markets at the MA Nonprofit Network conference and the MA Conference on Aging, respectively. Both received positive reviews by participants and we debuted this new video on our mobile markets.
â€¢ The Foundation hosted the 2018 Fair Food Network Boot Camp Pitch Competition at its Wellesley offices. Ten businesses competed and eighty people attended. The $7500 prize went to the Vermont Tortilla Company because of its inspiring food vision, while Mei Mei Restaurant (Boston) won the $2500 audience prize for its worker profit sharing model.

Harvard Pilgrim Health Care Health Equity Initiative

1. Create Performance Measurement Tools Focused on Vulnerable Populations
â€¢ Developed/launched a new well-being program for members, accounts, and employees.
â€¢ A new vendor has been implemented (Limeade)
â€¢ Enhanced and fully mobile user experience for members; tools include our transparency tool and Lifestyle Management coaching resources.
â€¢ Exploring opportunities for collaboration around scalable inclusion assessments and programming in 2019 when more members/accounts have been onboarded on to the system.
2. Improve Member Communications & Processes to Support Civil Rights Compliance Officer Function
â€¢ Interpreter and Translation Services â€“ Increased utilization in both translation and interpreter services. Majority of request and engagements are for Spanish language materials on service, products, and benefits. YTD 26 documents ranging from Schedules of Benefits to product/service offerings like Dr ONdemand and Healthy Delicious Foods education.
3. Building Network Capabilities to Serve Disparate Populations
â€¢ Completed annual analysis of member data/files to identify and reconcile race, ethnicity, and language
â€¢ **Inclusive systems/processes - Completed a systems and operation review to assess the impact of adding a new system field to capture non-binary gender identification during enrollment and claims processing. Gender markers have been removed from the claims process to mitigate the rejection of claims when the medical code does not match the recorded member gender
4. Demonstrate Adherence to State and Federal Program Service Agreements

â€¢ HEDIS: Statin Medicine Adherence Workgroup Established.
â€¢ Pilot work was paused in Q4 due to the unexpected passing of Raheem Baraka, President and CEO of Baraka Wellness, our community partner. Work is likely to shift towards enhancing plan-based member materials while a larger evaluation of this opportunity is completed.
5. Leadership in Health Equity & External Sharing of Best Practices
â€¢ **LGBTQ/Transgender Care â€" Exploring opportunities for a leadership role in efforts to implement health system data fields that capture non-binary gender identification.
â€¢ IT Assessment completed with NTT data analysis & PM resources. No systems upgrades scheduled due to cost considerations and external factors.
â€¢ Disparities Leadership Program â€" Program engagement and participation; sharing best practices, care delivery models (ACOs), and case study collaboration and analysis with colleagues, industry leaders and innovators.

Harvard Pilgrim Health Care Institute (HPHCI)

â€¢ We have partnered with diverse primary care organizations in MA to use electronic health records data to learn about ways to improve HIV prevention. This includes identifying people who might be at increased risk for becoming infected with HIV, so that their primary care providers can discuss HIV prevention options with them as part of primary care. One of the HIV prevention options that we have studied is HIV preexposure prophylaxis (PrEP), the use of antiretroviral medications by people who are at risk for acquiring HIV as a way to protect themselves from becoming infected. We have examined patterns of use and discontinuation of PrEP in primary care, including disparities in its use among priority populations, as a way to optimize the impact of PrEP on the HIV epidemic in MA and beyond.
â€¢ HPHCI faculty collaborated with colleagues at Fenway Health, a Boston community health center specializing in care for sexual and gender minorities, on studies related to PrEP. Daily oral PrEP, using a combination of the antiretroviral medications emtricitabine and tenofovir (Truvada), is highly effective in preventing HIV infection. PrEP could potentially provide a gateway to other types of health care for people at risk of HIV infection, just as family planning clinics provide a gateway to care for many women. HPHCI and Fenway researchers examined a group of nearly 6000 potential PrEP candidates at Fenway Health, finding that PrEP users were more likely to receive influenza vaccination, more likely to be screened for tobacco use and depression, and more likely to receive glucose testing, which is used for diabetes screening and monitoring. These results suggest that the benefits of PrEP potentially extend beyond HIV prevention to behavioral health and the prevention and treatment of other infectious and chronic diseases, both for patients at Fenway Health and more broadly.
â€¢ The Asthma in Families Facing Out-of-pocket Requirements with Deductibles (AFFORD) project is using claims data and interviews with Harvard Pilgrim members with asthma to understand the challenges that families face due to the costs of asthma medications in insurance plans with high deductibles. In particular, researchers are elucidating the benefits and challenges from having a preventive drug list, which reduces the cost families pay for important preventive asthma medications in a high-deductible plan.
â€¢ Increasing medication prices are of great concern to patients, payers, and the public. Researchers at the Institute and leaders at Harvard Pilgrim studied how increasing prices for medications affect the health plan and its members. They found that for most Harvard Pilgrim members, out-of-pocket spending on medications has slightly decreased. However, the insurer's spending on medications has continuously increased since 2011. In 2016, Harvard Pilgrim Health Care spent one in every four dollars on medications, more than it spent on members' hospital care. Increasing prices of specialty medications for severe chronic conditions were the drivers of the spending increase. Members who received these medications also spent about twice as much on medications out-of-pocket in 2016 compared to 2011.
â€¢ We continue to lead robust teaching activities that integrate population health in the training of medical students, residents, doctoral and post-doctoral research fellows, policy makers, and health system leaders, to improve the health of populations through clinical care, research, and delivery system and health policy leadership. All training experiences are informed by the health system and population perspectives of the Institute, and all faculty members teach in some capacity. For example, the Residency Program in Primary Care and Population Medicine is a collaboration among a tertiary academic hospital (Brigham and Women's Hospital), a system of connected outpatient care practices (Atrius Health) and a medical school department (the Department of Population Medicine at the Institute). These institutional arrangements and progressive educational programs have supported medical residents who are making noteworthy contributions to the improvement of health care delivery and population health. Graduates of this program are prepared to make contributions as superb clinicians, as academic physicians and researchers, and as leaders able to improve systems of care for populations.
â€¢ Faculty and staff from HPHCI continued to collaborate with colleagues at the Massachusetts Department of Public Health (MDPH) Bureau of Infectious Disease and Laboratory Sciences and Office of Population Health on the Electronic medical record Support for Public health (ESP) public health surveillance platform developed by HPHCI faculty (esphealth.org). ESP is an open-source software application that uses electronic health record data to automatically identify notifiable disease cases and submit case reports, using secure protocols, to state health departments. The system is also used to provide deidentified, aggregate summaries of the prevalence, care, and outcomes of selected chronic diseases. Work to expand ESP to new clinical sites is ongoing, with 6 new sites beginning implementation of the notifiable disease component of the system in 2018 and 3 additional community health centers identified for implementation and expanded reporting in 2019. An ESP-based project to enable HIV care continuum monitoring and response for people living with HIV/AIDS and chronic Hepatitis C was completed; these enhancements are expected to improve patient-level health outcomes and assist providers and MDPH with quality improvement activities. We also began work developing new algorithms for Lyme disease, Babesiosis, and Anaplasmosis, and completed work on a new Tuberculosis detection algorithm. In collaboration with MDPH we completed analyses of patients with multiple sexually transmitted infections to identify risk factors and potential points of intervention for MDPH, and examined patterns in Gonorrhea testing to understand the changing epidemiology of the infection. On the chronic disease surveillance side, we helped analyze population data on stroke and calculated the 10-year risk of cardiovascular disease for all patients under surveillance in order to characterize preventative care practices stratified by risk. We continue to enhance our web-based data visualization platform, the RiskScape, in order to present these data in a user-friendly, interactive fashion.

Plans for Next Reporting Year
Healthy Food Fund grantmaking initiative

In 2019, the Foundation will start new funding relationships with Massachusetts-based Healthy Food Fund grantees as 2018 ends the final year of this three-year initiative. The new grantee organizations will receive on-going technical assistance from the Foundation on evaluation, communication and financial sustainability as well as best practices. In addition, the Foundation will conduct an extensive assessment for its new strategic plan to start in 2019.

Harvard Pilgrim Health Care Institute (HPHCI)

HPHCI researchers will continue to work closely with MDPH to further develop both the notifiable disease and chronic disease surveillance capabilities of the system including new work on Lyme disease and Hepatitis B in pregnancy. We will also continue to seek opportunities to expand the number of participating sites across the Commonwealth. Institute and MDPH staff will also complete analyses examining the effect of an electronic medical record best practice alert on provision of expedited partner therapy for Chlamydia infection.

Beginning in 2019, HPHCI faculty will be collaborating with colleagues at three local clinical partners (Fenway Health, Atrius Health, and Boston Medical Center) on a project that will assess the impact of antiretroviral preexposure prophylaxis (PrEP) on health outcomes in men who have sex with men. Daily oral PrEP is highly effective in preventing HIV infection, and scale-up of PrEP is now a key goal of the federal initiative to end the HIV epidemic. However, it is unknown what increases in PrEP uptake will be needed to reduce HIV incidence to target levels, and what impact those increases might have on the incidence of other sexually transmitted infections. This NIH-funded project will apply advanced statistical methods to electronic health data collected during routine clinical care to answer these questions, which are relevant to men who have sex with men in the Boston area and more broadly.

Community Benefits Process

Community Benefits Leadership/Team
Michael Carson, President and Chief Executive Officer, Harvard Pilgrim Health Care (Foundation Board Chair) * Kevin Rasch, Esquire, Vice President of Public Affairs and Government Programs, Harvard Pilgrim Health Care * Karen Voci, President, Harvard Pilgrim Health Care Foundation * Suzanne Finn, Esquire, Associate General Counsel, Harvard Pilgrim Health Care (Foundation Board Clerk) * Elizabeth Creavin, Vice President and Controller, Harvard Pilgrim Health Care (Foundation Treasurer) * Michael Devlin, Director of Grants and Initiatives, Harvard Pilgrim Health Care Foundation * Janelle Woods-McNish, Director of Service & Giving, Harvard Pilgrim Health Care Foundationn * Sheila Fireman, Administrative Director, Harvard Pilgrim Health Care Institute * The Foundation Board of Directors

Community Benefits Team Meetings
The Foundation Board of Directors has complete program and fiduciary responsibility over the Foundation's work. They meet quarterly to review progress toward the Foundation's Community Benefit goals, which are to: 1. Provide support and technical assistance to nonprofits that increase access to healthy food for families and communities. 2. Ensure that older adults are educated on healthy eating and living. 3. Improve the health of communities through employee service and giving.

Community Partners
The Massachusetts Department of Public Health, the Massachusetts Department of Transitional Assistance, Tufts University Friedman School of Nutrition Science and Policy, DAISA Enterprises, Elder Services of the Merrimack Valley, Food Solutions New England, the Boys and Girls Clubs of Boston, and the Regional Environmental Council of Worcester were some of our partners for data that ultimately helped shape our choices for Community Benefits focus.

Community Health Needs Assessment

Date Last Assesment Completed and Current Status

September 2014 (also done in 2018 for programming to commence in 2019)

Consultants/Other Organizations

UMass Boston Center for Social Policy, DAISA Enterprises, Elder Services of the Merrimack Valley, Food Solutions New England, The Philanthropic Initiative and Rasky Baerlein.

Data Sources

Interviews, Other, Public Health Personnel, Expert Advisory Committee

CHNA Document - PDF format	Not Specified

Implementation Strategy (optional)

File Upload (optional)	HARVARD PILGRIM HEALTH CARE FOUNDATION IMPLEMENTAT

Community Benefits Programs

Boston Area Gleaners

Program Type	Direct Services,
Statewide Priority	Chronic Disease Management in Disadvantage Populations, Promoting Wellness of Vulnerable Populations, Reducing Health Disparity,
EOHHS Focus Issue(s) (optional)	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities (optional)	Not Specified
Target Population	• **Regions Served:** All Massachusetts, • **Health Indicator:** Other: Diabetes, Other: Nutrition, Overweight and Obesity, • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	**Goal Status**
to expand gleaning regions in Massachusetts by 25% per year and pay for a delivery and gleaning assistant.	Exceeded the gleaning region and hired a delivery/gleaning assistant.

Partners

Partner Name, Description	**Partner Web Address**
Greater Boston Food Bank	www.gbfb.org
Numerous food pantries throughout the region	too many to name

Contact Information	Laurie Caldwell, Executive Director Boston Area Gleaners 240 Beaver St., Waltham, MA 02452 (781) 894-3212 x101
Detailed Description	This program equips food banks and pantries with fresh food.

Boys and Girls Clubs of Boston

Program Type	Community Education, Community Participation/Capacity Building Initiative, Direct Services, Health Professional/Staff Training, Outreach to Underserved, Prevention,
Statewide Priority	Chronic Disease Management in Disadvantage Populations, Promoting Wellness of Vulnerable Populations, Reducing Health Disparity,
EOHHS Focus Issue(s) (optional)	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities (optional)	Not Specified
Target Population	• **Regions Served:** Boston, • **Health Indicator:** Other: Nutrition, Overweight and Obesity, • **Sex:** All, • **Age Group:** Adult-Young, • **Ethnic Group:** All, • **Language:** All,

Goal Description	**Goal Status**
to increase all opportunities for fresh, healthy food for children and their families in order to improve health and increase demand for healthy food.	7500 Club members and their families consumed over 40,000 meals and snacks consisting of fresh, healthy food.

Partners	
Partner Name, Description	**Partner Web Address**
Himmel Hospitality Group	http://grill23.com/about-us/our-story/
Contact Information	Grace Lichaa, Senior Director of Healthy Lifestyles, Boys & Girls Clubs of Boston, 15 Green Street, Charlestown, MA 02129
Detailed Description	To infuse a model of health and wellness into the Clubs through all food related programming at the Clubs.

Elder Services of the Merrimack Valley

Program Type	Community Education, Direct Services, Health Professional/Staff Training, Outreach to Underserved, Prevention,
Statewide Priority	Chronic Disease Management in Disadvantage Populations, Promoting Wellness of Vulnerable Populations, Reducing Health Disparity,
EOHHS Focus Issue(s) (optional)	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities (optional)	Not Specified
Target Population	• **Regions Served:** All Massachusetts, • **Health Indicator:** Other: Nutrition, Overweight and Obesity, Physical Activity, • **Sex:** All, • **Age Group:** Adult-Elder, • **Ethnic Group:** All, • **Language:** Chinese, Spanish,

Goal Description	Goal Status
to train 250 people in the evidence-based Healthy Eating for Successful Living curriculum.	381 people trained.

Partners	
Partner Name, Description	**Partner Web Address**
Councils on Aging	Not Specified
Senior Centers	Not Specified
Area Agencies on Aging	Not Specified
local departments of Public Health	Not Specified
YMCAs	Not Specified
Community Health Centers	Not Specified
Contact Information	Jennifer Raymond, JD, Director, Healthy Living Center of Excellence c/o Elder Services of the Merrimack Valley, 280 Merrimack Street, Lawrence, MA
Detailed Description	They operate the Healthy Eating for Successful Living program that provides nutrition and wellness education for both individuals and prospective trainers.

Enhance Asian Community on Health

Program Type	Community Education, Outreach to Underserved, Prevention, School/Health Center Partnership,
Statewide Priority	Chronic Disease Management in Disadvantage Populations, Promoting Wellness of Vulnerable Populations, Reducing Health Disparity,
EOHHS Focus Issue(s) (optional)	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities (optional)	Not Specified
Target Population	• **Regions Served:** Boston, Malden, Milton, Quincy, • **Health Indicator:** Other: Diabetes, Other: Nutrition, Overweight and Obesity, • **Sex:** All, • **Age Group:** Adult, • **Ethnic Group:** Asian, • **Language:** Chinese,

Goal Description	Goal Status
to educate Chinese-speaking older adults in the evidence-based Healthy Eating for Successful Living workshops conducted at senior centers, congregate housing, and the Manet Community Health Center.	A total of 750 seniors were outreached to and educated.

Partners

Partner Name, Description	Partner Web Address
Manet Community Health Center	http://www.manetchc.org/

Contact Information	Sara Tan, President & Executive Director Enhance Asian Community on Health 110 West Squantum Street, Quincy, MA 02171 857-472-3224
Detailed Description	This program addresses health disparities through healthy eating literacy training.

Gardening the Community

Program Type	Prevention,
Statewide Priority	Chronic Disease Management in Disadvantage Populations, Promoting Wellness of Vulnerable Populations, Reducing Health Disparity,
EOHHS Focus Issue(s) (optional)	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities (optional)	Not Specified
Target Population	• **Regions Served:** Springfield, • **Health Indicator:** Other: Nutrition, Overweight and Obesity, • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	Goal Status
to expand the Walnut Street site to increase production and create an on-site permanent farm stand. Funds will also support educational workshops.	Total low-income customer sales via the Farm Stand were: $37584; 50 people of all ages were educated through workshops and 3,000 pounds of food was given away to people who could not afford to buy food.

Partners

Partner Name, Description	Partner Web Address
Live Well Springfield, a coalition that provides skills, expertise, and experience to create successful public health campaigns and sustainable system changes to improve health and well-being in Western MA.	https://www.publichealthwm.org/what-we-do/coalition-building/live-well-springfield

Contact Information	Anne Richmond, Co-Director Gardening the Community PO Box 90774, Springfield MA 01139 413.693.5340
Detailed Description	Education programs accompany a garden expansion in an inner city neighborhood of Springfield.

Growing Places

Program Type	Direct Services,
Statewide Priority	Promoting Wellness of Vulnerable Populations, Reducing Health Disparity,
EOHHS Focus Issue(s) (optional)	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities (optional)	Not Specified
Target Population	• **Regions Served:** Fitchburg, Leominster, • **Health Indicator:** Other: Diabetes, Other: Nutrition, Overweight and Obesity,

	• **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	Goal Status
to provide hands-on technical assistance and education to gardeners in Leominster and Fitchburg through support of the Teaching Garden, Garden on the Go, and monthly cooking classes.	527 people participated in and completed workshops with 97% of participants reporting change in awareness of the importance of healthy food (self-reported/perception) and 68% of participants who have increased the variety of healthy food purchases/consumption.

Partners

Partner Name, Description	Partner Web Address
CHNA 9, the local community health network	https://www.chna9.com/index.html

Contact Information	Ayn Yeagle, Executive Director Growing Places 325 Lindell Ave., Leominster, MA 01453 (978) 598-3723, Ext. 801
Detailed Description	This program educates low-income communities in gardening and nutrition so they can lead a healthier life.

Mill City Grows

Program Type	Community Education, Direct Services, Outreach to Underserved, Prevention,
Statewide Priority	Chronic Disease Management in Disadvantage Populations, Promoting Wellness of Vulnerable Populations, Reducing Health Disparity,
EOHHS Focus Issue(s) (optional)	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities (optional)	Not Specified
Target Population	• **Regions Served:** Lowell, • **Health Indicator:** Other: Nutrition, Overweight and Obesity, • **Sex:** All, • **Age Group:** Adult, • **Ethnic Group:** All, • **Language:** All,

Goal Description	Goal Status
to improve access to healthy food for Lowell residents living in food deserts.	Over 64% of the $88k in sales were from SNAP/HIP/WIC/Senior Coupon purchases. MCG observed a drop in SNAP sales after the HIP suspension.

Partners

Partner Name, Description	Partner Web Address
Farmer Dave's	http://www.farmerdaves.net/

Contact Information	Lydia Sisson, Co-Director, Mill City Grows, 650 Suffolk Street, Suite G10, Lowell, MA 01854 978-455-2620
Detailed Description	Support for their mobile farmer's market which increases food access in the food deserts of Lowell.

Regional Environmental Council of Worcester

Program Type	Community Education, Direct Services, Outreach to Underserved, Prevention,
Statewide Priority	Chronic Disease Management in Disadvantage Populations, Promoting Wellness of Vulnerable Populations, Reducing Health Disparity,
EOHHS Focus Issue(s) (optional)	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities (optional)	Not Specified
Target Population	• **Regions Served:** Worcester, • **Health Indicator:** Other: Nutrition, Overweight and Obesity, • **Sex:** All,

	• **Age Group:** Adult, • **Ethnic Group:** All, • **Language:** All,

Goal Description	**Goal Status**
to improve access to healthy food for Worcester residents living in food deserts.	86% of all customers are using government subsidies to purchase their food on the mobile market. In addition, this was the first year we were able to conduct customer focus groups in addition to our regular customer surveys which yielded important and concrete feedback around product offering and price and reasons why residents chose to shop (or not shop) with us that were not captured in our surveys. We are planning to double down on this strategy in the 2019 season and establish a Cultural Advisory Board of customers who will receive a stipend and can make direct recommendations to staff.

Partners

Partner Name, Description	**Partner Web Address**
Schultz Farm	http://www.farmfresh.org/food/farm.php?farm=1576

Contact Information	Grace Sliwoski, Food Justice Director, Regional Environmental Council of Worcester, 9 Castle Street, Worcester, MA 508.799.9139
Detailed Description	To support the Veggie Mobile, a mobile farmer's market bringing low cost fruits and vegetables to low income families in Worcester.

Expenditures

Community Benefits Programs

Expenditures	Amount
Direct Expenses	$16,807,032.00
Associated Expenses	Not Specified
Determination of Need Expenditures	Not Specified
Employee Volunteerism	Not Specified
Other Leveraged Resources	$10,792,085.00

Net Charity Care

Expenditures	Amount
HSN Assessment	$18,676,702.00

Corporate Sponsorships	$898,144.00
Total Expenditures	$47,173,963.00
HMO Administrative Expenses	$147,537,665.00
Total Revenue for 2018	$1,344,633,989.00
Approved Program Budget for 2019 (*Excluding expenditures that cannot be projected at the time of the report.)	$9,534,135.00
HMO Hospital, Medical, and Other Health Care Costs	$1,128,261,417.00
Comments:	$14,332,601 is the expected 2018 Community Benefits Expenditures to be reported on the IRS Form 990.

Optional Information

Community Service Programs

Expenditures	Amount
Direct Expenses	$1,044,685.00
Associated Expenses	Not Specified
Determination of Need Expenditures	Not Specified
Employee Volunteerism	$102,736.00
Other Leveraged Resources	$47,004,629.00
Total Community Service Programs	$48,152,050.00

Link to HMO Formatted PDF Community Benefits Report:	Not Specified
Bad Debt:	Not Specified Not Specified
Optional Supplement:	Refer to the key accomplishments section entitled Harvard Pilgrim Health Care Health Equity Initiative.

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