LAHEY HOSPITAL & MEDICAL CENTER COMMUNITY BENEFITS REPORT

Fiscal Year 2020

Beth Israel Lahey Health

TABLE OF CONTENTS

SECTION I: SUMMARY AND MISSION STATEMENT

Summary and Mission Statement
Lahey Hospital & Medical Center (LHMC/LMCP) is a member of Beth Israel Lahey Health (BILH). BILH brings together an exceptional array of clinical organizations spanning the full continuum of health care delivery – academic and teaching hospitals, community hospitals, ambulatory and urgent care centers, behavioral health programs, and home care – in a shared mission to expand access to great care and advance the science and practice of medicine through groundbreaking research and education.

At the heart of BILH is the belief that everyone deserves high-quality, affordable health care. This belief is what drives BILH to work with community partners across the region to promote health, expand access, and deliver the best care in the communities BILH serves. BILH Community Benefits staff are committed to working collaboratively with BILH's communities to address leading health issues and create a healthy future for individuals, families, and communities.

At LHMC/LMCP, our mission guides us toward success. LHMC/LMCP is committed to providing superior health care leading to the best possible outcomes for every patient, exceeding our patients' high expectations for service each day, advancing medicine through research and the education of tomorrow's health care leaders, and promoting health and wellness in partnership with the diverse communities it serves.

The following annual report provides specific details on how LHMC/LMCP is honoring its commitment and includes information on LHMC/LMCP's Community Benefits Service Area (CBSA), community health priorities, target populations, community partners, and detailed descriptions of its Community Benefits programs and their impact.

More broadly, LHMC's Community Benefits mission is fulfilled by:

- **Involving LHMC's staff**, including its leadership and dozens of community partners in the community health assessment process as well as in the development, implementation, and oversight of the hospital's three-year Implementation Strategy;

- **Engaging and learning from residents** throughout LHMC's service area in all aspects of the Community Benefits process, including assessment, planning, implementation, and evaluation. The hospital pays special attention to engaging those community members who are not patients of LHMC and those who are often left out of assessment, planning, and program implementation processes;

- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to identify unmet health-related needs and to characterize

those in the community who are most vulnerable and face disparities in access and outcomes;

- **Implementing community health programs and services** in LHMC's CBSA that are geared toward improving the current and future health status of individuals, families, and communities by removing barriers to care, addressing social determinants of health, strengthening the health care system, and working to decrease the burden of leading health issues;

- **Promoting health equity** by addressing social and institutional inequities, racism, and bigotry and ensuring that all patients are welcomed and received with respect and have access to culturally responsive care; and

- **Facilitating collaboration and partnership** within and across sectors (e.g., public health, health care, social services, business, academic, and community health) to advocate for, support, and implement effective health policies, community programs, and services.

Target Populations
LHMC/LMCP's CBSA includes eight communities: Arlington, Bedford, Billerica, Burlington, Lexington, Lowell, Lynnfield, and Peabody. Given that LHMC/LMCP operates multiple buildings under a single state license and serves different geographic areas and populations, the communities that are part of the CBSA are an aggregate of these areas and populations. The CBSA does not exclude medically underserved, low-income, or minority populations. For this assessment, LHMC/LMCP made every effort to identify the health needs of all residents.

To target Community Benefits efforts and to comply with Commonwealth and federal guidelines, there was an effort to prioritize segments of the population that have complex health needs or that face significant barriers to care. With this in mind, four population segments were prioritized within LHMC/LMCP's CBSA: low-resource individuals and families, older adults, youth/adolescents, and individuals and families with chronic/complex conditions, regardless of whether they use or have used services at its facilities.

Basis for Selection
Community health needs assessments; public health data available from government Massachusetts Department of Public Health (MDPH, Boston Public Health Commission, federal agencies) and private resources (foundations, advocacy groups); LHMC/LMCP's areas of expertise.

Key Accomplishments for Reporting Year
The accomplishments highlighted in this report are based upon priorities identified and programs contained in LHMC/LMCP's FY19 Community Health Needs Assessment (CHNA) and FY20-22 Implementation Strategy (IS):

- LHMC provided a medication disposal box on-site at our pharmacy for use by community residents and collected and disposed of over 300 pounds of unwanted and unused medications.
- LHMC provided breast cancer risk assessments for over 22,000 people to identify those at high risk for the disease.
- LHMC partnered with Mill City Grows to provide funding for emergency support services during COVID-19. This funding helped provide over 400 families with fresh produce during the pandemic.
- The LHMC Interpreter Services Department provided support and assistance during 7,572 encounters in FY 20 in over sixty different languages.
- LHMC assisted 68,000 patients in FY20 who had Medicaid coverage, presented as self-paying and completed an application with a Financial Navigator, who qualified for upgraded MassHealth coverage, or otherwise required support navigating the financial components of their health care visit. This was an increase of 6,000 patients from FY19.
- LHMC improved the built environment by partnering with the Burlington Recreation Department to provide a free outdoor fitness court for the community. In FY20, it is estimated that over 12,000 people used the equipment.
- LHMC provided twenty-three internships in radiology, nuclear medicine, and sonology for students at surrounding universities to strengthen the local workforce.
- LHMC provided over fifty grants for people with cancer and their caregivers to help alleviate the financial burden of at-home or hospice care.
- LHMC continued to partner with the New Entry Sustainable Farming Project to provide weekly farmers markets at the Arlington, Burlington, and Billerica Councils on Aging. This program provides free, fresh produce every week to over 200 seniors at those locations and was modified to operate safely during the COVID-19 pandemic.
- LHMC helped support the Peabody Veterans Memorial High School Student Health Center, which provided services for over 350 unique individuals.
- LHMC provided funding to the Lowell Community Health Center to support emergent needs related to COVID-19, which helped provide supportive services for over 500 vulnerable individuals in the Lowell region, over 10,000 interpreter sessions, and a social media campaign to raise awareness about COVID-19.

For the FY20 reporting year, LHMC/LMCP dedicated a great deal of time and resources at the local level in response to the COVID-19 global pandemic. The hospital was intentional when assessing risk factors within our CBSA and worked closely with the local health department(s). Clinical staff provided infection control expertise to local health departments during their reopening plans. LHMC/LMCP worked to expand community testing access and worked with BILH as a system to develop and distribute written materials (in nine languages) to the communities most impacted by COVID-19 to help slow the spread. LHMC/LMCP also redeployed staff and procured tangible necessities for both the community at large and hospital staff, such as personal protective equipment (PPE), food, hand sanitizer, and other critical items.

Many of the programs highlighted in this report had to be modified significantly due to COVID-19 and related safety guidelines. In some cases, programs were expanded. In others, programs were cut or significantly reduced because of the COVID-19 pandemic.

Plans for Next Reporting Year

In FY19, LHMC/LMCP conducted a comprehensive and inclusive CHNA that included qualitative and quantitative data collection, robust community engagement activities, and an inclusive prioritization process. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY19. In response to the FY19 CHNA, LHMC/LMCP will focus its FY20-22 Implementation Strategy on three priority areas; these priority areas collectively address the broad range of health and social issues facing residents living in LHMC/LMCP's CBSA who face the greatest health disparities. These three priority areas are:

- Chronic/complex conditions and risk factors
- Mental health disorders and substance use disorders
- Social determinants of health and access to care

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). LHMC/LMCP's priorities are also aligned with the priorities identified by DPH to guide the Community-Based Health Initiative (CHI) investments funded by the Determination of Need (DON) process, which underscore the importance of investing in the Social Determinants of Health (ex. built environment, social environment, housing, violence, education, and employment).

The FY19 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions that are being used to inform and refine LHMC/LMCP's efforts. In completing the FY19 CHNA and FY20-22 Implementation Strategy, LHMC/LMCP, along with its other health, public health, social service, and community partners, is committed to improving the health status and well-being of all residents living throughout its CBSA. As discussed above, based on the CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that LHMC/LMCP's FY20-22 Implementation Strategy should prioritize certain demographic, socioeconomic, and geographic population segments that have complex needs and face barriers to care and service gaps, as well as other adverse social determinants of health. These factors put these segments at greater risk, limit their access to needed services, and can often lead to disparities in health outcomes. More specifically, the FY19 CHNA identified the importance of supporting initiatives that target low-income populations, youth, older adults, racially/ethnically diverse populations, limited English proficiency populations, and LGBTQ populations.

LHMC/LMCP partners with dozens of community-based organizations and service providers to execute its Implementation Strategy, including public agencies, social service providers, community health organizations, academic organizations, and businesses. In FY21,

LHMC/LMCP plans to continue to enhance our valuable community benefits programs offered in collaboration with community partners, including:

- Working with the Peabody YMCA, Burbank YMCA, and North Suburban YMCA to continue to increase access for vulnerable populations to opportunities for evidence-based physical fitness programs.
- Working with the Housing Corporation of Arlington to continue to expand its social worker program that provides resources, information, and counseling for low-to-moderate-income residents.
- Continuing to provide clinically based education opportunities done in collaboration with colleges to help strengthen the local workforce.
- Supporting the Serving Health Information Needs of Everyone program in collaboration with Minuteman Senior Services to provide no-cost insurance benefits counseling to members of the community to promote access to care.
- Supporting the New Entry Sustainable Farming Project and LHMC/LMCP's extremely successful farmers market program, which provides free, community-based produce for seniors, increasing access and reducing the barrier of cost to healthy eating.
- Continuing to provide our Medication Disposal Box to provide a safe and convenient way for community residents to dispose of unwanted or unused medications.

Hospital Self-Assessment Form

Working with its Community Benefits leadership team and its Community Benefits Advisory Committee (CBAC), the LHMC/LMCP Community Benefits team completed a hospital self-assessment form (Section VII, page [insert page number]). The LHMC/LMCP Community Benefits team also shared the Community Representative Feedback Form with many CBAC members and community stakeholders who participated in LHMC/LMCP's CHNA.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team and Community Benefits Advisory Committee (CBAC)

Lahey Hospital & Medical Center Community Benefits Advisory Committee 2020
Stathis Antoniades, Chief Operating Officer, Lahey Hospital & Medical Center
Sharon Cameron, Director, Peabody Health Department
Eric Conti, Superintendent, Burlington Public Schools; President, Middlesex League
Randi Epstein, Coordinator, Community Health Network Area 15
Pamela Hallett, Executive Director, Housing Corporation of Arlington
Christine Healey, Director, Community Relations, Beth Israel Lahey Health
Peter Kilcommons, Corporate Controller, Lahey Hospital & Medical Center
Rick Parker, Burlington Resident
Sharon Cameron, Director of Health and Human Services, City of Peabody
Michelle Snyder, Regional Manager, Community Relations, Lahey Hospital & Medical Center
Andy Villanueva, MD, Chief Quality Officer, Lahey Hospital & Medical Center, Lahey Hospital & Medical Center Board of Trustees
Kelly Magee Wright, Executive Director, Minuteman Senior Services
Michelle McCool-Heatley, ACNO Emergency Services, Lahey Hospital & Medical Center

The membership of LHMC/LMCP's Community Benefits Advisory Committee (CBAC) aspires to be representative of the constituencies and priority populations served by LHMC/LMCP's programmatic endeavors, including those from diverse racial and ethnic backgrounds, age, gender, sexual orientation, and gender identity, as well as those from corporate and non-profit community organizations. Senior management is actively engaged in the development and implementation of the Community Benefits plan, ensuring that hospital policies and resources are allocated to support planned activities.

It is not only the Board members and senior leadership who are held accountable for fulfilling LHMC/LMCP's Community Benefits mission. Among LHMC/LMCP's core values is the recognition that the most successful Community Benefits programs are implemented organizationwide and integrated into the very fabric of the hospital's culture, policies, and procedures. A commitment to Community Benefits is a focus and value manifested throughout LHMC's structure and reflected in how it provides care at the hospital and in affiliated practices.

LHMC/LMCP is a member of BILH. While LHMC/LMCP oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Strategy Officer. This structure ensures that Community Benefits efforts, prioritization, planning, and strategy align and are integrated with local and system strategic and regulatory priorities.

The LHMC/LMCP Community Benefits program is spearheaded by the Regional Manager of Community Benefits. The Regional Manager of Community Benefits has direct access and is accountable to the LHMC/LMCP President and the BILH Vice President of Community Benefits and Community Relations, the latter of whom reports directly to the BILH Chief Strategy Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of underserved populations are considered every day in discussions on resource allocation, policies, and program development.

This is the structure and methodology employed to ensure that Community Benefits is not the purview of one office alone and to maximize efforts across the organization to fulfill the mission and goals of Community Benefits.

Community Benefits Committee Meetings
November 8, 2019
January 9, 2020 (Annual Meeting)
May 21, 2020
September 28, 2020

Community Partners
The LHMC/LMCP recognizes its role as a tertiary/academic resource in a larger health system and knows that to be successful it needs to collaborate with its community partners and those it serves. LHMC/LMCP's CHNA and the associated Implementation Strategy were completed in close collaboration with LHMC/LMCP staff, its health and social service partners, and the community at large. LHMC/LMCP's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of LHMC/LMCP's mission.

LHMC/LMCP serves and collaborates with all segments of the population. LHMC/LMCP focuses its Community Benefits efforts on low-resource individuals and families, older adults, youth/adolescents, and individuals and families with chronic/complex conditions living in its CBSA.

LHMC/LMCP currently supports dozens of educational, outreach, community health improvement, and health system strengthening initiatives within the Commonwealth. In this work, the hospital collaborates with many leading health care, public health, and social service organizations. LHMC/LMCP also provides support to community health centers within its CBSA, including the Lowell Community Health Center and North Shore Community Health (NSCH). In FY20, LHMC/LMCP provided funding for the Lowell Community Health Center to provide funding for contact tracing efforts for COVID-19 patients. This partnership will continue in FY21 with support for Interpreter Services. LHMC/LMCP also continued its support for the NSCH student health center based at Peabody High School in FY20.

These health centers are ideal Community Benefits partners because they are rooted in their communities and, as federally qualified health centers, are mandated to serve low-income, underserved populations.

LHMC/LMCP is also an active participant in CHNA 15 and CHNA 13/14 and supports both organizations with annual DON funding. Joining with such grassroots community groups and residents, LHMC/LMCP strives to create a vision for both citywide and neighborhood-based health improvement. Another important partnership is LHMC/LMCP's involvement with the Greater Boston YMCA Association. LHMC/LMCP partners with several branches of the YMCA to provide opportunities for physical activity and wellness for residents of its CBSA.

LHMC/LMCP's Board of Directors along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its service area and beyond. World-class clinical expertise, education, and research, along with an underlying commitment to health equity, are the primary tenets of its mission. LHMC/LMCP's Community Benefits Department, under the direct oversight of LHMC/LMCP's Board of Directors, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations.

The following is a comprehensive listing of the community partners with which LHMC joins in assessing community need as well as planning, implementing, and overseeing its Community Benefits Implementation Strategy. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment (Section VII, page [insert number]).

Community Partners

- A Healthy Lynnfield Coalition
- American Cancer Society
- Arlington Housing Corporation
- Burbank YMCA
- Burlington Recreation Department
- Burlington School Department
- Community Health Network Area 13/14
- Community Health Network Area 15
- City of Peabody
- Lynnfield Public Schools
- Merrimack Valley Food Bank
- Metro North YMCA
- Mill City Grows
- Minuteman Senior Services
- New Entry Sustainable Farming Project
- North Shore Community Health
- North Suburban YMCA
- Town of Arlington

- Town of Bedford
- Town of Billerica
- Town of Burlington
- Town of Lexington
- Town of Lynnfield

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY19 CHNA along with the associated FY20-22 Implementation Strategy was developed over a ten-month period from October 2018 to August 2019. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and Federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill LHMC/LMCP's need to conduct a community health needs assessment, engage the community, identify priority health issues, inventory community assets, assess impact, and develop an Implementation Strategy. However, these activities are driven primarily by LHMC/LMCP's dedication to its mission, its covenant to the underserved, and its commitment to community health improvement.

As mentioned above, LHMC/LMCP's most recent CHNA was completed during FY19. FY20 Community Benefits programming was informed by the FY19 CHNA and aligns with LHMC/LMCP's FY20-FY22 Implementation Strategy. The following is a summary description of the FY19 CHNA approach, methods, and key findings.

Approach and Methods

The assessment began with the creation of a Steering Committee composed of representatives from the former Lahey Health system, including LHMC/LMCP, Winchester Hospital, and Beverly Hospital-Addison Gilbert Hospital. The hospital hired JSI, a public health research and consulting firm in Boston, to complete the CHNA and Implementation Strategy. The Steering Committee provided vital oversight of the CHNA approach, methods, and reporting process. This committee met monthly, in person and via conference call, to review project activities, vet preliminary findings, address challenges, and ensure alignment in CHNA approach and methods across the BILH system.

LHMC/LMCP engaged its CBAC, made up of hospital leadership and clinical staff, local service providers, and key community stakeholders, extensively throughout this process. This group met three times over the course of the assessment and provided input on the assessment approach, vetted preliminary findings, and helped prioritize community health issues and vulnerable populations. The CBAC also reviewed and provided feedback on the associated Implementation Strategy.

Finally, the Project Advisory Committee (PAC) was convened to provide input and feedback from a systemwide perspective. The PAC was composed of representatives from clinical and

administrative leadership and local public health officials, along with Community Relations staff. The PAC met three times over the course of the project, provided broad-based feedback on the approach, and vetted preliminary findings relative to priority community health issues and vulnerable populations.

Quantitative data from a broad range of sources was collected and analyzed to characterize communities in LHMC/LMCP's CBSA, measure health status, and inform a comprehensive understanding of the health-related issues. Sources included:

- U.S. Census Bureau, American Community Survey 5-Year Estimates (2013-2017)
- Massachusetts Department of Elementary and Secondary Education: School and District Profiles (2017 and 2018-2019)
- FBI Uniform Crime Reports (2017)
- MDPH, Registry of Vital Records and Statistics (2015)
- MDPH, Bureau of Substance Abuse Services (2017)
- MDPH, Annual Reports on Births (2016)
- Massachusetts Bureau of Infectious Disease and Laboratory Sciences (2017)
- Massachusetts Center for Health Information Analysis (CHIA) Hospital Profiles (FY 2013-2017)
- Massachusetts CHIA Hospital Discharges (2017)
- Massachusetts Healthy Aging Collaborative, Community Profiles (2018)
- Youth Risk Behavior Surveys (2017 and 2018)

JSI, working in collaboration with staff from BILH and CHIA, obtained federal FY17 hospital discharge data for municipalities within the Commonwealth. JSI analyzed the discharge data for the hospital's CBSA based on patient residence. JSI also developed statewide averages for comparative purposes. CHIA aggregates hospital discharge data from all hospitals in Massachusetts and makes it available to hospitals and researchers to evaluate morbidity, access to care, and health services utilization trends.

The data allowed for hospital-specific analyses based on where the patient was hospitalized within Massachusetts and patient origin analyses based on the patient's address of residence. Related to the CHNA activities, this data was used to:

- Measure hospitalization rates for major health issues as identified by stakeholders in the qualitative research
- Gauge access to high-quality primary and outpatient services for residents within the CBSA using the Agency for Health Research and Quality's Prevention Quality Indicators (PQIs) software

PQI rates were developed for eight chronic PQI measures, four of which are related to diabetes. PQIs use data from hospital discharges to identify admissions that might have been avoided through access to high-quality primary or outpatient care. The PQIs are population-based and, therefore, can help public health agencies, health care systems, and others interested in improving health care quality in their communities.

JSI compared municipal-level PQI rates with Massachusetts' statewide average.

Relative to most states, Massachusetts does an exemplary job at making comprehensive data available at the Commonwealth, county, and municipal levels through the MDPH. Historically, this data has been made available through the Massachusetts Community Health Information Profile (MassCHIP) data system, an automated and interactive resource provided by MDPH; MassCHIP is no longer being updated. To replace this system, MDPH is creating the Population Health Information Tool (PHIT), which will include municipal-level data stratified by demographic and socioeconomic variables (e.g., gender/sex, age, race/ethnicity, poverty level). At the time this report was produced, community profiles were not available via the PHIT. The most significant limitation this caused was the availability of timely data related to morbidity, mortality, and service utilization. The data sets used in this report are the most up to date provided by MDPH. This data was still valuable and allowed for identification of health needs relative to the Commonwealth and specific communities; however, these data sets may not reflect recent trends in health statistics.

Additionally, quantitative data was not stratified by age, race/ethnicity, income, or other characteristics, which limited the ability to identify health disparities in an objective way. Qualitative activities allowed for exploration of these issues, but the lack of objective quantitative data constrained this effort.

LHMC/LMCP recognizes that authentic community engagement is critical to assessing community needs, identifying health priorities and vulnerable populations, and creating a robust implementation strategy. The hospital was committed to engaging the community throughout this process. Using the community engagement continuum included in MDPH's Community Engagement Standards for Community Health Planning as a guide, LHMC/LMCP employed a variety of approaches to ensure that community members were informed, consulted, and involved throughout the assessment process, and that they were collaborators in ensuring that the Implementation Strategy addressed priority issues and vulnerable populations.

LHMC/LMCP's Community Benefits program is predicated on the notion of partnership and dialogue with its many communities. LHMC/LMCP's understanding of these communities' needs is derived from discussions with and observations by health care and health-related workers in the neighborhoods as well as more formal assessments through available public health data, focus groups, surveys, etc. This data was then augmented by demographic and health status information gleaned from a variety of sources, including the Massachusetts Department of Public Health, the Boston Public Health Commission, federal resources such as the Institute of Medicine and the Centers for Disease Control and Prevention, and review of literature relevant to a particular community's needs.

The articulation of each specific community's needs (done in partnership between LHMC/LMCP and community partners) is used to inform LHMC/LMCP's decision-making about priorities for its Community Benefits efforts. LHMC works in concert with community residents and leaders to design specific actions to be undertaken each year.

Summary of FY19 CHNA Key Health-Related Findings

Below is a high-level summary of health-related findings that were identified after a comprehensive review of all the quantitative and qualitative information that was collected as

part of the CHNA. A detailed and in-depth discussion of key findings is included in the full CHNA report.

- **The social determinants of health (e.g., transportation, economic stability, access to care, housing, food insecurity) affect many segments of the population.** A key theme from the assessment's key informant interviews, focus groups, listening sessions, and Community Health Survey was the continued impact that the social determinants of health have on residents of LHMC/LMCP's service area, especially those who are low-to-moderate income, frail or homebound, have mental health or substance use issues, or lack a close support system.

- **Certain populations are more vulnerable to health care disparities and barriers to care.** Despite the fact that Massachusetts has one of the highest rates of health insurance enrollment and the communities that make up LHMC/LMCP's service area have strong, robust safety net systems, there are still substantial numbers of low-income, Medicaid-covered, uninsured, and otherwise vulnerable individuals who face health disparities and are not engaged in essential medical and behavioral services. Efforts need to be made to expand access, reduce barriers to care, and improve the quality of primary care medical, medical specialty, and behavioral health services.

- **Mental health issues (e.g., depression, anxiety/stress, access to treatment, stigma) underlie many health and social concerns.** Nearly every key informant interview, focus group, and listening session included discussions on the impact of mental health issues. From a review of the quantitative and qualitative information, depression, anxiety/stress, and social isolation were the leading concerns. There were particular concerns about the impact of depression, anxiety, and e-cigarette/vaping on youth as well as social isolation among older adults.

- **Substance dependency continues to affect individuals, families, and communities.** The opioid epidemic continues to be an area of focus. Beyond opioids, key informants were also concerned with alcohol misuse, changing community norms in light of the legalization of recreational marijuana use, and e-cigarette/vaping among adolescents.

- **Chronic diseases (e.g., cardiovascular disease, cancer, diabetes, asthma) require more education, screening/early intervention, and management – and a focus on risk factors.** Although there was a major emphasis on behavioral health issues, many key informants, focus group participants, and listening session participants identified a need to address the many risk factors associated with chronic and complex health conditions. Physical inactivity and poor nutrition/lifestyle were discussed by many, with some of these issues being associated with age (mobility issues among older adults), education/health literacy (lack of understanding about healthy eating), and socioeconomic status (fresh foods being expensive, and gyms and health centers unaffordable). Addressing the leading risk factors is at the root of many chronic disease prevention and management strategies.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Social Determinants of Health and Access to Care – Patient Financial Counseling	
Brief Description or Objective:	The extent to which a person has health insurance that covers or offsets the cost of medical services coupled with access to a full continuum of high-quality, timely, accessible health care services has been shown to be critical to overall health and well-being. Access to a usual source of primary care is particularly important because it greatly impacts one's ability to receive preventive, routine, and urgent care, as well as chronic disease management services. Despite the overall success of the Commonwealth's health care reform efforts, information captured for this assessment shows that while the vast majority of the area's residents have access to care, significant segments of the population, particularly low-income and racial/ethnic minority populations, face significant barriers to care. These groups struggle to access services due to lack of insurance, cost, transportation, cultural/linguistic barriers, and a shortage of providers willing to serve Medicaid-insured or uninsured patients. To address these gaps, LHMC employs four MassHealth-certified application counselors who can screen patients and assist them in applying for state aid. They also estimate for patients their financial responsibility (copay, deductible, coinsurance, self-pay). The financial counselors spend their time with patients discussing financial assistance and estimates and helping patients understand their insurance benefits.

Target Population (indicate/select as many as needed for all fields):	• **Regions Served: All of Massachusetts** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training

☐ Health Screening
☐ Mentorship/Career Training/Internship
☐ Physician/Provider Diversity
☐ Prevention
☐ Research
☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Assist patients who are uninsured to assess their eligibility for and align them with state and hospital-based financial assistance programs.	LHMC assisted 68,000 patients in FY20 who had Medicaid coverage, presented as self-paying, and completed an application with a Financial Navigator, and who qualified for upgraded MassHealth coverage or otherwise required support navigating the financial components of their health care visit. This was an increase of 6,000 patients from FY19. The ages of patients served were: • 0-17 years (5%) • 18-35 years (31%) • 36-53 years (30%) • 54-70 years (30%) • 71-107 years (4%) Their employment status at time of service: • 13,450 employed full time or part time • 11,770 unemployed • 2,450 self-employed • 3,330 retired • 3,850 disabled • 1,780 full- or part-time students	1	3	Process Goal
Assist community members in completing applications for Medicaid.	LHMC assisted 681 community members in completing applications for Medicaid FY20, which represented a 59% increase from FY19.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
None	N/A

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Social Determinants of Health and Access to Care – Interpreter Services

Brief Description or Objective:	An extensive body of research illustrates the health disparities and differences in health care access and utilization that exist for diverse individuals/cohorts and foreign-born populations. According to the Centers for Disease Control and Prevention (CDC), non-Hispanic blacks have higher rates of premature death, infant mortality, and preventable hospitalization than do non-Hispanic whites. Hispanics have the highest uninsured rates of any racial or ethnic group in the United States. Asians are at a higher risk for developing diabetes than are those of European ancestry, despite a lower average body mass index (BMI). These disparities show the disproportionate and often avoidable inequities that exist within communities and reinforce the importance of understanding the demographic makeup of a community to identify populations more likely to experience adverse health outcomes. The LHMC/LMCP service area is quite diverse. While many municipalities are predominantly white, there are significant populations of Asian and Hispanic/Latino residents throughout the service area. Language barriers pose significant challenges to providing effective and high-quality health and social services. To address this need, and in recognition that language and cultural obstacles are major barriers to accessing health and social services and navigating the health system, LHMC/LMCP offers an extensive Interpreter Services program that provides interpretation (translation) and

	assistance in over 60 different languages, including American Sign Language, and hearing augmentation devices for those who are hard of hearing. The Interpreter Services Department routinely also helps with facilitating access to care, helping patients understand their course of treatment, and adhering to discharge instructions and other medical regimens. LHMC/LMCP also routinely translates materials, such as legal consents for treatment, patient education forms, and discharges, to continue to reduce barriers to care.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: All of Massachusetts** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable

EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Provide culturally responsive care through the Interpreter Services Department.	In FY20, LHMC interpreters reported 7,572 total encounters. The top three languages were Spanish, the Chinese languages (Mandarin and Cantonese), and Portuguese languages (Portuguese and European).	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
None	N/A

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.

Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Social Determinants of Health and Access to Care – Merrimack Valley Food Bank Community Market Program	
Brief Description or Objective:	In FY20, LHMC partnered with the Merrimack Valley Food Bank (MVFB) to provide funding to support its Community Market Program, which serves residents of four Lowell Housing Authority (LHA) properties, offering them the opportunity to supplement their food by enjoying fresh produce at no cost. Bringing the market to the LHA properties helps residents who have difficulty traveling to a grocery store or pantry. The convenience of having fresh produce available outside one's front door may encourage individuals to eat more fresh fruits and vegetables. In addition to the fresh produce, the market frequently offers bottled water, juice, and other items. The market operates in a different location each Friday so that residents of each complex are able to attend once per month. There are interpreters at the markets, where most guests are speakers of other languages, and outreach materials are translated into Spanish and Khmer for all partner sites. On the Fridays when the market takes place, MVFB staff and volunteers transport and distribute food from their Lowell food distribution center to one of the four market sites. The first time they attend, residents register by providing proof of residency and income verification, as well as their household size and demographic information. Once they have registered, they just need to check in with the MVFB staff at the beginning of each market so that we can track participation. The amount of food given to each attendee is based on the size of their household. The market season had to be shortened this year due to a surge in COVID-19 cases in Lowell and the restrictions put in place by the housing properties; however, households received an average of just over 92 pounds of food over the course of the July – September season, or an average of more than 30 pounds per visit. An additional 56 residents of one site, the Francis Gatehouse

	Apartments, received a $50 supermarket gift card in partnership with the United Way of Mass Bay and Merrimack Valley. Until a week prior to the distribution date, November 20, the organization decided to increase the amount of the gift cards being given instead of providing a bag of Thanksgiving food that would have included shelf stable items and fresh produce, thus minimizing the potential spread of infection. Three LHA administrative staff helped support the nutritional needs of these vulnerable neighbors by notifying residents of the distribution of gift cards prior to the distribution day, and LHA staff along with 2 regular MVFB Community Market volunteers slid the cards underneath residents' doors.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Lowell** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☐ All ☒ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

DON Health Priorities (select up to 3):	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Increase access to fresh produce for residents of Lowell.	In this year's Community Market program, a total of 621 clients received food, and the program distributed 17,532.25 pounds of food to these residents – the equivalent of 14,610 meals. The number of participants and the amount of food distributed are both significantly smaller than in the previous year due to COVID-19 restrictions and residents' hesitancy to attend, as well as the shortened program season.	1	1	Process Goal
Serve a diverse population of residents of Lowell.	The population breakdown for FY20 is as follows: • 2 % African/Black • 37% Asian • 32% White • 28% Hispanic Of the FY20 ethnicities, the following age groups were served: • 17% Children 0-17 • 44% Adults 18-64 • 39% Seniors 65+	1	1	Process Goal

Partners

Partner Name, Description	Partner Web Address
Merrimack Valley Food Bank Planned, communicated, and coordinated food ordering, volunteer service, transportation, and distribution of food in 4 locations, for a total of 14 distributions, the final one being supermarket gift cards.	www.mvfb.org

Lowell Housing Authority Assisted in planning and communication to residents at each property about the program.	www.lhma.org

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Social Determinants of Health and Access to Care – Mill City Grows Food Access Programming

Brief Description or Objective:	From April – September 2020, LHMC supported Mill City Grows (MCG) in delivering emergency response food access programming. This included: 1) Establishing an online produce store that offers limited deliveries to families in quarantine. 2) Providing donations of produce directly to customers as well as to emergency food providers such as the Merrimack Valley Food Bank. 3) Increasing our produce harvest through expanding our Urban Farm crop plan as well as utilizing school gardens to grow produce to be distributed to Lowell Public School students and their families. 4) Establishing a weekly farm share program for low-income families. 5) Creating a plan to operate Mobile Markets in alignment with federal, state, and local health guidelines to stop the spread of COVID-19.

Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Lowell** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☒ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☒ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs

Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Serve 400 families through online orders and other COVID-19 safe food distribution methods.	433 households were served via an online ordering program, and 121 families were served via weekly CSA produce share programs. Of those orders, 34% required delivery because they were quarantining or immunocompromised. 55% were low income and used SNAP/HIP to purchase their produce or received donated food. 38% reported they were facing a food emergency and didn't have enough food to feed their families. Of these 121 families served through the Farm Share Program: 33% (40 families) were families with children in Lowell Public Schools; 12% paid for food using SNAP/HIP benefits; 68% received the food at no cost to them (these shares were subsidized through grants and donations). This program was successful and will continue through the winter.	1	1	Process Goal
Distribute food at no cost to 60% of customers during quarantine period who are low income or experiencing a food access emergency.	55% of online sales, 81% of CSA customers and 50% of MM customers, received food at no cost to them (this is 51% of overall customers). Four weekly markets from July – November 2020 were also in operation. 3,500 customers were served at these markets. 50% of MM customers used SNAP/HIP, WIC, or Sr. Coupons to purchase produce.	1	1	Process Goal

	In addition, 5,300 pounds of produce was donated to emergency food distributors, which could provide one day's worth of healthy produce for over 3,000 people.			
Target high-risk and food insecurity (low-income families with children, disabled elders, and refugees and immigrants) communities.	Created partnerships with Lowell Public Schools, International institute of New England, and Active Day to reach these communities, and served weekly produce to 84 households in these target populations for 20 weeks. (This equals about 3,400 pounds of produce.)	1	1	Process Goal

Partners

Partner Name, Description	Partner Web Address
Mill City Grows Program Managers	www.millcitygrows.org
International Institute of New England Partners in outreach to immigrants/refugees	https://iine.org/
Active Day of Lowell Providing food to disabled elders	https://www.activeday.com/locations/states/m
Lowell Public Schools Collaborating to repurpose school gardens, provide outreach to remote students, provide foods to student families	https://www.lowell.k12.ma.us/
Lowell Community Health Center Outreach to low-income patients, MM location	https://www.lchealth.org/
Boys & Girls Club of Greater Lowell MM location, providing food resources to low-income families with children	https://lbgc.org/
Community Teamwork, Inc. Worked with to establish multilingual, COVID-19-safe farmers markets	https://www.commteam.org/
Lowell Senior Center	https://www.lowellma.gov/373/Senior-Center

Providing food to low-income elders

Cambodian Mutual Assistance Association http://www.cmaalowell.org/wp/
Providing food to Southeast Asian community

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Social Determinants of Health and Access to Care– Bedford Facilitates Access to Services and Transportation (B-FAST)

Brief Description or Objective:	In the most recent LHMC CHNA, 30% of Community Health Survey respondents identified transportation issues as barriers that prevent people from being able to live a healthy life. In order to address this need in FY20, LHMC partnered with the Town of Bedford to provide funding for their Bedford Facilitates Access to Services and Transportation (B-FAST) Program. B-FAST seeks to address one of the top barriers that residents report prevent them from accessing mental health services: access to transportation for appointments and programs that support residents' mental health. Bedford is a community with limited transportation options and is not connected to a commuter rail or subway system; only one significant bus line runs through town; there is no public transportation to connect residents living in apartment complexes in eastern Bedford to the town services in the center of town; and narrow streets, limited sidewalks, and few bike lanes make pedestrian and bicycle travel difficult. Residents were hesitant to take MTBA public transportation once COVID-19 struck. While there is Bedford Local Transit (BLT), a fare-based, fixed-route van service to several shopping destinations in town, and some door-to-door dial-a-ride service, it only operates between 8 am and 4 pm on weekdays and only within Bedford with sporadic fixed routes to shopping destinations in Burlington. The BLT ceased

	operation during the early days of the COVID-19 outbreak. The B-FAST program initially sought to address the transportation gap by providing information to residents on all the existing transportation options available, instruction on the use of a Rideshare application and, for those residents who require funding to support a ride to their mental health appointment or program, support for the use of the Rideshare company for attending mental health appointments and programs with funding from this grant. COVID-19 resulted in our town offices being closed for several weeks early in the pandemic. The Council on Aging, where most of the ride-share training was to take place, is still closed to the public. Because of the limited manner in which they could provide training – they still wanted to provide services to residents in need with access to mental health support services and appointments – efforts were made to outreach to social service providers in Bedford. Town social workers, violence prevention coalition, police department, school guidance counselors, Council on Aging, clergy partners, and other town collaborators were informed of the B-FAST program and were asked to direct residents in need of rides to mental health services to contact town social workers. Additionally, because the training on the use of ride-share service was stymied by the pandemic, there was an additional effort to use grant funds to provide services from Uber and local taxi services.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Bedford** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: English, Spanish** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status

	☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☒ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Reduce the transportation issues as a barrier to accessing physical and mental health needs by completing training and outreach on rides available for accessing mental health services by April 2020.	Bedford HHS initiated outreach to Lyft to conduct resident training, and we had dates set up but had to cancel due to COVID-19. Outreach on availability of funds for transportation to appointments commenced in March 2020 and continues today.	1	1	Process Goal
By April 2020, amend program to provision of access to Uber and local cab company for resident access to mental health services.	Contracted with Bedford Red Cab, a local taxi company, and connected (or assisted with connection of) residents to Uber or taxi company.	1	1	Process Goal
By December 2020, evaluate data gathered from grant program to inform future town programming and services.	Age range of residents served: 40-84 19.7% of rides were for medical appointments. 10.4% of rides were for mental health appointments. 4.6% of rides were for legal meetings/hearings. 65.1% were for mental health supportive services (food pantry, groceries, library, employment)	1	1	Outcome Goal

Partners

Partner Name, Description	Partner Web Address
Bedford Health & Human Services Lead, coordination of rides and access to MH service	https://www.bedfordma.gov/health-human-se
Bedford COA Coordination of rides for seniors	https://www.bedfordma.gov/council-on-aging
Bedford At-Risk Task Force Identified residents in need of grant services	https://www.bedfordma.gov/police

Domestic Violence Prevention Network Referral of rides for domestic violence clients	https://www.bedfordma.gov/police/pages/dor -violence-resources
Bedford Food Bank Outreach on program to clients	https://www.bedfordma.gov/BedfordFoodBa

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Social Determinants of Health and Access to Care – LHMC Transportation Programs

Brief Description or Objective:	The LHMC CHNA identified transportation as one of the major barriers to care within its service area. While social determinants of health affect all populations, community and organizational experts expressed concern that seniors may feel these effects more acutely. Many older adults live on fixed incomes with limited funds for medical expenses, leaving them less able to afford the high costs associated with negative health outcomes. Transportation was also consistently mentioned as a major barrier to senior well-being, as many elders no longer drive and find themselves with fewer transportation options in LHMC's suburban setting. LHMC also set improving access through transportation as a key Implementation Strategy goal and participates in a regional transportation planning collaborative. In response, LHMC provides a variety of ways to help bridge the gaps that can be caused by lack of transportation, including providing free taxi and Uber rides and free parking vouchers to local Councils on Aging. In FY20, LHMC also provided support to the Peabody Council on Aging for their Project Mobility program, which provides rides to medical appointments, shopping, the Adult Day Health Program, and the senior center for lunch and activities, as well as many miscellaneous rides. During the

	pandemic, it also is providing rides for medical appointments, shopping and delivering frozen meals to seniors in need.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: All Massachusetts; Peabody** • **Gender: All** • **Age Group: Adults; Elderly** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☒ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs

Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	**Goal Status**	**Program Is in X Year**	**Of X Years**	**Goal Type**
Increase access to transportation for area residents.	Provided transportation vouchers for 58 people in FY20. Provided over 30,000 rides to Peabody residents in FY20 through Project Mobility.	1	3	Process Goal
Use Project Mobility to deliver meals for free to older adults who are unable to grocery shop or cook during COVID-19.	Over 18,000 meals have been delivered in FY20.	1	1	Process Goal

Partners

Partner Name, Description	**Partner Web Address**
Middlesex 3 Coalition Provide regional collaboration for transportation initiatives	www.middlesex3.org
Burlington Council on Aging Distribute parking vouchers	https://www.burlington.org/509/Council-On-Aging
Peabody Council on Aging Transportation shuttle program manager	https://peabodycoa.org/

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Social Determinants of Health and Access to Care – Strengthening the Local Workforce: LHMC Internship Programs

Brief Description or Objective:	Lack of gainful and reliable employment is linked to several barriers to care, including lack of health insurance, inability to pay for health care services and copays, and inability to pay for transportation to enable individuals to receive services. In key informant interviews and focus groups, participants stressed that while unemployment may be low across the service area, many live on fixed incomes or are underemployed. Certain populations struggle to find and retain employment for a variety of reasons – from mental and physical health issues to lack of child care to transportation issues and other factors. In recognition of this significant health need, LHMC is committed to collaborating with partners to strengthen the local workforce by supporting job training and internship programs. Every year, through the Radiology Job Training Program, students from surrounding colleges and universities are given the opportunity to receive hands-on clinical experience in radiation, breast imaging, CT scan, nuclear medicine, and ultrasound technologies. Internships range from 6 months to 2 years and interns are supervised and educated by LHMC staff members. LHMC partners with Bunker Hill Community College, Middlesex Community College, Massachusetts College of Pharmacy and Health Science, and Regis College on this program. In FY20, 16 students went through this program and 2 people were employed by LHMC after completing their internship in the Radiologic technology program. 4 students went through the Nuclear Medicine Program (2 students per semester) – there were no open positions available.

	3 students went through the Sonography Program, and we hired 2 after their internship was complete. 0 Mammography and 0 CT interns in FY20.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: All Massachusetts** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☒ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs

Additional Program Descriptors (program tags)	☐ Community Education ☐ Community Health Center Partnership ☒ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	**Goal Status**	**Program Is in X Year**	**Of X Years**	**Goal Type**
Provide clinical-based education opportunities to help strengthen the local workforce.	In FY20, LHMC provided: • 3 year-long internships for students in ultrasound technologies; 2 hired by LHMC post-internship. • 4 3-month internships in nuclear medicine. • 16 2-year radiology internships; 2 of those graduates were hired by LHMC post-internship.	1	3	Process Goal

Partners

Partner Name, Description	**Partner Web Address**
Regis College	www.regiscollege.edu
Middlesex Community College	www.bhcc.edu
Bunker Hill Community College	www.middlesex.mass.edu
Massachusetts College of Pharmacy and Health Sciences	www.mcphs.edu

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health

41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Social Determinants of Health and Access to Care – Community-Based Trauma Support, Education, and Advocacy	
Brief Description or Objective:	LHMC's Trauma Department provides numerous programs within its surrounding communities and is committed to educating the community about preventable causes of injury and death. Department staff also regularly work with area first responders and businesses on trainings and regularly participate in drills, task forces, and simulations for widespread disasters. In FY20, LHMC collaborated with partners on three emergency preparedness drills. LHMC has also chosen to focus its community-based education efforts on providing hemorrhage control trainings. According to the World Health Organization, uncontrolled post-traumatic bleeding is the leading cause of potentially preventable death among trauma patients. LHMC joined the Department of Homeland Security's Stop the Bleed program in FY17 and has provided education to local law enforcement, first responders, schools, and community groups on how to apply tourniquets. Instructors provided hands-on teaching to non-health care workers on the various ways to control bleeding, whether using only their hands or a full trauma first aid kit. In FY20, LHMC was able to provide four trainings in our surrounding communities. Due to the COVID-19 pandemic, many of our planned programs were cancelled. LHMC also focused its injury prevention initiative on decreasing the incidence of motor vehicle crashes by hosting an awareness campaign for the new Massachusetts Hands-Free Driving Law. Motor vehicle crashes are among one the leading cause of injury for Lahey Hospital and Medical Center Level I Trauma Center. Nationally, 14% of all distracted affected crashes involved cell phone use. The new hands-free driving law (Bill H.4203) has the potential to reduce crash-related catastrophes while driving. This awareness campaign highlighted the importance of taking measures to educate the public on the benefits of the cell

	phone hands-free mode so drivers can keep their hands on the steering wheel. LHMC hosted a distracted driving awareness campaign on February 24, 2020, which provided information and education on passage of the new hands-free driving law. Members of AAA, a collaborating agency, were on-site to address the questions of staff, patients, and passerby regarding the new law and ways to decrease distracted driving. This was a successful event with over 100 participants. To enhance our trauma program offerings, in FY20, LHMC also began to offer a free support group for survivors of trauma. The program is designed to help survivors and their family members navigate their recovery to minimize psychosocial distress and optimize positive behavioral outcomes. A survey tool has been developed to identify improvement in psychosocial aspects, such as depression, alcohol use, tobacco use, and PTSD, in a pre/post format. There were twelve scheduled session in FY20 (although once again monthly scheduled programs for March through September were canceled).
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: All of Massachusetts** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Type:	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☒ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs
Additional Program Descriptors (program tags):	☒ Community Education ☐ Community Health Center Partnership ☒ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Provide trainings, drills, and simulations to area first responders and community partners.	LHMC provided three trainings for area first responders and partners in FY20.	1	3	Process Goal
Teach hemorrhage-control techniques to immediate responders to use in a mass casualty or active shooter event.	In FY20, LHMC trained 51 community members throughout our CBSA at 4 separate events.	1	3	Process Goal
Provide a free support group for survivors of trauma and their families.	LHMC held five support group sessions of the Trauma Survivors Network Support Group in FY20, with the goal to increase participation in FY21.	1	3	Process Goal
Provide advocacy and education for safe driving.	Hosted an awareness campaign for the Massachusetts Hands-Free Driving Law. Hosted a distracted driving awareness campaign attended by over 100 people.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Region 3 Hospitals	N/A
Region 4AB Hospitals	N/A
Burlington Fire	https://www.burlington.org/169/Fire
Burlington Police	https://www.bpd.org/
Armstrong Ambulance	https://armstrongambulance.com/
Peabody Fire	https://www.peabodyfire.org/

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Social Determinants of Health and Access to Care – Increasing Opportunities for Physical Activity: Community-Based Exercise Programs	
Brief Description or Objective:	LHMC partners with several community-based organizations, including the North Suburban YMCA and Arlington and Burlington Councils on Aging, to offer free exercise classes and opportunities for fitness for community members. LHMC provides funding and staff to the Burlington Council on Aging to support its free fitness programs. Twice a week, staff from LHMC's Rehabilitation Services Department facilitate an hour-long exercise class for seniors. This program has currently been suspended during the COVID-19 pandemic. LHMC also provides funding for several other exercise classes that the Council on Aging offers. LHMC also provides funding to the North Suburban YMCA to support a free aqua aerobics class for Burlington and Arlington seniors. All programs ceased to operate in person during the COVID-19 pandemic, but the Burlington Council on Aging has been able to operate three of the classes virtually.

Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Burlington, Arlington** • **Gender: All** • **Age Group: Elderly** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs

Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	**Goal Status**	**Program Is in X Year**	**Of X Years**	**Goal Type**
Provide opportunities for community members to participate in group exercise classes at no cost to them.	In FY20, LHMC provided staff support to the Burlington Council on Aging twice a week until March 2020 to lead a free exercise class for seniors. LHMC also provided funding to support in-person and virtual exercise classes that had 1,566 registrants. The average age of participants was 77, and over 22% of participants were over the age of 85.	1	3	Process Goal

Partners

Partner Name, Description	**Partner Web Address**
Arlington Council on Aging Program partner	https://www.arlingtonma.gov/departments/he human-services/council-on-aging
Burlington Council on Aging Program site	https://www.burlington.org/509/Council-On-.
North Suburban YMCA Program site	https://ymcaboston.org/contact/

Contact Information
Michelle Snyder

Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Social Determinants of Health and Access to Care – Serving Health Information Needs of Everyone (SHINE) Program	
Brief Description or Objective:	LHMC continued its extremely successful partnership with Winchester Hospital and Minuteman Senior Services in FY20 to continue to provide SHINE counselors at the Arlington and Burlington Councils on Aging and at a designated site on the LHMC campus at 41 Mall Road. From April – September of FY20, counseling was provided virtually. The consumers served in the LHMC region received no-cost, one-on-one insurance benefits counseling provided by state-certified SHINE volunteers or staff members. LHMC is the only acute care health system serving as a SHINE counseling site in Massachusetts. The collaboration includes private, in-kind space so SHINE counselors can be accessible to the hospital community, volunteer support provided by the LHMC Volunteer Services Department, and related services.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Arlington, Burlington, Billerica** • **Gender: All** • **Age Group: Adult; Elderly** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status

	☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs

Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Provide Medicare beneficiaries and their family members with confidential and unbiased health insurance information to address inpatient, outpatient, and prescription drug benefit gaps in coverage.	In FY20, 520 individuals were served at the LHMC, Arlington COA, and Burlington COA sites. Beneficiaries by Age Group • 65-74 = 361 • 75-84 = 83 • 85 or older = 36 • 64 or younger = 36 • Not collected = 4 Beneficiaries by Gender Total number = 520 Breakdown by count as follows: • Female = 321 • Male = 195 • Other = 2 • Not collected = 2 Beneficiaries by Assets Total number = 520 Breakdown by count as follows: • Above LIS Asset Limit = 339 • Below LIS Asset Limit = 91 • Not collected = 90 Beneficiaries by Monthly Income Total number = 520 Breakdown by count as follows: • At or above 150% FPL = 334 • Below 150% FPL = 98 • Not collected = 88	1	3	Process Goal

Develop a screening tool to assess social determinants of health and the need for additional services for clients.	A 39-question assessment tool was developed in FY20.	1	3	Process Goal
Implement the screening tool and provide referrals for clients who identified a need.	335 people participated in the voluntary survey in FY20. Referrals were made for participants to over 10 community-based organizations for additional services.	1	3	Process Goal

Partners

Partner Name, Description	**Partner Web Address**
Minuteman Senior Services Program Administrator	https://www.minutemansenior.org/

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Social Determinants of Health and Access to Care – Increasing Food Access for Seniors: Council on Aging Farmers Market Program

Brief Description or Objective:	Good nutrition helps prevent disease and is essential for the healthy growth and development of children and adolescents. The *Dietary Guidelines for Americans* states that about half of all American adults – 117 million individuals – have one or more preventable chronic diseases (*Dietary Guidelines for Americans*, 2015). Diet-related chronic diseases include cardiovascular disease, high blood pressure, and type 2 diabetes. Survey data from the CDC's state indicator report on fruits and vegetables shows that in

	2018, only 14% of adults met the daily fruit intake recommendation and only 11.1% of adults met the vegetable recommendation (CDC, 2018). Moreover, according to a recent survey conducted by the Massachusetts Healthy Aging Collaborative, in Arlington, only 32%; in Burlington, only 38%; and in Billerica, only 19% of seniors are getting the recommended 5 servings of fruits and vegetables per day. Issues of access to information as well as equitable access to healthy foods both play a role in these low figures. To continue to address this need, LHMC partnered with the New Entry Sustainable Farming Project, an organization that grows organic produce locally for Middlesex County, and ran farmers markets for a total of 20 weeks. This year, the partnership continued programming at the Burlington, Arlington, and Billerica Councils on Aging in spite of the challenges posed by the COVID-19 pandemic. Depending on location, the program served 50-80 seniors per week from June through October, and on average, participants took home 6 varieties of fresh, local produce each week. In total, the program distributed more than 40,000 pounds of produce to the community.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Arlington, Burlington, Billerica** • **Gender: All** • **Age Group: Elderly** • **Race/Ethnicity: All** • **Language: English, Chinese** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Provide seniors in Arlington, Billerica, and Burlington with fresh fruits and vegetables.	The program served between 50-80 seniors per week, depending on location. Approximately 40,000 pounds of produce was distributed in total over the course of 20 weeks between all three locations. Over 80% of all program participants are over age 70, and over 50% live alone. 50% also report that their annual income is less than $30,000 per year, and over 40% report that they've used a food bank program within the past year.	1	3	Process Goal
Increase consumption of fresh fruits and vegetables by program participants.	69% of program participants reported that they ate more fruits and vegetables over the course of the program. 81% reported that they ate a greater variety of produce over the course of the program.	1	3	Outcome Goal
Increase access to fresh fruits and vegetables for program participants.	78% of program participants reported that it was easier for them to get fruits and vegetables during the program.	1	3	Outcome Goal
Increase knowledge of healthy eating for program participants.	73% of program participants reported that they gained more knowledge of food/recipes.	1	3	Outcome Goal
Decrease feelings of social isolation for program participants.	50% of program participants reported that this program decreased feelings of social isolation for them.	1	3	Outcome Goal

Partners

Partner Name, Description	Partner Web Address
New Entry Sustainable Farming Project Provides food for market	https://nesfp.org/

Burlington Council on Aging Market site	https://www.burlington.org/509/Council-On-
Billerica Council on Aging Market site	https://www.town.billerica.ma.us/136/Counci Aging
Arlington Council on Aging Market site	https://www.arlingtonma.gov/departments/he human-services/council-on-aging

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Social Determinants of Health and Access to Care – Community-Based Exercise Classes: Enhance Fitness

Brief Description or Objective:	LHMC continued its partnership with Metro North YMCA to offer free Enhance Fitness classes in the Peabody and Lynnfield communities. Enhance Fitness is a group exercise program for older adults that uses simple, easy-to-learn movements that motivate participants to stay active, energized, and empowered to sustain independence throughout their life. In addition to providing access to a healthy and safe lifestyle, the Enhance Fitness program at the Y helps participants make vital social connections, which helps curb the social isolation that many older adults face. 16% of Peabody residents 65+ and 18% of Lynnfield residents 65+ live alone. This year, the Peabody and the Lynnfield Senior Centers began to offer Enhance Fitness programs at their facilities. On October 1, 2020, the Y launched Enhance Fitness at both the Peabody and Lynnfield Senior Centers while continuing to run the program on-site at the Y. Despite COVID-19 bringing the program to a halt on March 16, 2020, the program still positively impacted the lives of more than 90 participants from October 1, 2019, through March 14, 2020. During the shutdown, the Y also

	called many seniors to check in on them, created a closed Enhance Fitness Facebook Group, and developed virtual classes for Enhance Fitness participants.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Lynnfield, Peabody** • **Gender: All** • **Age Group: Elderly** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need:	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs

Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
To increase participation in the EF program by offering free access for seniors at the Peabody and Lynnfield Senior Centers.	During this reporting period, the Y was able to serve an additional 58 seniors off-site in person (94 in total). The Y also created 2 videos during the closure that garnered more than 2,500 views.	1	3	Process Goal
Increase general health, physical ability, and physical activity of participants.	94 individuals were surveyed. Post-survey questions assessed the program's impact on health and fitness and had the following results: • More than 25% of participants reported an improvement in general health. • More than 91% of participants reported an improvement in physical ability. • 44% of participants reported that they have either maintained or improved their workout routine, with the same intensity of Enhance Fitness. Participants were also evaluated on fitness checks and were asked to complete 3 exercises to the best of their ability on the first and last days of the sessions. • Up-and-go – The number of seconds it took to stand, walk 8 feet, and return to sitting was recorded. This metric showed a	1	3	Outcome Goal

	75% improvement in the post-assessment. • Arm curls – The number of reps completed by each arm in 30 seconds was recorded. This metric showed a 60% improvement in the post-assessment. • Chair stands – The number of stands from a seated position in 30 seconds was recorded. This metric showed a 77% improvement in the post-assessment. Overall, there was a significant improvement in participants' performance in all 3 fitness tests as compared with the initial assessment.			

Partners

Partner Name, Description	**Partner Web Address**
Metro North YMCA Association Program lead	www.ymcametronorth.org
Lynnfield Council on Aging Program site and recruited participants	https://www.town.lynnfield.ma.us/council-ag
Peabody Council on Aging Program site and recruited participants	www.peabodycoa.org

Contact Information

Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Social Determinants of Health and Access to Care – Domestic Violence Support Group	
Brief Description or Objective:	The 2010 National Intimate Partner and Sexual Violence Survey data for Massachusetts residents mirrored the national data: Nearly 1 in 2 women and 1 in 4 men in Massachusetts had experienced sexual violence victimization other than rape. Nearly 1 in 3 women and 1 in 5 men in Massachusetts had experienced rape, physical violence, and/or stalking by an intimate partner in their lives. In response to the community need to address this issue, LHMC has identified raising awareness about domestic violence as an Implementation Strategy priority. In FY20, LHMC continued our successful partnership with Saheli, a Burlington-based regional service organization, to provide a Saheli-conducted support group for survivors and victims of domestic violence. The group was supposed to meet 8 times in spring/fall, using themes/topics from a manual titled *The Power to Change*. This manual was developed by several European domestic violence agencies to provide support to survivors of domestic violence. Saheli has successfully used this model for several support groups, starting in 2013, to provide group support to survivors/clients. The COVID-19 pandemic had an immediate effect on Saheli's support group. Stay-at-home orders meant that many survivors were locked down with their abusers, and many did not have access or means to contact their advocates. The few survivors who were able to contact their Saheli advocates expressed an urgent need for support groups as a way to deal with the isolation and increased violence brought on by the pandemic. Saheli started a virtual support group in April 2020, targeting vulnerable survivors and making sure that these survivors could safely attend the support group. For survivors that did not have computers or access to technology, Saheli provided them with Chromebooks and helped them set them up. Each virtual session from April had about an average of 12 survivors attend. Saheli continued to structure the sessions around 7 topics from *The Power to Change* and kicked off with a discussion about domestic violence. Additional topics

	included understanding self-esteem; identifying and meeting personal goals; socialization of South Asian women and gender stereotyping; healthy relationships: identifying and communicating needs; healthy relationships: exploring boundaries; coping with positive and negative emotions; and assertiveness versus aggression. The sessions were held every Thursday starting April 15 and continuing till June 25, 2020. To continue the support group enhancement from FY19, Saheli continued with financial literacy sessions among survivors and helped them with filing their taxes. To address the need, Saheli extended the support group for 4 more weeks to help survivors understand issues related to personal finance and budgeting, credit scores, and the importance of emergency savings.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Arlington, Bedford, Billerica, Burlington, Lexington, Lowell** • **Gender: Female** • **Age Group: Adult** • **Race/Ethnicity: Asian** • **Language: Hindi, Punjabi, Bengali, Gujarati, Tamil, Arabic** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☒ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs
Additional Program Descriptors (program tags)	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☒ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Empower women by helping them build positive self-esteem and healthy relationships.	There were between 10 and 12 recurring attendees during the spring and summer virtual support group. Many other survivors joined as their time permitted. This group consisted of 8 women from South Asia and 2 women from the Middle East (Egypt and Morocco).	1	1	Process Goal
Provide trauma relief through yoga.	7 to 9 women attend on a regular basis. The majority is South Asian and 2 are Arab.	1	1	Process Goal
Provide group intervention for treatment of trauma to Arabic-speaking survivors of domestic violence.	10 to 12 Arab women attend the group regularly and are learning healing techniques from a licensed therapist.	1	1	Process Goal

Partners

Partner Name, Description	Partner Web Address
Saheli Boston Program lead	www.saheliboston.org

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Social Determinants of Health and Access to Care – Domestic Violence Initiative	
Brief Description or Objective:	The 2010 National Intimate Partner and Sexual Violence Survey data for Massachusetts residents mirrored the national data: Nearly 1 in 2 women and 1 in 4 men in Massachusetts had experienced sexual violence victimization other than rape. Nearly 1 in 3 women and 1 in 5 men in Massachusetts had experienced rape, physical violence, and/or stalking by an intimate partner in their lives. More than 1 in 7 women had been raped. LHMC data also shows that there were 14 incidences of domestic violence, 94 incidences of elder abuse, 33 cases of child abuse, and 9 cases of abuse of disabled persons reported to the medical social work team in FY20 (as well as 229 incidences of elder self-neglect). The problem isn't new. LHMC has long collaborated with local police and community organizations to provide crisis intervention and links to services for victims of domestic violence, and they are committed to alleviating the public health and social problems associated with relationship violence in all forms, including spousal violence and elder abuse. Formed in 1992, LHMC's Domestic Violence Initiative (DVI) is a group that includes physicians and nonclinical staff from departments such as behavioral health, clergy, general internal medicine, and social work, as well as the Emergency Department. Community members include law enforcement representatives and local emergency resource groups. LHMC convenes community partners serving victims of domestic violence on a quarterly basis to discuss best practices and resource sharing and to encourage a collaborative approach to addressing the problem.

Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Burlington** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☒ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☒ Health Professional/Staff Training

☐ Health Screening
☐ Mentorship/Career Training/Internship
☐ Physician/Provider Diversity
☐ Prevention
☐ Research
☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Heighten awareness of domestic violence, provide crisis intervention and links to services, strengthen community partnerships, and train clinical staff to recognize and respond to the needs of victims.	In FY20, LHMC hosted 3 meetings of community organizations that serve victims of domestic violence to share information and resources (Note: Fourth meeting postponed due to facilitator LOA). LHMC also facilitated a medical grand rounds to help providers identify and appropriately manage patients who might be victims of abuse from diverse cultures.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Saheli Boston DVI Partner	www.saheliboston.org
Burlington Police Department DVI Partner	www.burlington.org/departments/police/inde:
REACH Beyond Domestic Violence DVI Partner	www.reachma.org
Burlington Council on Aging DVI Partner	www.burlington.org/residents/council_on_ag here_are_we.php
Burlington Youth and Family Services DVI Partner	www.burlington.org/residents/community_lif ter/index.php
Minuteman Senior Services DVI Partner	https://www.minutemansenior.org/about-us

Boston Area Rape Crisis Center DVI Partner	https://barcc.org/
Burlington Public Schools DVI Partner	https://www.burlingtonpublicschools.org/

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Social Determinants of Health and Access to Care – Improving the Built Environment: Burlington Fitness Court

Brief Description or Objective:	Lack of physical fitness and poor nutrition are among the leading risk factors associated with obesity and chronic health issues such as heart disease, hypertension, diabetes, cancer, and depression. Adequate nutrition helps prevent disease and is essential for the healthy growth and development of children and adolescents. Overall fitness and physical activity reduce the risk for many chronic conditions and are linked to good emotional health. The LHMC CHNA identified that approximately 1 in 5 adults (21%) reported getting no physical activity in the past 30 days. As a response, to increase access to and the availability of free exercise equipment for the community, LHMC has partnered with the Burlington Recreation Department and the National Fitness Campaign (NFC) to fund an outdoor fitness court. The NFC Fitness Court is a full-body circuit-training system designed for adults of all ages and fitness levels. Each fitness court features 30 individual pieces of equipment and shock-resistant sports flooring, and includes exercise stations that allow for up to 28 individuals to use the court at the same time. Workouts are app driven and can be tailored for each participant. Research is increasingly demonstrating links between specific community factors, such as the availability of parks, accessibility of healthy foods, and walkability of neighborhoods, and the choices people make in their daily lives. The Fitness Court opened in June 2019, and the Burlington Recreation Department has

	hosted several free pilot classes, hired a Fitness Court coordinator, and is hosting a scheduled biweekly class in FY20. The Burlington site was also selected by NFC as a pilot study site and is being closely monitored for users and total impact. In FY20, based on app data, the fitness court served the following users: • 4.9% age 14-17 • 33.3% age 18-29 • 46.3% age 30-49 • 15.5% age 50+ 49% of users identified themselves as female and 48% as male. 3% chose not to identify their gender.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Burlington** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

DON Health Priorities (select up to 3):	☒ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Increase total number of users through classes and other activation activities.	In FY20, it is estimated that there were 12,775 total users of the Fitness Court. There were 3.5 app users per day. The NFC estimates total users to be 10% of the total users, based on existing data from other sites. Based on that estimate, there are 35 users per day, an increase from FY19.	1	3	Process Goal
Improve the overall health of Fitness Court users through increasing daily caloric expenditure.	The primary data point used for individual use remains Fitness Court app data, showcasing total active users on the platform. It is important to note that this study is speculative in nature, extrapolating nationwide estimates for caloric expenditure as it relates to body composition. Historically, an estimated 5%-10% of total Fitness Court users at a given location use the app. Thus, estimates can be created on total users, both digital and nondigital. • Estimated average participation duration was 4.5 minutes. • Caloric expenditure for an average adult per 4.5 minutes was 77 calories. • Estimated total caloric expenditure for FY20 was 983,675 calories.	1	3	Outcome Goal

Partners

Partner Name, Description	Partner Web Address
Burlington Recreation Department Program Manager	www.burlington.org/community_developmer eation/parks.php
National Fitness Campaign Provides evaluation through app	https://nationalfitnesscampaign.com/

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Social Determinants of Health and Access to Care – Lowell Community Health Center COVID-19 Pandemic Support

Brief Description or Objective:	In FY20, LHMC provided support to the Lowell Community Health Center for its COVID-19-related activities, including interventions conducted by community health workers (CHWs) and medical interpreters (MIs), along with related patient/community education and engagement. Front-line staff have been working hard to allay anxiety in the community about COVID-19, ensure that patients are educated on telehealth access, and connect vulnerable patients with needed supports during this period of social isolation. In collaboration with the Lowell Health Department, the health center also helped individuals with access to testing and provided support for a contact tracing intervention to reduce virus transmission. Additional supports included patient communications that included multilingual postings on social media; the patient portal and the health center website; messaging for the local access Khmer-language TV program; alignment with the City of Lowell on COVID-19-related testing and prevention campaigns, and other community-facing activities to improve access to care for the area's most vulnerable populations during this challenging time.

Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Billerica, Lowell** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: English, Spanish, Portuguese, Khmer, Arabic, Swahili** • **Environment Served:** ☐ All ☒ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☒ Community Health Center Partnership

☐ Health Professional/Staff Training
☐ Health Screening
☐ Mentorship/Career Training/Internship
☐ Physician/Provider Diversity
☐ Prevention
☐ Research
☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Launch monthly patient newsletter (email, patient portal) with translations into Spanish, Portuguese, Khmer, Swahili.	5 issues with translated versions. Content examples: 07/10/2020: Lowell CHC Board Resolution on Racial Equity, COVID-19 Testing Hours [26.1% open rate; 1,492 "hits"]. 07/31/2020: Patient Portal; Free COVID-19 Testing Sites; [38.2% open rate; 2,179 "hits"]. 09/04/2020: Vaccinations, Youth Services, and COVID-19 Testing; [50.2% open rate; 2,861 "hits"].	1	1	Process Goal
Interpreter Department staff to deliver on average 2,500 sessions a month.	July – September 2020, MI staff provided 10,195 interpreter sessions (Spanish, Khmer, Portuguese, Arabic, Swahili, Laotian, and Kikuyu).	1	1	Process Goal
Develop and deploy a multilevel, multilingual social media educational campaign for COVID-19.	COVID-19-related information posted to Facebook, Instagram, and patient portal, with Spanish, Portuguese, Khmer, and Swahili translations. E.g., Contact Tracing, COVID-19 Testing, Face Coverings, health center "How to Reach Us" video. Khmer-language local access TV program, Jivit Thmei, resumed filming in mid-August and through 9/30 aired 7 health news programs (COVID-19 education/prevention focus).	1	1	Process Goal
CHWs provide as many as 80 assists/month to quarantining patients to address SDoH (e.g., food, clothing, insurance applications assistance, referrals	Between July – September, CHW staff responded to 563 requests for immediate needs. We receive referrals from clinical departments via eCW (electronic health record system) and track outputs using the patient's electronic	1	1	Process Goal

and appointments, transportation)	health record and an SDoH tracking tool.			
Actively engage in community and state events on racial equity, COVID-19 access, and overall workforce capacity building and education.	Hosted Town Hall Meeting with Faith-Based Leaders from over 10 faith-based organizations. Lowell CBC participated on a COVID-19 Panel. Communitywide forums hosted by LLAMA (Lifting Lowellians: Assistance and Mutual Aid), Lowell Telecommunications, and Colores Latinos TV. English (5/14/20) and Spanish (5/21/20). Goal Met: Participation, Lowell Diversity, Equity, Inclusion committee. Goal met: Disseminated, participated in the MA DPH COVID-19 Community Impact Survey. Experiences shared in the survey will contribute to new statewide solutions, especially targeting people of color/historically underserved communities that have been disproportionately impacted by COVID-19. The Community Health Program Director also contributed to the MDPH Office of CHWs' new resource: "Effective Ways to Engage CHWs in the COVID-19 Period." This document identifies ways CHW employers are adapting CHW work to further assist the community during the pandemic.	1	1	Process Goal

Partners

Partner Name, Description	Partner Web Address
Lowell Community Health Center Program Manager	https://www.lchealth.org/
City of Lowell Contact tracing	https://www.lowellma.gov/
Greater Lowell Health Alliance Resource for information dissemination to the community	https://www.greaterlowellhealthalliance.org/
MA Contact Tracing Collaborative	https://www.wbur.org/commonhealth/2020/0rail-of-infections-coronavirus-travel

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Social Determinants of Health and Access to Care – COVID-19 Support Programs

Brief Description or Objective:	In FY20, LHMC provided support for numerous individuals and community-based organizations for testing and to mitigate the social effects of COVID-19. One way in which the organization did so was to partner with the City of Peabody and Armstrong Ambulance to provide free COVID-19 testing for some of the city's most vulnerable residents at low-income housing sites. Based on findings from the most recent CHNA, Peabody residents are largely older, more diverse, and more vulnerable to health disparity than the majority of those in the LHMC service area. The J.B. Thomas Lahey Foundation at LMCP funds programs that support the identified health needs of residents of Peabody, with the goal of improving community health. This year, many of their grants focused on providing COVID-19 relief in the surrounding community. Grant funding went toward projects that focused on testing efforts and food relief for both the local food pantry and the council

	on aging. In total, over $150,000 was provided from the Foundation for these efforts. Clinically, there is no clear consensus regarding which patients can be safely discharged from the ED when COVID-19 is suspected. Patients with COVID-19 have been shown to be at risk for precipitous decline in oxygenation and clinical status. During the time of the COVID-19 pandemic, primary care and outpatient follow-up are challenging to maintain and access may be limited. In order to address this health concern, in FY20 the LHMC instituted an outpatient pulse oximetry monitoring program to provide an additional safety net for patients with COVID-19 discharged from the ED. Patients who screen into the program are provided with a pulse oximeter to monitor their blood oxygen levels and heart rate and are instructed on its use. Patients then receive automated texts twice a day that ask them to provide their pulse ox and blood pressure readings, and also asks whether they are feeling better, worse, or the same so that any potential decline in health can be caught as early as possible. If patients have not responded within 48 hours, an Advanced Practitioner then follows up with them directly to assess their health, encourage response, or suggest alternative treatment. Depending on the severity of symptoms, patients receive these check-ins anywhere from 7-14 days after presenting in the ED.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: All Massachusetts, Peabody** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: English, Spanish, Portuguese** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status

	☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☒ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☒ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Provide free COVID-19 testing to residents in the City of Peabody.	637 individuals were screened at 6 public events in FY20. Testing efforts continue into FY21.	1	1	Process Goal
Provide support to community-based organizations for COVID-19 relief.	In FY20, LMCP, through the J.B. Thomas Lahey Foundation, provided $95,000 in support for food relief and over $50,000 in support for COVID-19 testing efforts in the City of Peabody.	1	1	Process Goal
Provide clinical support for moderate-risk individuals with COVID-19.	Approximately 200 pulse oximeters were distributed to patients through the monitoring program in FY 20	1	1	Process Goal

Partners

Partner Name, Description	Partner Web Address
City of Peabody Provide Community Testing Program Manager	https://www.peabody-ma.gov/
Armstrong Ambulance Conduct testing	https://armstrongambulance.com/

Contact Information

Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Chronic/Complex Conditions and Risk Factors – Community Education: Women's Health Lecture Series	
Brief Description or Objective:	The Women's Leadership Council (WLC) at LHMC was founded in 2004 by a group of female community leaders and physicians with the goal of educating and empowering women to be their own health care advocates. One of the ways they achieve that mission is through the Women's Health Lecture Series, a forum that supports education and health care advocacy for women of all ages. Recently, the lecture series has been renamed the Women's Leadership Council Health Lecture Series, and it supports education and health care advocacy for people of all ages. The lecture topics are derived directly from the LHMC/LMCP CHNA and are chosen by the WLC Education Committee and Philanthropy, with input from the Clinical Advisory Committee. The lectures are free and open to the public. The audience averages about 125-150 people. In FY20, the WLC hosted two lectures on the following topics: To Sleep, Perchance to Dream ● Paul Gross, MD (202 people attended) Skin Care Protection, Detection and Treatment ● Laura Sowerby, MD The third lecture was canceled due to COVID-19. Seeing 20/20 in 2020: Glaucoma and Cataract Management ● Shiyoung Roh, MD
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: All** • **Gender: All** • **Age Group: Adults; Elderly** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History

	☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (program tags):	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Educate the community on important and timely health issues.	Approximately 226 people were served through this program in FY20.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Northbridge Insurance Agency Funding Partner	https://www.nbins.com/

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Chronic/Complex Conditions and Risk Factors – Community Education: Bone Health & Osteoporosis Prevention

Brief Description or Objective:	According to the American Orthopaedic Association, fragility fractures have become nearly epidemic in the United States among older adults, with over 2 million fractures occurring each year – more than the total number of heart attacks, strokes, and breast cancers combined. Moreover, at least 44 million Americans are affected by osteoporosis or low bone density. Due to an aging population, the number of Americans with osteoporosis or low bone density is expected to increase significantly. Nearly half of all women and more than a quarter of all men will suffer fragility fractures in their lifetime. In order to combat this growing crisis, LHMC is committed to injury prevention through its Bone Health & Osteoporosis Prevention Program. The program provides an education class to patients and community members who are either referred by their physician or self-referred. The program provides patients with information for understanding the diagnosis of osteopenia and/or osteoporosis, discusses

	treatment measures to improve bone health after a fracture, provides education on the types of exercises necessary to promote bone health and prevent falls, provides information on a healthful diet with important nutrients that contribute to bone health, and aims to reduce the burden of fragility fractures for the individual and community. The majority of participants were from Middlesex and Essex Counties, and most of those were from Burlington and surrounding cities and towns, including Lexington, Wilmington, and Woburn, and several participants were from New Hampshire. All participants were women (100%) age 50 or older. In FY20, LHMC also utilized a bone index scanner that continues to undergo testing for accuracy in order to bring the scans into the community in FY21.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: All Massachusetts** • **Gender: All** • **Age Group: Adults, Elderly** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need:	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☒ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Provide information and motivation for lifestyle changes to positively impact bone health.	LHMC provided 2 classes in FY20. Program evaluation included a 10-item post-program survey, rating the effectiveness of the class and to what degree the participant could apply the information and skills learned to improve their bone health. In addition, participants were asked what they found most helpful about the presentations. The following are some of the comments provided by the participants: • Participants reported new ideas and information to apply to their lifestyles for better health, such as diet and exercise routine. • Participants plan to make changes to their exercise routine and take vitamin D and calcium as recommended by their health care professional. • Participants reported that background and explanation of medications provided better understanding for decision-making and adherence to treatment. • Participants reported that the handouts were helpful and reinforced	1	3	Process Goal

	the information presented.			
Provide free Bindex bone scans to patients referred to the program.	119 scans completed during FY20. Education was provided during the screening process, and each scan took between 5-10 minutes.	1	3	Process Goal

Partners

Partner Name, Description	**Partner Web Address**
N/A	N/A

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Chronic/Complex Conditions and Risk Factors – Educating the Community: Cooking Up Good Health

Brief Description or Objective:	To help address the issue of obesity, LHMC hosts Cooking Up Good Health cooking classes. Led by a Registered Dietitian, Cooking Up Good Health is a free cooking demonstration and nutrition class series that is open to the entire community. In FY20, LHMC hosted 3 sessions of the class, where participants learned different culinary tips and nutrition information about meals, snacks, sides, and desserts. Four additional classes were planned for 2021 but were cancelled due to the COVID-19 pandemic.

Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Billerica, Burlington** • **Gender: All** • **Age Group: Adults** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need:	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs

Additional Program Descriptors (program tags):	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Serve 10 or more participants per session.	Approximately 15 people attended each class with a total of 45 people served through the program in FY20.	1	3	Process Goal
Promote Cooking Up Good Health in the community through social media.	All 3 classes were advertised on the LHMC Facebook page, along with their recipes. The page has a reach (based on likes) of almost 16,000 people.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
N/A	N/A

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Chronic/Complex Conditions and Risk Factors – Healthy State: Web-Based Health News	
Brief Description or Objective:	More people are turning to web-based resources for health information. By providing expert health information, personal stories, and connections to resources, Healthy State provides health information to educate and influence people to change their unhealthy behaviors and encourages interventions capable of improving health status. Healthy State is a health news website that highlights the expertise of our practitioners across the organization. We collaborate with practitioners (doctors, advanced practitioners, staff, etc.) on stories across various service lines to share information relevant to our audience. Story topics range from health and wellness to patient and colleague anecdotes to community programs. The site offers free, easy-to-read articles for the community. The site strategically addresses health issues that are most pressing to the community, including: • Cancer awareness, with articles on the benefits of cancer screenings, including information on breast, skin, colon, cervical, prostate, and lung cancers. • Sports and exercise safety, healthful eating, high blood pressure, and heart health. • Seasonal wellness tips, including educating residents about the differences between a cold and the flu. Water safety is also included. • Emerging health concerns, such as new forms of smoking and understanding Juul and other vaping/e-cigarette product health risks. Articles also address the increase in suicide rates and how to speak to a child about suicide.

Target Population (indicate/select as many as needed for all fields):	• **Regions Served: All Massachusetts** • **Gender: All** • **Age Group: Adults** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need:	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs

Additional Program Descriptors (program tags):	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	**Goal Status**	**Program Is in X Year**	**Of X Years**	**Goal Type**
Healthy State seeks to influence personal health choices and to inform people about ways to enhance health or avoid specific health risks by: Increasing knowledge and awareness of a health issue. Influencing behaviors and attitudes toward a health issue. Dispelling misconceptions about health.	Page views: 72,205 Return users: 8,700 Average session duration: 24 seconds Pages per session: 1.13	1	3	Process Goal

Partners

Partner Name, Description	**Partner Web Address**
N/A	N/A

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Chronic/Complex Conditions & Risk Factors – Increasing Access and Supportive Services for Cancer Patients

Brief Description or Objective:	Oncology nurse navigators are registered nurses with oncology-specific clinical knowledge, who offer individualized support and assistance to patients and their caregivers to help them make informed decisions about their care and to overcome barriers to optimal care. The navigators establish contact with newly diagnosed cancer patients and/or caregivers to guide them through the disease-specific care system and provide an understanding of the clinical pathways established by the disease-specific systems. Navigators help direct patients to health care services within the organization for timely treatment and survivorship. Navigators also identify and address barriers to care that might keep the patient from receiving timely and appropriate treatment for their cancer diagnosis by connecting them with resources and health care and support services in their communities.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: All Massachusetts** • **Gender: All** • **Age Group: Adults; Elderly** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status

	☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☒ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
To guide patients through the complexities of the disease, direct them to health care services for timely treatment and survivorship, and actively identify and address barriers to care that might prevent them from receiving timely and appropriate treatment. In addition, the nurse navigator connects patients with resources and health care and support services in their communities and assists them in the transition from active treatment to survivorship.	In FY20, the navigators served on average between 10-15 individuals per day.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
None	N/A

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Chronic/Complex Conditions and Risk Factors – Cancer Programs: Screening & Prevention	
Brief Description or Objective:	Chronic conditions such as heart disease, cancer, stroke, Alzheimer's disease, and diabetes are the leading causes of death and disability in the United States; they are also the leading drivers of the nation's $3.3 trillion annual health care costs. Over half of American adults have at least one chronic condition, while 40% have two or more. Screening is an essential tool to identify cancers early. Because the risk for breast cancer is not the same for all women, some women need more advanced screening beyond the standard recommendations. In response to this identified community need, LHMC has implemented an assessment screening tool at the Burlington, Peabody, and Lexington locations to help community residents determine whether they might be at risk for breast cancer. Using an electronic tablet, people confidentially answer questions that help determine whether they may be at a higher risk for breast cancer. The assessment, evaluation, and follow-up are all provided at no cost to participants. Results are given to their physicians, who can help them determine whether they might benefit from a higher level of screening beyond regular checkups and mammograms. LHMC is also a long-standing partner with the American Cancer Society on many community-based prevention activities.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: All Massachusetts** • **Gender: All** • **Age Group: Adults, Elderly** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History

	☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need:	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☒ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Identify persons who may be at a higher risk for breast cancer and provide screening follow-ups to their physicians.	In FY20, LHMC completed 17,896 risk assessments for over 18,322 unique individuals. 14.2 % of patients screened across the system were identified as having a high lifetime risk of breast cancer.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
American Cancer Society	https://www.cancer.org/

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Chronic/Complex Conditions and Risk Factors – Cancer Programs: Caregiver Support

Brief Description or Objective:	In the most recent CHNA, caregiver support was consistently brought up as a serious issue in community interviews and forums. Many people undergoing cancer treatment rely on family members or aides to manage their care. Between navigating the health system, organizing appointments and medications, and making major medical decisions on behalf of their loved one, stress and burnout among caregivers was reported by stakeholders as one of the greatest threats to senior well-being. In direct response, in our most recent Implementation Strategy, LHMC identified as a goal enhancing caregiver support and reducing family/caregiver stress.

	One way that LHMC is addressing that goal is through the Harpley Fund. This fund provides grants of up to $1,500 to families of people undergoing cancer treatment to help provide financial support for private-duty nursing services or end-of-life care.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: All Massachusetts** • **Gender: All** • **Age Group: Adults, Elderly** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use

	☐ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Provide grants of up to $1,500 for individuals undergoing cancer treatment for end-of-life care.	In FY20, 39 individuals received grants through the Harpley Fund.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
N/A	N/A

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Chronic/Complex Conditions and Risk Factors – Cancer Programs: PINK Breast Cancer Support	
Brief Description or Objective:	In response to the priorities identified in our CHNA, LHMC partnered with the Burbank YMCA to conduct the PINK Program. In FY20, this program was able to serve 93 people in two PINK sessions at the Burbank YMCA, as well as through the ongoing PINK Maintenance Program. In fall 2019, 12 people registered and 9 completed the program. 35 people participated in PINK maintenance. In spring of 2020, 9 people enrolled, 8 completed the program. 37 people participated in the PINK Maintenance Program. No PINK programs were held at the LHMC site due to no staff instructors (fall 2019) and the coronavirus pandemic (spring 2020). When branches closed in March due to the pandemic, all PINK classes continued virtually with their current participants until regularly planned completion. The PINK Program for breast cancer survivors is a locally developed program specifically designed to help breast cancer survivors boost energy, increase strength, and restore ease of movement while performing daily tasks. Classes are tailored for the different types of breast cancer surgeries and adapted for all fitness levels. The instructors are trained in cancer survivorship, post-rehabilitation exercise, and supportive cancer care. Through PINK, survivors and their families receive a membership at the YMCA for the duration of the program, whether they are new to the program or participate in the maintenance program. Beyond addressing the physical and emotional needs of this population, the PINK Program provides social/emotional support that cancer survivors find very valuable. Because cancer can change their lives so drastically, participants welcome meeting others who know what they are going through and value working with instructors who genuinely care about the progress they make. This was the genesis for the PINK Maintenance Program, which allows graduated participants to continue their journey to health with the support of staff and other survivors.

Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Arlington, Bedford, Billerica, Burlington, Lexington, Lowell, Lynnfield, Peabody** • **Gender: Female** • **Age Group: Adults, Elderly** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need:	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs

Additional Program Descriptors (program tags):	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☒ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Increase mobility, balance and opportunities for exercise for cancer survivors to return to health.	The PINK Program has a pre- and post-physical assessment and uses the Promis-29 as a psychosocial measurement. The physical assessment includes range of motion for arms and flexibility and balance. Generally, participants experienced significant increases in physical activity, overall quality of life, and fitness performance, as well as decreases in cancer-related fatigue. The program is run twice a week, as participants are encouraged to stick with the program during the early part of the session. After 12 program weeks, the 37 participants surveyed who utilized the PINK Program experienced the following: Assessments: • 85% improved lower body strength (wall squat time). • 78% improved single leg balance. • Range of motion assessment was inconclusive, as many began the program with 100% range of motion. • 66% improved energy level and reduced feelings of fatigue. • 40% improved pain interference in activities of daily life.	1	3	Outcome Goal

Partners

Partner Name, Description	Partner Web Address
YMCA of Greater Boston-Burbank YMCA Program Manager	https://ymcaboston.org/

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Chronic/Complex Conditions and Risk Factors – Cancer Programs: Livestrong

Brief Description or Objective:	Over the past several decades, the number of cancer survivors has dramatically increased – from 3 million (1.5% of the U.S. population) in 1971 to 9.8 million in 2001 to 14.5 million (4.6%) in 2014. Projections indicate that the number of cancer survivors will reach at least 19 million by 2024. According to data from the CDC, nearly 8,000 people suffer from cancer in Middlesex County, which includes the North Suburban YMCA's service area. To address this issue, LHMC partnered with the North Suburban YMCA on their Livestrong Program. In FY20, 19 people at the North Suburban YMCA participated in the program (9 in the spring and 10 in the fall). Of those, 7 completed the 12-week program in the fall of 2019. The spring 2020 session had to halt in-person class sessions in March (after week 6) due to the coronavirus pandemic and the closure of our branches. Sessions were offered virtually for 8 weeks for participants (who had been in-session at the time of the closure) from all 13 branches. Attendance was optional and was not tracked. Classes are tailored for all cancer survivors, regardless of stage of diagnosis or treatment, and adapted for all fitness levels. Two trained and certified instructors run each session

	for 12 weeks, with 8-10 participants meeting twice a week. Staff members are trained on the unique physical and emotional needs of cancer survivors, curriculum, and best practices. They work with each participant to create an individualized exercise program from pre-program assessment results, and then teach and demonstrate exercise technique and safety considerations. This individualized attention helps participants meet their goals and overcome their specific barriers.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Arlington, Bedford, Billerica, Burlington, Lexington, Lowell, Lynnfield, Peabody** • **Gender: All** • **Age Group: Adults; Elderly** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable

EOHHS Health Need:	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (program tags):	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☒ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Create communities among cancer survivors and guide them through safe physical activity, helping them build supportive relationships leading to an improved quality of life.	Livestrong at the YMCA has an established, research-based evaluation plan that uses pre- and post-assessment tests. The detailed assessments evaluate arm function and range of motion; lymph node prognosis; shoulder flexion, extension, and abduction; and posture. Program participants are asked to rate overall quality of life, ability to perform daily tasks, mobility, eating habits, fitness level, perceived body image, current energy levels, and overall happiness. The program collects pre- and post-assessment data to show participants' progress over the 12 weeks in the areas of cardiovascular endurance, strength, flexibility, mobility, and behavioral health. Among the 19 participants who graduated, the results were as follows: • 50% reported improvement in fatigue. • 81% reported improvement in pain interference in activities of daily life.	1	3	Outcome Goal

Partners

Partner Name, Description	Partner Web Address
YMCA of Greater Boston-North Suburban YMCA Program Manager	https://ymcaboston.org/

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Chronic/Complex Conditions and Risk Factors – Increasing Caregiver Support: Burlington Council on Aging Memory Café	
Brief Description or Objective:	In the most recent LHMC CHNA, stakeholder interviews and community feedback revealed significant concerns for the older adult population, including topics covering neurological issues (e.g., Alzheimer's, dementia) and caregiver support. One way LHMC is addressing this identified health need is through a partnership with the Burlington Council on Aging to provide a Memory Café once a month for persons with dementia and their caregivers. Sessions met in-person until March at which point the meetings were suspended until August when an attempt was made to host them virtually. Memory Cafés are welcoming social gatherings for people living with dementia and their families, friends, or professional caregivers. They are meant to provide a welcoming, stigma-free social setting where people living with dementia and their care partners can meet others and enjoy time together. Cafés aim to decrease the social isolation that often accompanies dementia.

Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Burlington** • **Gender: All** • **Age Group: Adults; Elderly** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need:	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs

Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☒ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Provide support through the Memory Café to 15 participants per class.	51 individuals have attended one or more Memory Cafés, with an average of 30 participants per month. Even with the break for COVID-19, the number of participants has increased. The age range for participants is 66-91.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Burlington Council on Aging Program Manager	www.burlington.org/residents/council_on_ag here_are_we.php
Alzheimer's Association Content Producer	www.alz.org

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Chronic/Complex Conditions and Risk Factors – A Matter of Balance	
Brief Description or Objective:	LHMC has a robust, dedicated Trauma Department committed to community-based injury prevention for older adults. According to the American Orthopaedic Association, fragility fractures have become nearly epidemic in the United States among older adults, with over 2 million fractures occurring each year – more than the total number of heart attacks, strokes, and breast cancers combined. Moreover, at least 44 million Americans are affected by osteoporosis or low bone density. Due to an aging population, the number of Americans with osteoporosis or low bone density is expected to increase significantly. Nearly half of all women and more than a quarter of all men will suffer fragility fractures in their lifetime. Based on this data and community feedback in the most recent CHNA, mobility and falls prevention for older adults continues to be a priority for LHMC's injury prevention program. In FY20, LHMC continued to focus on fall prevention strategies, but due to the COVID-19 pandemic all on-site programs had to be cancelled.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Burlington** • **Gender: All** • **Age Group: Elderly** • **Race/Ethnicity: All** • **Language: English** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Type:	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need:	☒ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (program tags):	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Provide training for community members to become certified Matter of Balance instructors.	Three individuals were trained as Matter of Balance coaches in FY20.	1	3	Process Goal
Plan programming for Matter of Balance for FY21 to accommodate for COVID-19 restrictions.	Program planning for FY21 includes: Injury prevention coordinator will participate in Master Training for Virtual Programming. Coordinate coaches classes for virtual program in the community. Offer virtual programs to LHMC community members.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
N/A	N/A

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Mental Health and Substance Use – Saheli's Enhancing Access to Mental Health Services Program	
Brief Description or Objective:	In FY20, LHMC partnered with Saheli on their initiative to enhance access to mental health services for their clients. An important goal of Saheli for 2020-2021 was to expand and improve Saheli's mental health services based on an identified need among the South Asian women who approach Saheli for its services. The South Asian community has diverse religious and cultural backgrounds and languages, and consequently has varying English language proficiency. This makes finding culturally and linguistically competent mental health services essential. To meet this demand, Saheli intended to increase and strengthen its mental health services to survivors and their children. The goal of Saheli's new mental health program was to work toward a multipronged approach that would focus on lasting well-being rather than short-term solutions. Saheli would offer: • Focused individual counseling sessions by a culturally competent therapist. • Ongoing mental and emotional support through regular counseling and information about other issues affecting South Asian and Arab survivors of domestic violence. Effects of abuse and trauma are long-lasting. Survivors can be triggered into feeling fearful, hopeless, guilty, anxious, and depressed. They often require regular check-ins and counseling sessions. Mental health services provided by Saheli will allow survivors to access concentrated support through regular counseling sessions. This need became even more evident during the COVID-19 pandemic. Many survivors saw an escalation of violence due to being locked down with their abusers. Many survivors now had to take care of their children on their own and homeschool them, which was a challenge for limited-English-speaking survivors. And above all, the isolation and anxiety caused by the pandemic's effect on their economic and mental well-being needed to be addressed immediately. Saheli's mental health program provided timely intervention and access to mental health services to survivors.

	To achieve the objectives toward expanding and strengthening Saheli's mental health services, Saheli engaged a Mental Health Counselor, who could speak four South Asian languages, to offer culturally competent counseling services. The counselor offered individual counseling sessions to survivors identified by Saheli advocates as needing urgent and critical mental health intervention. The sessions are 45 minutes long and are offered weekly to individual survivors, for 8 weeks at a time. After the first cohort of survivors undergoing counseling sessions completed their 8 weeks, the next cohort of survivors started individual therapy. For many survivors this was the very first time that they had experienced individual mental health therapy by a culturally competent counselor. Ten survivors from Saheli received 8 weeks of individual therapy, starting from June 2020. Saheli survivors also expressed their need for parenting support. Many survivors are newly single mothers, many are learning to share custody, and most of them had to deal with homeschooling their kids during the pandemic. Saheli started parenting classes for survivors; they are led by the newly engaged mental health counselor. Four sessions were offered in August 2020 that covered parenting basics, questions by survivors, communicating effectively with children, and more. The classes ran every Monday for 2 hours in August 2020. They were attended by an average of 10-12 survivors.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Arlington, Burlington, Billerica, Lexington, Lowell** • **Gender: Female** • **Age Group: Adults, Teenagers** • **Race/Ethnicity: Asian, Arab** • **Language: English, Hindi, Tamil, Urdu** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History

	☐ LGBT Status ☒ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☒ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☒ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Increased access to culturally competent mental health counselor	10 survivors received individual mental health counseling.	1	1	Process Goal
Provide participants with medical information about relevant mental health information	20 survivors received mental health information.	1	1	Process Goal
Provide participants with information on healthy communication/ relationship with children	12 survivors learned healthy communication with their children as a result of parenting classes.	1	1	Process Goal

Partners

Partner Name, Description	Partner Web Address
Saheli Boston Program lead	www.saheliboston.org

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Mental Health and Substance Use – REACH Beyond Domestic Violence Mental Health Support Groups

Brief Description or Objective:	In FY20, LHMC provided support to REACH Beyond Domestic Violence to develop support groups for domestic abuse survivors who are also involved with substance abuse. The support group materials and curriculum were created by a staff member of REACH who holds a license in addiction counseling. REACH advocates work almost daily with

	survivor clients who use drugs and alcohol as a coping mechanism, and the original intent was to offer the support groups to them first and then gradually expand the program to a larger catchment area. Outreach and education efforts were made for referrals to the Department of Children & Families, area police departments, local hospitals, and the aides of the state legislators who serve the same towns as REACH. The letter of invitation was accompanied by an informational flyer (attached) that they could give to people seeking help, or it could be used as reference to give them digestible information. Referrals continue to come in as our partners identify patients and clients who would benefit from the program. Most of the survivors who were referred to us do not use substances themselves, but their partners do and often this dynamic is part of the domestic abuse. Conversations with these survivors focus on the impact of their partners' substance abuse on the DV they experienced. Challenges posed by COVID-19 were significant for this program as counselors cannot see their clients directly to recruit them into the support group, and there are often technology barriers and privacy issues with doing a support group virtually.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Billerica, Lowell** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☐ All ☒ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☒ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☒ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☒ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☒ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Develop content for a support group for domestic violence survivors who are experiencing issues with substance use.	Course curriculum, including a screening tool and course syllabus, was developed. Recruitment materials and the screening tool were shared with community partners in an effort to gain referrals.	1	1	Process Goal
Provide substance use and safety assessments.	Five substance use and safety assessments were completed.	1	1	Process Goal
Gather referrals from community partners to provide substance abuse and mental health services.	Gathered 12 referrals overall; 4 of the clients are currently working with REACH staff to complete a safety plan. Of the 5 substance abuse assessments, no referrals were made for treatment since the person assessed was not the one using substances. They were referred to Al-Anon.	1	1	Process Goal

Partners

Partner Name, Description	Partner Web Address
REACH Beyond Domestic Violence Program Manager	https://reachma.org/
Burlington Police Department Provided referrals	https://www.bpd.org/

Contact Information

Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Mental Health and Substance Use – Supporting the Community: Grant Funding	
Brief Description or Objective:	LHMC provides funding to community organizations aligned with the needs identified in our CHNA through the J.B. Thomas Lahey Foundation Program and through our scheduled DON payments to the Community Health Network Areas in our service area. In FY20, LHMC continued our 6-year Department of Public Health scheduled payments to Community Health Network Areas 15 and 13/14 for our Emergency Department project. The funding provided goes toward grants focused on youth behavioral health and elder health – 2 priority populations in the LHMC CHNA. In FY20, due to the extraordinary nature of the COVID-19 pandemic, funding was provided to emergency relief funds for a wider range of human and social services organizations in order to meet basic needs for vulnerable populations. In collaboration with Community Health Network Area 15, LHMC grant funding supported 81 programs: 3 Multiyear Impact Grants, 6 Collaborative Grants, 20 MiniGrants, 9 Capacity Building Grants, 7 COA Programming Grants, 13 COVID-19 Response and Relief Grants, 14 Training and Professional Development Grants, 1 Facilitated Learning Community Symposium (FLCS) on Youth Mental Health, 2 Community Cohort Grants to FLCS Participant Communities, 4 Elder Health Workshops, and 2 Healthy Community Resource Forum Speakers. In collaboration with Community Health Network Area 13/14, LHMC grant funding provided $200,000 to the Essex County Community Foundation (ECCF) COVID-19 Relief Fund. These dollars were distributed to dozens of organizations, providing essential services in the areas of mental health, elder health, health care, and homeless/emergency shelters. In addition to the ECCF COVID-19 Relief Fund, CHNA 13/14 also provided 4 direct grants to the Lynn Community Health Center and 3 local youth-serving organizations. Funding to Lynn Community Health Center was emergency support for COVID-19 safe shelter for homeless individuals; the 3 grants to youth-serving organizations met emergency COVID-19-related needs at Children's Friend & Family Services, Centerboard, and The Haven Project.

Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Bedford, Burlington, Lexington, Lynnfield, Peabody** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs

Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	**Goal Status**	**Program Is in X Year**	**Of X Years**	**Goal Type**
Provide annual funding to Community Health Network Areas 13/14 and 15 for grants that address community health needs.	In FY20, LHMC DON funding supported over 80 programs, grants, and community initiatives to address community need.	1	1	Process Goal

Partners

Partner Name, Description	**Partner Web Address**
CHNA 13/14 Grant Administrator	https://www.eccf.org/
CHNA 15 Grant Administrator	https://www.chna15.org/home

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Mental Health and Substance Use – Increasing Access to Community-Based Mental Health Services	
Brief Description or Objective:	In FY20, LHMC supported the Peabody Veterans Memorial High School (PVMHS) Student Health Center (SHC) with funding for services not currently covered by insurance. The mission of the SHC is to provide high-quality comprehensive health care to students in order to support optimal health and academic outcomes. The mission of the SHC aligns closely with the priorities identified by LHMC in its most recent CHNA. For example, the SHC improves access to behavioral health and substance abuse services by offering these services on-site, and it integrates those services into primary medical care. The SHC also identifies students with chronic conditions and helps them improve self-management of those conditions. In addition, the SHC, through its partnership with Haven From Hunger, helps promote wellness through health education and healthy eating. The SHC provides an integrated model of care in its approach. Services offered include management of chronic illnesses, such as asthma and diabetes; urgent care visits; immunizations; routine and sports physicals; health education; and confidential services, including reproductive health care and behavioral health services. As evidenced by the center's staffing structure, behavioral health care is a significant focus, with individual therapy and group counseling services provided for issues such as depression, anxiety, stress management, and substance use. All students using the clinic are screened for behavioral health needs through use of the CRAFFT Screening Tool for adolescent substance use. The 2019-2020 school year was the sixth full year of operation for the PVMHS Student Health Center. The PVMHS Student Health Center continues to provide integrated medical and behavioral health services for students every day that school is in session. Appointments and walk-in services are available. Included services are physical exams, sick appointments, management of chronic illnesses, immunizations, confidential services, substance use cessation and education, group therapy, individual therapy, and consultation services for medical and behavioral health issues. In March 2020, with school

	transitioning to remote learning due to the COVID-19 pandemic, they shifted to telephonic visits to provide medical and behavioral health visits to students. The SHC also provided additional BH services to fill a need for the Health Center and participated in screening and result visits for COVID-19 testing to high-risk populations such as the homeless and home health aides in the surrounding communities. LHMC also provides funding to the Town of Burlington to support their Youth and Family Services Department. Burlington Youth and Family Services (BYFS) has as its goal and mandate to provide a range of services designed to improve the quality of life for Burlington families with children, adolescents, and young adults and provides a variety of counseling, intervention, and supportive services.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: Peabody, Burlington** • **Gender: All** • **Age Group: Teenagers; Children** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

DON Health Priorities (select up to 3):	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☒ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Provide support and funding for services at the PVMHS SHC that meet a critical, identified community need.	In FY20, the SHC had the following impacts: Pre-pandemic: 284 unique individuals were served in 732 medical visits and 683 behavioral health visits between September 2019 – March 13, 2020. From March 13, 2020 – June 30, 2020, 84 individuals were served. There were 335 medical visits for COVID-19 testing/screening, 429 behavioral health visits, and 28 visits for other health center patients, non-SBHC. The top 3 diagnoses pre-pandemic were for anxiety disorder, major depressive disorder, and immunization. The top 3 diagnoses during the pandemic were for major depressive disorder, anxiety disorder, and reaction to severe stress.	1	1	Process Goal

Partners

Partner Name, Description	Partner Web Address
North Shore Community Health Program Manager	https://www.nschi.org/
Peabody Veterans Memorial High School Program Site	https://peabody.k12.ma.us/schools/pvmhs/
Burlington Youth and Family Services	https://www.burlington.org/529/Services-We-Provide

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Mental Health and Substance Use – Medication Disposal Program

Brief Description or Objective:	As part of our commitment to helping address the issue of prescription drug misuse, LHMC continued its successful medication disposal kiosk to safely dispose of expired or unwanted medication at the Burlington location. Medications can be dropped off 24 hours a day, 7 days a week and are safely disposed of in accordance with Drug Enforcement Administration regulations. According to the National Institutes of Health (NIH) National Institute on Drug Abuse, an estimated 54 million people have used medications for nonmedical reasons at least once in their lifetime. Opioids are among the most misused prescriptions, with 75% of those who abuse them reporting their first opioid was a prescription. The NIH reports that unintentional opioid pain reliever deaths have quadrupled since 1999 and that nearly 80% of heroin users reported using prescription opioids prior to heroin.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: All Massachusetts** • **Gender: All** • **Age Group: Adults; Elderly** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status

	☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☒ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☒ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
To provide a safe and convenient way for community members to dispose of unwanted or unused medications.	In FY20, LHMC collected and disposed of over 345 gallons of medications. This represents a decrease from FY19 of 48%, largely due to decreased traffic into the hospital during the COVID-19 pandemic.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
Medsafe Medication Disposal Company	www.medsafe.com

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Mental Health and Substance Use – Collaborative Care Model

Brief Description or Objective:	The National Alliance on Mental Illness (NAMI) reports that 1 in 4 individuals experiences a mental illness each year, underscoring a critical need for mental health care access across all patient populations. In the 2019 LHMC Community Health Needs Assessment, mental health – including depression, anxiety, stress, serious mental illness, and other conditions – was overwhelmingly identified as one of the leading health issues for residents of the service area. Further, individuals from across the health service spectrum discussed the burden of mental health issues for all segments of the population, specifically the prevalence of depression and anxiety.

	In an effort to meet this need, Lahey Health Primary Care adopted the Collaborative Care Model (CoCM). The model will be expanded to additional communities throughout the Beth Israel Lahey Health service area. Collaborative Care is a nationally recognized primary care–led program that specializes in providing behavioral health services in the primary care setting. The services are provided by a licensed behavioral health clinician and they include counseling sessions, phone consultations with a psychiatrist, and coordination and follow-up care. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treating a variety of medical and mental health conditions. The primary care provider and the behavioral health clinician develop a treatment plan that is specific to the patient's personal goals. The behavioral health clinician uses therapies that are proven to work in primary care. A consulting psychiatrist may advise the primary care provider on medications that may be helpful.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: All Massachusetts** • **Gender: All** • **Age Group: Adults; Elderly** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status

Program Type:	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☒ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
To increase access to behavioral health services.	In FY20, LHMC provided behavioral health clinicians at four LHMC primary care practices, reaching 2,340 patients.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
None	N/A

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Mental Health and Substance Use – Hospital-Based Screening and Addiction Support

Brief Description or Objective:	As a Level I Trauma Center, LHMC provides screening, brief intervention, and referral to treatment (SBIRT) for persons presenting as trauma cases to the ED with an elevated blood alcohol level (BAL) or a positive CAGE screening. SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur. It has been demonstrated that trauma centers can use the teachable moment generated by an injury to implement an effective injury prevention strategy and provide alcohol and/or drug use counseling for patients presenting to the hospital because of substance use. LHMC works collaboratively with social work, nursing, physicians, and all members of the care team to ensure screening, intervention, education, and referral to treatment is provided to every patient. In FY20, LHMC instituted a program of Medication Assisted Treatment MAT through the Emergency Department (ED). Through a series of institutional protocols,

the hospital has the capacity to possess, dispense, administer, and prescribe opioid agonist treatment (i.e., buprenorphine and/or methadone), including partial agonist treatment (buprenorphine), and offer such treatment to patients who present in an acute-care hospital ED for care and treatment of an opioid-related overdose.

Patients who present with an overdose are triaged and have a COWS (Clinical Opioid Withdrawal Scale) performed by an RN (if patient has presented for care and treatment for opioid-related overdose or complaining of opioid withdrawal after recent history of opioid abuse). A medical screening exam is performed, and the patient is then screened for a substance use disorder (SUD). A practitioner, including MD/DO, NP, or PA, interviews the patient about his/her opioid use and examines him/her for signs/symptoms of withdrawal. If the patient is interested in assistance with his/her opioid use disorder and does not meet the exclusion criteria, the practitioner may consider initiating MAT. The provider then works with the patient (and, if available, the family, caregiver, and/or legal guardian) to develop a treatment plan or MAT option. Patients who are in active withdrawal can be provided a dose of buprenorphine and are monitored and then receive a prepackaged take-home kit with enough doses to sustain them until a follow-up appointment. They are also provided with packets or educational materials, referral information, and consent forms and counseled that recovery encompasses other biopsychosocial factors. Patients are provided with appropriate referrals, including psychiatry, social work, and support groups as well as to a community-based recovery coach or other resources. They are also provided with a naloxone rescue kit.

Target Population (indicate/select as many as needed for all fields):	• **Regions Served: All Massachusetts** • **Gender: All** • **Age Group: Adults; Teenagers; Elderly** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☐ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☒ Substance Use ☐ Additional Health Needs

Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☒ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group

Goal Description	**Goal Status**	**Program Is in X Year**	**Of X Years**	**Goal Type**
Provide SBIRT for persons presenting as trauma cases in the ED with an elevated BAL or positive CAGE screening.	In FY20, LHMC provided SBIRT screenings for 126 individuals.	1	3	Process Goal
Provide MAT for patients who choose treatment in the ED and dispense take-home kits.	5 patients were provided with MAT in FY20.	1	3	Process Goal

Partners

Partner Name, Description	**Partner Web Address**
None	N/A

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Mental Health and Substance Use – Increasing Access: Outpatient Behavioral Health Services	
Brief Description or Objective:	Mental health – including depression, anxiety, stress, serious mental illness, and other conditions – was overwhelmingly identified in stakeholder feedback as one of the leading health issues for residents of LHMC/LMCP's service area in the most recent Community Health Needs Assessment. Individuals from across the health services spectrum discussed the burden of mental health issues for all segments of the population, specifically the prevalence of depression and anxiety. Additionally, 46% of Community Health Survey respondents identified mental health as a health issue that people struggle with. Survey respondents also identified outpatient mental health service as the hardest health service for people to access. In an effort to increase access to these vital and necessary services, LHMC provides a hospital-based, outpatient program for adults with complex medical and psychiatric needs in a single care setting. This is a unique service within the community, with psychiatry and behavioral health specialists coordinating evaluation and treatment, along with medical and surgical specialists, to provide whole-person care. Services include 24-hour emergency care, individualized/family therapy, stress management, and many other programs designed to enhance access to behavioral health resources in the community. LHMC/LMCP also provide nine support groups between the two hospital sites that help to provide counseling and support for individuals undergoing cancer treatment as well as other chronic diseases, such as ALS, COPD, and kidney disease.
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: All Massachusetts** • **Gender: All** • **Age Group: Adults; Teenagers; Elderly** • **Race/Ethnicity: All** • **Language: All** • **Environment Served:** ☒ All ☐ Urban

	☐ Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Domestic Violence History ☐ Incarceration History ☐ LGBT Status ☐ Refugee/Immigrant Status ☐ Veteran Status
Program Type:	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☐ Housing ☐ Violence ☐ Education ☐ Employment ☒ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☒ Mental Health and Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (program tags):	☐ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☒ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Provide behavioral health resources and supportive services.	In FY20, LHMC provided 9 support groups at the Burlington and Peabody locations.	1	3	Process Goal

Partners

Partner Name, Description	Partner Web Address
None	N/A

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

Mental Health and Substance Use – Supporting the Community: Place of Promise Adult Long-term Residential Addiction Recovery Program

Brief Description or Objective:	In the most recent LHMC CHNA, Along with mental health, substance use was named as a leading health issue among key informants, focus group/listening session participants, and Community Health Survey respondents. Behavioral health providers reported that individuals continue to struggle to access care services, including rehabilitation and detox, outpatient treatment, and medication-assisted treatment. To help address this need, in FY20, LHMC partnered with Place of Promise to provide support for their adult long-term residential addiction recovery program. Place of Promise, based in Lowell, MA, is a faith-based 501(c)(3) non-profit organization that provides adult long-term residential addiction recovery. Place of Promise operates 4 residential homes that provide addiction recovery supports. One-on-one

	counseling sessions include medical and clinical counseling, chronic illness management, and mental health counseling. Most residents come to Place of Promise with long-neglected medical and mental health issues. As a result, significant time is spent coordinating with the PCP and multiple specialists to develop and implement a care plan for each resident. The goal of the program is to prepare residents with the tools and skills to return to their homes and communities to live productive lives free from addictions, and to provide them with ongoing support when needed. There were 57 total persons served through this program in FY20. Most residents came directly from hospitals, detoxes, prisons, and other (time-limited) addiction recovery programs. Referral source breakdown: Prisons: 38% Hospitals, Detoxes, and Addiction Recovery Programs: 30% Family: 15% Courts: 10% Churches: 5% Self: 2% The profile of residents served: Alcohol Abuse: 67% (Age at Start: 12) Drug Abuse: 83% (Age at Start: 15) Opioid Abuse: 84% (Age at Start: 18) Physically Abused: 58% Sexually Abused: 67% Incarcerated: 83% Homelessness: 100%
Target Population (indicate/select as many as needed for all fields):	• **Regions Served: All Massachusetts** • **Gender: All** • **Age Group: All** • **Race/Ethnicity: All** • **Language: English, Khmer, Kikuyu, Swahili, Spanish, Portuguese** • **Environment Served:** ☒ All ☐ Urban ☐ Rural ☐ Suburban

	• **Additional Target Population Status:** ☒ Disability Status ☒ Domestic Violence History ☒ Incarceration History ☒ LGBT Status ☒ Refugee/Immigrant Status ☒ Veteran Status
Program Type:	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
DON Health Priorities (select up to 3):	☐ Built Environment ☐ Social Environment ☒ Housing ☐ Violence ☐ Education ☒ Employment ☐ None/Not Applicable
EOHHS Health Need:	☐ Chronic Disease ☐ Housing/Homelessness ☐ Mental Health and Mental Illness ☒ Substance Use ☐ Additional Health Needs
Additional Program Descriptors (program tags):	☒ Community Education ☐ Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐ Physician/Provider Diversity ☐ Prevention ☐ Research ☒ Support Group

Goal Description	Goal Status	Program Is in X Year	Of X Years	Goal Type
Serve 50 individuals in Level I and Level II adult addiction recovery homes.	57 total individuals were served.	1	1	Process Goal
Serve 40 individuals in the Level III (post program, former residents and families) program.	59 total individuals were served.	1	1	Process Goal
Implement and deploy a change in thinking assessment in the Level I and Level II programs.	Using the TCI Criminal Thinking Scale as a pseudo pre-/post-assessment, Place of Promise was able to collect information from Level I and II residents. Residents were given the option to complete this assessment. Based on a minimum of 4 months between assessments, Place of Promise measured (on average) the following change in thinking domains: • No improvement in Entitlement • 5% improvement in Justification • 4% improvement in Personal Irresponsibility • 9% improvement in Power Orientation • 5% improvement in Cold Heartedness • No improvement in Criminal Rationalization	1	1	Outcome Goal
Measure a 5% relapse rate of program participants while in the program (Level I and Level II).	Goal Exceeded: 2% Relapse Rate In-Program	1	1	Outcome Goal
Measure 5% relapse rate for residents that	Goal Met: 5% Relapse Rate Post-Program	1	1	Outcome Goal

completed the Level I or Level II program in 2018, 2019, or 2020.				

Partners

Partner Name, Description	**Partner Web Address**
Place of Promise Program Manager	https://placeofpromise.org/

Contact Information
Michelle Snyder
Regional Manager, Community Benefits/Community Relations
Beth Israel Lahey Health
41 Mall Rd.
Burlington, MA
Michelle.snyder@bilh.org
781-744-7907

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$1,142,445	-
Community-Clinical Linkages	$33,687	-
Total Population or Communitywide Interventions	$913,351	$819,638
Access/Coverage Supports	$7,228,026	$12,674
Infrastructure to Support CB Collaborations	$186,005	-
Total Expenditures by Program Type	$9,503,514	$832,312
CB Expenditures by Health Need		
Chronic Disease	$3,186,275	$330,256.00
Mental Health/Mental Illness	$3,275,541	$312,781.00
Substance Use Disorders	$43,201	$6,000
Housing Stability/Homelessness	$2,145,492	$16,000
Additional Health Needs Identified by the Community	$853,005	$167,274
Total by Health Need	$9,503,514	$832,312
Leveraged Resources		
Total CB Programming	$526,518	
Net Charity Care Expenditures		
HSN Assessment	$5,444,562	
Free/Discounted Care	-	
HSN Denied Claims	$3,316,616	

Total Net Charity Care	**$8,761,279**	
Total CB Expenditures	**$18,791,311**	

Additional Information	
Net Patient Services Revenue	**$1,181,181,017**
CB Expenditure as % of Net Patient Services Revenue	**1.59%**
Approved CB Budget for FY22 (Excluding expenditures that cannot be projected at the time of the report)	**$9,503,514**
Bad Debt Certification	**$6,147,087**
Optional Supplement	**-**
Comments	**LHMC also makes an annual Payment in Lieu of Taxes (PILOT) to the City of Peabody and Town of Burlington in the amount of $605,000**

SECTION VI: CONTACT INFORMATION

Michelle Snyder
Lahey Hospital & Medical Center
Community Benefits and Community Relations
41 Mall Rd.
Burlington, MA 01805
781-744-7907
Michelle.snyder@bilh.org

SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

Note: This form is to be completed in the two fiscal years following the hospital's completion of its triennial Community Health Needs Assessment.

I. Community Benefits Process:

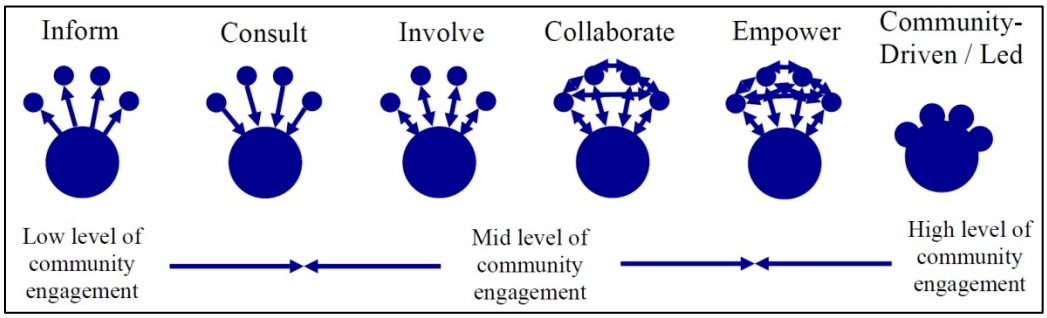
- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? ☒ Yes ☐ No
    - If so, please list updates:
      LHMC added as members Sharon Cameron, Director of Public Health, City of Peabody; Rick Parker, Burlington resident; Pamela Hallett, Executive Director, Housing Corporation of Arlington. Lisa Neveling, Bruce MacDonald, Linda McGoldrick, and Michael Bonfanti all ended their terms on the CBAC.

II. Community Engagement:

1. If there have been any updates to the key partners with whom the hospital collaborates, please indicate in the table below. Please feel free to add rows as needed.

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement**
Peabody Health Department	Sharon Cameron, Director of Health & Human Services	Local Health Department	Program partner; participates on CBAC
Metro North YMCA Association	Rob Lowell, Peabody YMCA Executive Director	Other	Program partner for Enhance Fitness Program
Lowell Community Health Center	Karen Myers, Director of Foundation Grants and Donation	Community Health Centers	Program partner
New Entry Sustainable Farming Program	Jacob Weiss, Program Administrator	Other	Program partner for food relief programs

2. Please use the spectrum below from the Massachusetts Department of Public Health[1] to assess the hospital's level of engagement with the community in implementing its plan to address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.



Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Inform	LHMC will engage in its CBAC further in FY21 in the process of development and implementation of its plan	Involve
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Consult	LHMC met with its CBAC on a regular basis to discuss programs, funding allocation, and prioritization in FY20. At the LHMC annual meeting, Community Benefits staff conducted a poll of community members to ascertain their priorities and where they thought funding should go.	Involve

[1] "Community Engagement Standards for Community Health Planning Guideline," Massachusetts Department of Public Health, *available at*: http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf. For a full description of the community engagement spectrum, see page 11 of the Attorney General's Community Benefits Guidelines for Non-profit Hospitals.

Implementing Community Benefits programs	Collaborate	LHMC collaborated with many partners on community benefits programs in FY21. Community Benefits staff reached out to partners during COVID-19 to discuss priorities, existing program feasibility, and changes to programs based on needs that were derived from the community.	Collaborate
Evaluating progress in executing Implementation Strategy	Collaborate	LHMC began its new IS in FY20 and collaborated with the CBAC members to evaluate programs for this past fiscal year. LHMC looks forward to continuing to collaborate and respond to changing health needs in FY21-22.	Collaborate
Updating Implementation Strategy annually	Consult	LHMC made updates in FY20 to reflect changing health needs in the community posed by COVID-19.	Involve

- For categories where community engagement did not meet the hospital's goal(s), please provide specific examples of planned improvement for next year:

  LHMC remains committed to community engagement. During FY20, LHMC undertook its triennial Community Health Needs Assessment and prioritization process. Guided by LHMC's Community Benefits Advisory Committee and conducted in collaboration with community partners, this initiative employed a comprehensive community engagement process. In FY21, LHMC will continue

to work with its CBAC and community partners to engage the community, including holding an annual public meeting. Additionally, LHMC will engage with our community by continuing to expand its successful Community Grants Program, community benefits program collaboration, and participation on many boards and community groups, including both CHNA 15 and CHNA 13/14.

3. Did the hospital hold a meeting open to the public (either independently or in conjunction with its CBAC or a community partner) at least once in the last year to solicit community feedback on its Community Benefits programs? If so, please provide the date and location of the event. If not, please explain why not.

LHMC held a public meeting on January 9, 2020, in collaboration with Winchester Hospital and Community Health Network Area (CHNA) 15 at the offices of Minuteman Senior Services, 26 Crosby Drive, Bedford. Additionally, LHMC shared highlights of its Community Benefits program at meetings throughout its CBSA when engaging with the community during the triannual CHNA. These meetings were held March 7, 2019, and May 2, 2019.

III. Updates on Regional Collaboration:

1. If the hospital reported on a collaboration in its **Year 1 Hospital Self-Assessment**, please briefly describe any updates to that collaboration, including any progress made and/or challenges encountered in achieving the goals of the collaboration.

LHMC is part of the Beth Israel Lahey Health (BILH) system community health planning process. In 2019, BILH formed a systemwide Community Benefits Committee (CBC). This Committee provides strategic direction for all 10 BILH hospitals and their affiliates and seeks to ensure that strategies are in place to meet the health care needs of at-risk, underserved, uninsured, and government-payer patient populations in the communities. Guided by the CBC, the hospitals Community Benefits staff meet regularly to review regulatory requirements and share community health programming best practices. Together, hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact.

The COVID-19 pandemic has impacted the hospital's process for engaging its community and developing responsive community benefits programs. As a system, BILH came together to meet the needs of patients hospitalized with COVID-19. In addition to treating the critically ill, BILH hospitals collaborated with one another and with many community organizations on supply and resource distribution. All BILH hospitals reacted to urgent and unforeseen needs by restructuring/realigning Community Benefits programs to meet emerging and ongoing issues and challenges related to the pandemic.

2. If the hospital entered a regional collaboration in the past year, please provide the information requested of regional collaborations on p. 5 in the **Year 1 Hospital Self-Assessment Form.**