Community Benefits Report

Fiscal Year 2022

Beth Israel Lahey Health
Lahey Hospital & Medical Center

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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. LHMC's Community Benefits staff are committed to working collaboratively with its communities to address the leading health issues and create a healthy future for individuals, families and communities. While LHMC oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure makes sure that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WECARE:*

- ***W**ellbeing - We provide a health-focused workplace and support a healthy work-life balance*
- ***E**mpathy - We do our best to understand others' feelings, needs and perspectives*
- ***C**ollaboration - We work together to achieve extraordinary results*
- ***A**ccountability - We hold ourselves and each other to behaviors necessary to achieve our collective goals*
- ***R**espect - We value diversity and treat all members of our community with dignity and inclusiveness*
- ***E**quity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.*

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 underserved 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.

Priority Cohorts

LHMC's CBSA includes Arlington, Bedford, Billerica, Burlington, Danvers, Lexington, Lowell, Lynnfield, and Peabody. In FY 2022, LHMC conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included extensive data collection activities, substantial efforts to engage LHMC's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. While LHMC is committed to improving the health status and well-being of those living throughout its entire CBSA, per the Commonwealth's updated community benefits guidelines, LHMC's FY 2023 - 2025 Implementation Strategy (IS) will focus its Community Benefits resources on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved living in its CBSA.

Based on the assessment, community characteristics that were thought to have the greatest impact on health status and access to care in the LHMC CBSA were issues related to age, race/ethnicity, language, and immigration status. While the majority of residents in the CBSA were predominantly white and born in the United States, there were non-white, people of color, immigrants, non-English speakers and foreign-born populations in all communities.

There was consensus among interviewees and focus group participants that older adults, people of color, recent immigrants, and non-English speakers faced systemic challenges that limited their ability to access health care services. While relatively small, these segments of the population were impacted by language and cultural barriers that limited access to appropriate services, posed health literacy challenges, exacerbated isolation, and may have led to discrimination and disparities in access and health outcomes.

One issue to be noted was the lack of data available by gender identity and sexual orientation at the community or municipal level. Research shows that those who identify as lesbian, gay, bisexual, transgender, and/or queer/questioning experience health disparities and challenges accessing services.

LHMC is committed to promoting health, enhancing access, and delivering the best care for those in its CBSA. Over the next three years, LHMC will work with its community partners to develop and/or continue programming geared to improving overall well-being and creating a healthy future for all individuals, families, and communities. In recognition of the health disparities that exist for certain segments of the population, investments and resources will focus on improving the health status of the following cohorts within the community health priority areas.

- Youth
- Low-Resourced Populations
- Older Adults
- LGTBQIA+
- Racially, ethnically, and linguistically diverse populations

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

Key Accomplishments for Reporting Year
LHMC's most recent CHNA and IS were conducted and approved by the Board during the fiscal year ended September 30, 2022. That CHNA and IS will inform the Community Benefits mission and activities of LHMC for the fiscal years ending September 30, 2023; September 30, 2024; and September 30, 2025.

This report covers LHMC's fiscal year ending September 30, 2022. The previous CHNA and accompanying IS were approved by the LHMC Board before September 30, 2019 and informed the LHMC's Community Benefits initiatives for the fiscal years ending September 30, 2020; September 30, 2021; and September 30, 2022. As such, the accomplishments and activities included in this section as well as in Section IV: Community Benefits Programs relate to the CHNA and Implementation Strategy approved as of September 30, 2019.

- LHMC provided breast cancer risk assessments for over 20,000 people to identify those at high risk for the disease.
- LHMC assisted patients in FY22 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.
- LHMC provided 24 internships in radiology, nuclear medicine, and sonology for students at surrounding universities to strengthen the local workforce.
- 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.

- LHMC helped support the Peabody Veterans Memorial High School Student Health Center, which provided services for over 300 unique individuals.
- LHMC provided funding to the Lowell Community Health Center to support their interpreter services program. Interpretation is required in 45% of the health center's total encounters.
- LHMC provided support to the Greater Boston YMCA and the Metro North YMCA for their evidence-based Enhance Fitness Program. Over 50 older adults participated in the program and 100% reported an improvement in their overall health.
- LHMC partnered with the Merrimack Valley Food Bank to provide a farmers market program at three low-income housing sites in the city of Lowell that served 674 people.
- LHMC partnered with Saheli to provide support for their Supportive Housing Services Program which served over 75 individuals in FY21.

Plans for Next Reporting Year

In FY 2022, LHMC conducted a comprehensive and inclusive CHNA that included extensive data collection activities, substantial efforts to engage LHMC's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. In response to the FY 2022 CHNA, LHMC will focus its FY 2023 - 2025 IS on four priority areas. These priority areas collectively address the broad range of health and social issues facing residents living in LHMC's CBSA who face the greatest health disparities. These four priority areas are:

- Equitable Access to Care
- Social Determinants of Health
- Mental Health and Substance Use
- Complex and Chronic Conditions.

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's priorities are also aligned with the priorities identified by the Massachusetts Department of Public Health (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 (i.e., built environment, social environment, housing, violence, education, and employment).

The FY 2022 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions being used to inform and refine LHMC's efforts. In completing the FY 2022 CHNA and FY 2023 - 2025 IS, LHMC, along with its other health, public health, social service, and community partners, is committed to promoting health, enhancing access and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identify, sexual orientation, disability status, immigration status, or age. As discussed above, based on the FY 2022 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that for LHMC's FY 2023 - 2025 IS, it will work with its community partners within the CBSA to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, LHMC's Community Benefits investments and resources will focus on the improving the health status, addressing disparities in health outcomes, and promoting health equity for its priority cohorts, which include youth; low-resourced populations; older adults; racially, ethnically and diverse populations; LGBTQIA+; and older adults.

LHMC will partner with clinical and social service providers, community-based organizations, public health officials, elected/appointed officials, hospital leadership and other key collaborators throughout its CBSA to execute its FY 2023 – 2025 IS.

- **Equitable Access to Care**
  - LHMC will provide support to the Lowell Community Health Center for its interpretation services.

- **Social Determinants of Health**
  - LHMC will provide internship and job training opportunities for community members

- **Mental Health and Substance Use**
  - LHMC will provide support to the Town of Burlington for their substance use counselor and other mental and behavioral health supports

- **Complex and Chronic Conditions**
  - LHMC will continue its partnership with local Councils on Aging and New Entry Sustainable Farming Project to provide a community-based free farmers market program

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 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
LHMC's Board of Trustees along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its CBSA and beyond. LHMC's Community Benefits Department, under the direct oversight of LHMC's Board of Trustees, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations. Hospital senior leadership is actively engaged in the development and implementation of the LHMC's Implementation Strategy, ensuring that hospital policies and resources are allocated to support planned activities.

It is not only the LHMC's Board of Trustee members and senior leadership who are held accountable for fulfilling LHMC's Community Benefits mission. Among LHMC's core values are the recognition that the most successful Community Benefits programs are implemented organization wide 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 BILH and LHMC's structure and reflected in how care is provided at the hospital and in affiliated practices.

While LHMC oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure makes sure that Community Benefits efforts, prioritization, planning, and strategy focus on equity and align and are integrated with local and system strategic and regulatory priorities to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WECARE:*

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

This structure and methodology are 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 BILH and LHMC's Community Benefits program.

Community Benefits Advisory Committee (CBAC)
The LHMC Community Benefits Advisory Committee (CBAC) works in collaboration with LHMC's hospital leadership, including the hospital's governing board and senior management to support LHMC's Community Benefits mission to serve its patients compassionately and effectively, and to create a healthy future for them, their families, and BIDMC's community. The CBAC provides input into the development and implementation of LHMC's Community Benefits programs in furtherance of LHMC's Community Benefits mission. The membership of LHMC's CBAC aspires to be representative of the constituencies and priority cohorts served by LHMC'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.

The LHMC CBAC met on the following dates:

December 14, 2021
March 15, 2022
May 17, 2022
June 21, 2022 – annual public meeting
September 6, 2022

Community Partners
LHMC 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's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy were completed in close collaboration with LHMC's staff, community residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership and other key collaborators from throughout its CBSA. LHMC's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of LHMC's mission.

LHMC currently supports numerous of educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA. In this work, LHMC collaborates with many of its local community-based organizations, public health departments, municipalities and clinical and social service organizations. LHMC has a particularly strong relationship with the Lowell Community Health Center, North Shore Community Health Center, and Saheli, among many other organizations.

The following is a comprehensive listing of the community partners with which LHMC collaborated with on its FY 2020 – 2022 IS, as well as on its FY 2022 CHNA. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment Form.

- A Healthy Lynnfield Coalition
- American Cancer Society
- Burbank YMCA
- Burlington Recreation Department
- Burlington School Department
- Community Health Network Area 13/14
- Community Health Network Area 15
- City of Peabody
- Housing Corporation of Arlington
- 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
- Saheli
- 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 FY 2022 Community Health Needs Assessment (CHNA) along with the associated FY 2023-2025 Implementation Strategy was developed over a twelve-month period from September 2021 to September 2022. 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 the LHMC'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's dedication to its mission, its covenant to cohorts who have been historically underserved, and its commitment to community health improvement.

As mentioned above, LHMC's most recent CHNA was completed during FY 2022. FY 2022 Community Benefits programming was informed by the FY 2019 CHNA and aligns with LHMC's FY 2020 – FY2022 Implementation Strategy. The following is a summary description of the FY 2022 CHNA approach, methods, and key findings.

Approach and Methods
The FY 2022 assessment and planning process was conducted in three phases between September 2021 and September 2022, which allowed LHMC to:

- assess community health, defined broadly to include health status, social determinants, environmental factors and service system strengths/weaknesses;
- engage members of the community including local health departments, clinical and social service providers, community-based organizations, community residents and LHMC's leadership/staff;
- prioritize leading health issues/population segments most at risk for poor health, based on review of quantitative and qualitative evidence;
- develop a three-year Implementation Strategy to address community health needs in collaboration with community partners, and;
- meet all federal and Commonwealth Community Benefits requirements per the Internal Revenue Service, as part of the Affordable Care Act, the Massachusetts Attorney General's Office, and the Massachusetts Department of Public Health.

LHMC's Community Benefits program is predicated on the hospital's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address inequities and socioeconomic barriers to accessing care, as well as the current and historical discrimination and injustices that underlie existing disparities. Throughout the CHNA process, efforts were made to understand the needs of the communities that LHMC serves, especially the population segments that are often disadvantaged, face disparities in health-related outcomes, and who have been historically underserved. LHMC's understanding of these communities' needs is derived from collecting a wide range of quantitative data to identify disparities and clarify the needs of specific communities and comparing it against data collected at the regional, Commonwealth and national levels wherever possible to support analysis and the prioritization process, as well as employing a variety of strategies to ensure community members were informed, consulted, involved, and empowered throughout the assessment process.

Between October 2021 and February 2022, LHMC conducted 20 one-on-one interviews with key collaborators in the community, facilitated four focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 950 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 1,000 community residents, clinical and social service providers and other community partners.

The articulation of each specific community's needs (done in partnership between LHMC and community partners) is used to inform LHMC'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 collaboratively undertaken each year. Each component of the plan is developed and eventually woven into the annual goals and agenda for the LHMC's Implementation Strategy that is adopted by the LHMC's Board of Trustees.

Summary of FY 2022 CHNA Key Health-Related Findings

Equitable Access to Care

- Individuals identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system level, meaning that the issues stem from the way in which the system does or does not function. System level issues included providers not accepting new patients, long wait lists, and an inherently complicated healthcare system that is difficult for many to navigate.
- There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forego or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.

Social Determinants of Health

- The social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions influence and define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to economic insecurity, education, food insecurity, access to care/navigation issues, and other important social factors.
- There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, survey, and listening sessions suggested that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, food security/nutrition, and economic stability.

Mental Health and Substance Use

- Anxiety, chronic stress, depression, and social isolation were leading community health concerns. The assessment identified specific concerns about the impact of mental health issues for youth and young adults, the mental health impacts of racism, discrimination, and trauma, and social isolation among older adults. These difficulties were exacerbated by COVID-19.

- In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services.
- Substance use continued to have a major impact on the CBSA; the opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities, including mental health, housing, and homelessness. Individuals engaged in the assessment identified stigma as a barrier to treatment and reported a need for programs that address common co-occurring issues (e.g., mental health issues, homelessness).

Complex and Chronic Conditions

- Chronic conditions such as cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease contribute to 56% of all mortality in the Commonwealth and over 53% of all health care expenditures ($30.9 billion a year). Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

For more detailed information, see the full FY 2022 LHMC Community Health Needs Assessment and Implementation Plan Report on the hospital's website.
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 FY21, LHMC/LMCP provided funding for the Lowell Community Health Center for their interpreter services program. This partnership will continue in FY22. LHMC/LMCP also continued its support for the NSCH student health center based at Peabody High School in FY21,

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 Determination of Need (DON) funding. 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 Trustees 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 48).

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Patient Financial Counseling** **Health Issue: Additional Health Need as Defined by Community**	
Brief Description or Objective	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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Assist patients who are uninsured to assess their eligibility for and align them with state and hospital-based financial assistance programs.
Goal Status	LHMC assisted 31,798 patients in FY22 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. 1242 community members received assistance applications for Medicaid.
Program Year: Year 3	**Of x Years: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Interpreter Services** **Health Issue: Additional Health Need as Defined by Community**	
Brief Description or Objective	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.

Program Type	☐ Direct Clinical Services ☒ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population or Community Wide Intervention
Program Goal(s)	Provide culturally responsive care through the Interpreter Services Department
Goal Status	LHMC interpreters reported 64,409 total encounters. The top three languages were Spanish, the Chinese languages (Mandarin and Cantonese), and Portuguese languages (Portuguese and European).

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Merrimack Valley Food Bank Community Market Program** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	LHMC partners 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.
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒ Total Population or Community Wide Intervention
Program Goal	Increase access to fresh produce for residents of Lowell.
Goal Status	In this year's Community Market program, a total of 674 clients received over 13,546 pounds of food.
Program Goal	Serve a diverse population of residents of Lowell.
Goal Status	The population breakdown for the period 7/1/22-11/30/22 is as follows: 2% African/Black; 27% Asian; 55% White; 16% Hispanic. Of the ethnicities served during this time period, the following age groups were served: 14% Children 0-17; 30% Adults 18-64; 56% Seniors 65+. 40% Male and 60% Female

Program Year: Year 3	Of X Years: Year 3	Goal Type: Process Goal

Priority Health Need: Social Determinants of Health and Access to Care (In database) Program Name: Mill City Grows Community Gardens Program Health Issue: Additional Health Needs as Defined by Community	
Brief Description or Objective	LHMC partners with Mill City Grows (MCG) to provide funding for improvements to its community-based garden program. MCG, a longtime partner of LHMC, has designed and built and now oversees 21 community and school gardens in Lowell that are used by over 6,500 Lowell residents. In this urban environment environmental challenges exist that contribute to health inequities among low-income families, elders, immigrants and refugee residents. Low-income neighborhoods are blighted by vacant, contaminated and underutilized lots containing soils with legacy heavy metals and other toxins that are remnants of Lowell's industrial past. This renders much of the open space in these neighborhoods unsuitable for recreational use with little incentive for developers to remediate the land.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	50% of participants increase physical activity as a result of community gardening
Goal Status	90.4% reported physical activity in the gardens 1 time or more per week; 59.4% reported physical activity in the garden 2-7 times per week.
Program Goal(s)	50% of participants increase produce consumption as a result of community gardening
Goal Status	64% of gardeners report eating more produce; 33% report eating the recommended 5+ servings per day.
Program Goal(s)	50% of participants increase skills or knowledge as a result of community gardening
Goal Status	65% reported increasing skills or knowledge as a result of community gardening
Program Goal(s)	Grow 12,000 pounds of produce for participant consumption
Goal Status	15,300 pounds of produce raised in community gardens.
Program Goal(s)	Enroll 450 gardeners in 8 gardens

Goal Status	465 total individuals are currently enrolled as gardeners. Gardens are currently 88% enrolled.
Program Goal(s)	Increase ability to manage repairs of garden beds by September 2022
Goal Status	As of August 2022, construction of an outdoor woodshop and storage area to support garden bed repairs has been completed

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Strengthening the Local Workforce: Internship Programs** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	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.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide clinical-based education opportunities to help strengthen the local workforce.
Goal Status	In FY22, LHMC provided: 2 internships for students in diagnostic Ultrasound; 1 graduating intern was hired by LHMC; 4 three-month internships in nuclear medicine; 18 two-year radiology internships (9 –first year students and 9 second year graduating students) of those 8 were hired by LHMC post-internship.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Community-Based Exercise Programs** **Health Issue: Additional Health Needs as Defined by Community**		
Brief Description or Objective	LHMC partners with the Burlington Council on Aging to offer free exercise classes and opportunities for fitness for community members.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide opportunities for community members to participate in group exercise classes at no cost to them.	
Goal Status	In FY22, LHMC provided funding to the Burlington Council on Aging for a Senior Stretch program that operated both virtually and in-person and a Tai Chi Class. Overall, the classes served almost 150 older adults in Burlington with Senior Stretch (in-person) reporting 71 unduplicated, 1819 duplicated; Virtual Senior Stretch 59 unduplicated 3207 duplicated and Tai Chi 40 unduplicated 451 duplicated, virtual Tai Chi 17 unduplicated 378 duplicated. The classes run once a week for 52 weeks per year and operate both virtually and in-person in FY22.	
Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: YMCA Enhance Fitness Program** **Health Issue: Additional Health Needs as Defined by Community**		
Brief Description or Objective	LHMC partners with the Greater Boston YMCA and the Metro North YMCA to provide Enhance Fitness Classes. Enhance Fitness is an evidence-based health intervention offsetting the effects of aging and chronic illness as well as minimizing fall risk. Participants work on cardio and muscular strength, balance, flexibility, and stability, all while engaging in a supportive social community.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase general health, physical ability, and physical activity of participants from the participant pre & post assessments.	
Goal Status	Greater Boston YMCA Program Data 46 total Participants have participated in the program at both the Burbank and North Suburban branches with an overall 78% attendance.	

	Fitness checks and were completed on the first and last days of each sessions, with the goal of the program being to progress participants to achieve their age/gender predicted norms for lower body strength (Chair Stand test), Upper Body Strength (Arm Curl test) and Mobility (Up and Go test). Lower Body Strength/Chair stands: Overall 65% improved or maintained at average or above · Burbank YMCA: 43% improved or maintained at average or above. · North Suburban: 86 % improved or maintained at average or above Upper Body Strength/Arm Curl test. Overall 86% improved or maintained at average or above · Burbank YMCA: 93% · North Suburban YMCA: 100% Mobility/Up-and-Go test: Overall 34% improved or maintained at average or above · Burbank YMCA: 29% improved or maintained at average or above · North Suburban YMCA:43% improved or maintained at average or above Metro North YMCA Program Data During the reporting period of 10/1/2021-9/30/2022, 37 clients participated in the Enhance Fitness program. 20 participants completed both the pre and post assessment and had the following results. • 95% of participants reported an improvement in general health. • 80% of participants reported an improvement in physical ability. • 80% of participants reported that they have either maintained or improved their workout routine, with the same intensity of Enhance Fitness. • There was a 100% reduction in the amount of participant falls in the last 4 months of post assessment Participants were also evaluated on fitness checks and were asked to complete three exercises to the best of their ability on the first and last days of the sessions. • The number of seconds it took to stand, walk eight feet, and return to sitting was recorded. This metric showed that 65% of participants improved and 5% of participants maintained in the post-assessment. • Arm curls: The number of reps completed by each arm in 30 seconds was recorded. This metric showed that 65% of participants improved and 10% of participants maintained in the post-assessment. • Chair stands: The number of stands from a seated position in 30 seconds was recorded. This metric showed that 55% of participants improved and 25% of participants maintained in the post-assessment. Overall, there was a significant improvement in participants' performance in all three fitness tests as compared with the initial assessment.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Serving Health Information Needs of Everyone (SHINE) Program** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	LHMC maintains extremely successful partnership with Winchester Hospital and Minuteman Senior Services 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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By the end of FY22, Minuteman Senior Services Regional SHINE program will perform 150 pre and post BILH specific consumer assessments to assist in link consumers to additional community health benefits.
Goal Status	A revised pre/post assessment was launched in April 2022. 217 assessments were completed 4/22-9/22 using new tool 32 consumers wanted more information on Minuteman service and 3 consumers were directed to their COA for information.
Program Goal(s)	By the end of FY22 Minuteman Senior Services Regional SHINE program will provide Medicare benefits counseling to 650 individuals who reside in Arlington, Burlington and Winchester.
Goal Status	At the end of FY22 Minuteman Senior Services Regional SHINE program provided Medicare counseling to 652 consumers in the three BILH communities; 201 consumers were served in Winchester specifically and 451 consumers received Medicare counseling in Arlington and Burlington.
Program Goal	By the end of FY22, Minuteman Senior Services Regional SHINE program will offer 6 community education presentation to people new to Medicare or who are retiring to insure consumers make educated health insurance decisions
Goal Status	Minuteman Senior Services Regional SHINE program conducted 4 community education presentations and 1 in-service for staff at Winchester Cancer Care Center.

Program Goal	By the end of FY22, Minuteman Senior Services will establish one new SHINE counseling site at public housing located within Arlington, Burlington or Winchester for low to moderate income individuals to receive counseling regarding cost savings programs for Medicare beneficiaries.
Goal Status	Minuteman Services is collaborating with Arlington Housing Authority currently and negotiating SHINE memorandum of understanding.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care
Program Name: Lowell Community Health Center Keys to Health Equity Project: Language Supports
Health Issue: Additional Health Needs as Defined by Community

Brief Description or Objective	LHMC partners with the Lowell Community Health Center on their interpreter services program. Nearly 40% of Lowell CHC patients are best served in languages other than English, this grant will strengthen the health center's capacity to deliver on-demand language services for more than half of their 35,000 patients.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide funding to support interpretation services to the Lowell Community Health Center.
Goal Status	In FY22, 48.28% of a total of 138,100 patient visits (all cause) to the Lowell Community Health Center required language access to interpretation in more than 50 languages and dialects, translation of COVID-19 and other health guidance and information.
Program Goal(s)	Serve a diverse population of residents of Lowell.
Goal Status	79% identify as a Racial/Ethnic Minority, with 33% Hispanic/Latino. 24% of patients identify as Non-Hispanic/White; 21% as Asian; 12% Black/African-American, and 10% as other/unknown. In calendar year 2021, 45% of 31,243 patients requested interpretation in over 60 languages to 14,059 patients. 49% of patients live at or below 200% Federal Poverty Guidelines, and 33% live below 100% FPG.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Improving Access to Transportation--Arlington Council on Aging** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	LHMC partners with the Arlington Council on Aging to help to provide a curb to curb transportation to in-person medical appointments for underserved populations. There is no charge to older adults utilizing these rides and would include rides to all medical appointments within Arlington and surrounding towns. All COA transportation options follow strict COVID-19 safety protocols. With LHMC's support, the Arlington COA recruited additional volunteers to help to specifically outreach into populations of focus for the community, including people of color.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide free rides to medical appointments for a diverse population of Arlington older adults.
Goal Status	In 2022, the COA used the funds from this grant to support 61 older adults with medical transportation needs. These rides all went to and from medical appointments outside of Arlington and were completed by ArlBel Taxi or Uber through our Uber Central Platform. This grant allowed these 61 individuals completed 71 one-way rides.
Program Year: Year 3	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Council on Aging Farmers Market Program** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	LHMC partners with the New Entry Sustainable Farming Project to run 20-week farmers' markets at Burlington, Arlington, and Billerica Councils on Aging. 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. LHMC also supports a monthly grab and go program at the Burlington Council on Aging during the months that the market is not running to help to provide a socialization opportunity for older adults and as a way for staff to check on the well-being of their clients.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By September 30th, 2022 participants will report feelings of reduced social isolation from participating in the market.

Goal Status	From the pre/post survey: · 48% reported reduced feelings of isolation
Program Goal (s)	By September 30th, 2022 participants will report both an increase in access and ease of obtaining fresh fruits and vegetables.
Goal Status	From the pre/post survey: · 86% agreed that it was easier to get fresh produce · 90% agreed they ate a greater variety of foods and veggies
Program Goal (s)	By September 30th, 2022 participants will report eating higher quantities and higher quality produce.
Goal Status	From the pre/post survey: · 85% agreed they ate a higher quality of produce · 82% ate more fruits and veggie
Program Goal(s)	Provide seniors in Arlington, Billerica, and Burlington with fresh fruits and vegetables.
Goal Status	The program served between 50-80 seniors per week, depending on location. 98% of the survey respondents stated they came more than once to the market. · 74% were female · 4% Hispanic or Latino · Average age 76 · 52% have an annual income of less than $30,000

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Burlington Affordable Housing Coordinator** **Health Issue: Housing/Homelessness**	
Brief Description or Objective	LHMC collaborates with the Burlington Affordable Housing Coordinator. This position administers the affordable housing program for the Town of Burlington which provides support, referrals and assistance for those who are undergoing a period of housing instability. This program primarily serves residents of Burlington who are seniors or are experiencing homelessness.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Provide supportive services related to housing to Burlington residents such as referrals and assistance programs to those experiencing housing instability.
Goal Status	• Number of encounters: 23 • Number of referral: 9 • Demographics of people served: All encounters were with residents that qualify as low income.

Program Year: Year 2	**Of X Years: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Homelessness Prevention Program--Citizens Inn** **Health Issue: Housing/Homelessness**	
Brief Description or Objective	LHMC supports the Citizens Inn's Homelessness Prevention Program which provides longer-term supportive case management services to our clients who have moved on to permanent housing or are experiencing a housing crisis. The case management team works with each family to create a personalized stabilization plan. This plan not only addresses issues of economic stability, such as establishing a budget and setting up a bank account, it also creates support structures in the community, such as: monitoring school attendance and educational progress for children; assisting with landlord relations; and facilitating access to health care services. Case managers ensure that clients are referred to all the right places and support services, so none of these things become a barrier to stability.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By September 2021, the Homelessness Prevention Program will provide supportive services, such as food and employment assistance, for clients that allow them to remain housed.
Goal Status	Haven Food pantry clients 2,400 monthly + Other 126 in FY22.(•Shelter Stabilization- families that exited shelter and are provided services from our stabilization team (Edie/Shani) with monthly checkups to ensure the families are maintaining their new housing situation • Haven Resource Center- families that walk into the Resource Center request and help/services other than food from the pantry; ex: DTA/SNAP benefits, rental assistance, utility assistance, job search, legal services, health services, Digital Equity, etc. • Peabody Housing families/Resident Services Coordinator (Jenna); Families in Peabody Housing are referred to the Resident Services Coordinator to get assistance with a variety of needs including rental assistance, utility assistance, connection to legal services, health services, etc.)

Program Goal(s)	By September 2021, the Homelessness Prevention Program will assist clients in finding or maintaining housing.
Goal Status	Other – 279 in FY22(•Shelter Stabilization- families that exited shelter and are provided services from our stabilization team (Edie/Shani) with monthly checkups to ensure the families are maintaining their new housing situation • Haven Resource Center- families that walk into the Resource Center request and help/services other than food from the pantry; ex: DTA/SNAP benefits, rental assistance, utility assistance, job search, legal services, health services, Digital Equity, etc. • Peabody Housing families/Resident Services Coordinator (Jenna); Families in Peabody Housing are referred to the Resident Services Coordinator to get assistance with a variety of needs including rental assistance, utility assistance, connection to legal services, health services, etc.)
Program Year: Year 2	**Of X Years: Year 2** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Housing Corporation of Arlington Homelessness Prevention Program** **Health Issue: Housing/Homelessness**	
Brief Description or Objective	LHMC supports the Housing Corporation of Arlington's Homelessness Prevention Program (HPP). The program operates by identifying Arlington's residents who are most in need and stabilizing them with services coordinated by the Arlington Human Services Network (AHSN). The HPP interview process includes an assessment/case management service to see whether the family requires more than rental assistance. They help with applying for social security, medical insurance, food stamps, or referring to other partners for services.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By the end of 2021, HCA will assist 107 families in the HCA housing development with case management, homeless prevention funds, and ten head of household assist in finding jobs.
Goal Status	As of November 2022, HCA's social workers had provided 117 clients with the following types of assistance: • Eighty-seven clients will be able to maintain or find housing through the Homelessness Assistance Program • Twenty clients were provided with case management services such as applying for social security, medical insurance, food stamps, etc. • Seventeen residents are currently collaborating with staff to find jobs and are currently preparing a resume, interview skills, and how to interview by using zoom. • Fifteen attended Financial Education workshops

Program Year: Year 3	Of X Years: Year 3	Goal Type: Process Goal

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Saheli Housing Stabilization Program** **Health Issue: Housing/Homelessness**	
Brief Description or Objective	LHMC partners with Saheli on its Housing Stabilization Program (SHSP) which provides housing support services for domestic violence survivors, many of whom are immigrants. This program helps to make housing accessible and affordable for those who are often disproportionately affected by homelessness. Through this program, Saheli provides rental assistance for up to 6 months; offers financial assistance in the form of flex funds to help with a short term crisis that could jeopardize a survivor's housing; provides housing advocacy services to develop a personalized Housing Stabilization Plan for each survivor and link them to community resources; enrolls survivors into Saheli's Economic Empowerment Program to help survivors build credit, manage personal finances, learn basic English and access job and career-related resources.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Assist 50 immigrant survivors to secure safe housing and avoid homelessness by providing temporary housing stabilization assistance and supports.
Goal Status	Assisted 75 survivors with housing advocacy and stabilization.
Program Goal	60% (30/50) of immigrant survivors obtaining safe housing will participate in the Economic Empowerment Program.
Goal Status	In FY22, Saheli hired a new Economic Empowerment Specialist who will assist with this goal.
Program Goal	Increase number of immigrant survivor families receiving full rental assistance for one year from 3 to 6 in 2022, as they work on achieving economic stability.
Goal Status	Assisted 6 families with full rental assistance for more than 6 months

Program Year: Year 2	Of X Years: Year 2	Goal Type: Process Goal

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Increasing Access to Supportive Housing Services: 12 Russell Terrace Resident Support Program** **Health Issue: Housing/Homelessness**	
Brief Description or Objective	LHMC provided support to help to offset the cost of the resident services coordinator at an affordable housing site in Arlington. This role is essential to allowing residents of the facility and regularly meets with residents to help them become educated about their housing and advise them if there are any lease violations, connects residents with services such as medical, mental health programs, food stamps such as SNAP benefits, and any rental assistance programs. The coordinator also regularly makes referrals to the Caritas Homelessness Prevention Program, an early intervention for residents who miss a rent payment and provides coaching, repayment plans, and referral to assistance programs, while fostering accountability, so residents can continue to maintain their affordable housing.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By September 2022, 100% of residents at 12 Russell Terrace, Arlington, will continue their individual physical, mental and behavioral stabilization enough to maintain their affordable housing.
Goal Status	In FY 22, 18/18 residents utilized Caritas Resident Supportive Services to connect to services and opportunities that enabled them to stabilize and retain their affordable housing.
Program Goal(s)	By September 2022, 100% of residents at 12 Russell Terrace will have stabilized housing.
Goal Status	100% (18/18) residents have maintained their stabilized housing status.
Program Year: Year 2	**Of X Years: Year 2** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Infrastructure to support Community Benefits collaborations across BILH hospitals** **Health Issue: Various**	
Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital worked together to plan, implement, and evaluate Community Benefits programs. Staff worked together to plan and implement the FY22 Community Health Needs Assessment and each created an Implementation Strategy that is uniform across all of the hospitals. Community Benefits staff continued to understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH continues to refine the Community Benefits (CB) database, as part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2022, plan and implement the Community Health Needs Assessment and create the Implementation Strategy to address the priorities that is approved by the hospital Board of Trustees.
Goal Status	All 10 BILH Community Benefits hospitals received Board of Trustee approval on their Community Health Needs Assessment and Implementation Plan.
Program Goal(s)	By September 30, 2022, in partnership with MGB, create and implement a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits data to more accurately capture and quantify CB/CR activities and expenditures.
Goal Status	All FY22 regulatory reporting data were entered into the Community Benefits Database.
Program Year: Year 1	**Of X Years: Year 1** / **Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Bone Health and Osteoporosis Prevention Program** **Health Issue: Chronic Disease**	
Brief Description or Objective	LHMC conducts a Bone Health and Osteoporosis Prevention program to help patients understand a 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.

Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide free Bindex bone scans to patients referred to the program. Increase the number of scans in FY 2022.	
Goal Status	42 scans completed during FY22. Education was provided during the screening process, and each scan took between 5-15 minutes.	
Program Goal(s)	Provide information and motivation for lifestyle changes to positively impact bone health. Improve access to patients through an improved referral process utilizing the "Ambulatory referral to Orthopaedic Specialty Classes"	
Goal Status	LHMC provided 5 of classes with a total of 49 participants in FY22. The program transitioned to a virtual platform in FY 2021 and has remained virtual this year. As a result of the program participants expressed more interest and participation in our community fall prevention programs. The following are some of the comments provided by the participants: really enjoyed the class; Thank you for the program; The program gave us a lot of information to think about and follow through on. Thank you for the wonderful seminar. Participants expressed appreciation for the virtual platform.	
Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Burlington Diabetes Care Program** **Health Issue: Chronic Disease**		
Brief Description or Objective	LHMC partners with the Town of Burlington to support the Burlington Diabetes Care Program. This program provides assistance for Town of Burlington Employees who have a diagnosis of pre-diabetes or are diabetic. The program provides those who are identified with an annual foot exam, eye exam, and an A1C analysis, among other support services, every six months with no copays for participants. This program is intended to help offset the cost of these services to help to avoid serious chronic conditions often associated with diabetes and pre-diabetes.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Improve A1c3 of 25% of participants.	
Goal Status	50% of program participants had a reduction in A1C. 11% of program participants maintained a healthy A1C of 7 or below	

Program Goal(s)	Provide education, support, and intervention for persons with diabetes.

Goal Status	• Number of people served:
	  ○ 93 Members with diabetes
	  ○ 28 Enrolled in the program
	  ○ 20 Adherent
	  ○ 20 Adherent in last 12 months
	• Demographics of people served:
	  ○ Eligible 45% female 55% male
	  ○ Enrolled 19% female 39% male
	  ○ Adherent 63% female 45% male

Program Year: Year 2	**Of X Years: Year 2**	**Goal Type: Outcomes Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Cooking Up Good Health** **Health Issue: Chronic Disease**	
Brief Description or Objective	LHMC provides free nutrition and cooking classes to community members through its Cooking Up Good Health series. Participants learn different culinary tips and nutrition information about meals, snacks, sides, and desserts.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Launch a virtual cooking class program.
Goal Status	In FY 22, LHMC hosted their Cooking Up Good Health Series in a virtual format and hosted a total of nine classes with an average participation of 7 people per class.
Program Goal(s)	100% of attendees will report more confidence in using healthier ingredients when cooking a meal.
Goal Status	In FY 22, over nine classes, an average of 97% of program participants reported being more confident in using healthier ingredients when cooking a meal.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Memory Café** **Health Issue: Chronic Disease**		
Brief Description or Objective	LHMC partners with the Burlington Council on Aging to provide a monthly Memory café. The Memory Café provides activities and support for people with cognitive impairment as well as their caregivers in a safe, supportive, and welcoming space.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide support through the Memory Café to 15 participants per class.	
Goal Status	38 unduplicated individuals attended the Memory Cafe in FY 22 and 186 duplicated individuals. The age range for participants is 66-91 with one 21 year old.	
Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Livestrong** **Health Issue: Chronic Disease**		
Brief Description or Objective	LHMC partners with the North Suburban YMCA on their exercise-based Livestrong Program for cancer survivors. 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 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.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Create communities among cancer survivors and guide them through safe physical activity, helping them build supportive relationships leading to an improved quality of life.	
Goal Status	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. This session marked our association's relaunch of this much loved program following the pandemic and was our first in-person session held in over 2 years. Given the extended hiatus of this programs availability, our referrals tended to be patients who were still in the midst of their cancer treatment whereas typical enrolment cycles tend to be more balanced between those currently in treatment and those who have had some time since their treatment ended. We had 36 request to join the program, although several had to withdraw (7) or postpone (14) their enrollment to our upcoming spring 2023 session due to their health or the demands of their treatment regimen. 15 participants graduated, the overall results were as follows: • 83% Attendance • 78% improvement in leg strength; • 58% improvement in upper body strength 33% improvement in endurance

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: PINK Breast Cancer Support** **Health Issue: Chronic Disease**	
Brief Description or Objective	LHMC partners with the Burbank YMCA to provide a PINK support program for breast cancer survivors. The PINK Program 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.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide supportive services to breast cancer survivors.
Goal Status	The PINK Program has been restructured, and is now offered as a continuously operating, drop-in group exercise class/program with unique social support for breast

	cancer survivors. The YMCA relaunched the in-person class (was entirely virtual during Covid related closures) and 21 total people participated during this funding cycle.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Oncology Nurse Navigator and Supportive Services for Cancer Patients** **Health Issue: Chronic Disease**	
Brief Description or Objective	LHMC provides oncology navigation services for patients with a cancer diagnosis. RNs with oncology-specific clinical knowledge work with newly diagnosed cancer patients by offering individualized support and assistance with coordinated care through a holistic and collaborative approach that includes communication and coordination with the patient's family and/or caregivers along with a multidisciplinary team consisting of physicians, nurse practitioners, oncology nurses, and social workers.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	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.
Goal Status	In FY22, the navigators served on average between 10-15 individuals per day.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Cancer Programs: Screening & Prevention** **Health Issue: Chronic Disease**	
Brief Description or Objective	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 and provides support to the American Cancer Society on many community-based prevention activities.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Identify persons who may be at a higher risk for breast cancer and provide screening follow-ups to their physicians.
Goal Status	In FY22, LHMC completed 20,689 risk assessments for 20,134 unique individuals. 13% of patients screened across the system were identified as having a high lifetime risk of breast cancer and 27% were identified as having a high-risk mutation.
Program Year: Year 3	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington Council on Aging Outreach Workers** **Health Issue:**	
Brief Description or Objective	LHMC partners with the Burlington Council on Aging on outreach workers who provide essential services to seniors in the town. Staff regularly meet with individuals on a variety of issues and provide support, guidance and referrals to services, helping to bridge the gaps for groups who are disproportionately affected by barriers to care.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide referrals for program clients to supportive services.

Goal Status	The social workers made 495 referrals to various agencies such as Legal Services, adult day health, housing and Minuteman Senior Services for home care services, health insurance benefits (SHINE), protective services just to name a few. Most of those referrals also stayed with the COA for ongoing case management.
Program Goal(s)	Provide supportive services to Burlington residents
Goal Status	The Burlington Council on Aging social workers had 1962 encounters serving 504 people (including family members or caregivers).

Program Year: Year 2	**Of X Years: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington Police Department Substance Use Coordinator** **Health Issue: Substance Use Disorders**	
Brief Description or Objective	LHMC partners with the Burlington Police Department to provide a substance use coordinator. The coordinator provides essential outreach to persons identified by police as having substance use issues. The position provides support and referrals for those individuals and coordinates between multiple town and community agencies to ensure they receive essential services.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide referrals and supportive services to persons with substance use disorder.

Goal Status	• Number of individuals contacted for substance use coordinator: 55
	• Number of referral who accepted services: 27
	• Demographics of people served:
	  ○ By gender male 40 & female 15
	  ○ By age 15 to 19 = 1, 20 to 39 = 31, 40 to 59 = 19, 60 and over =4

Program Year: Year 2	**Of X Years: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington Youth & Family Services** **Health Issue: Mental Illness and Mental Health**		
Brief Description or Objective	LHMC partners with Burlington Youth & Family Services support on support groups, trainings for staff to enhance services, and clinical consultation services from behavioral health providers.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide supportive mental health services to youth in Burlington.	
Goal Status	• Number of annual visits: 4,616 • Number of referrals: 438 • Number of trainings: 6 • Number of support groups and individuals served through support groups: 14 groups, and 155 attended.	
Program Year: Year 2	**Of X Years: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Collaborative Care Model** **Health Issue: Mental Illness and Mental Health**		
Brief Description or Objective	BILH Behavioral Services provides a number of different programs and services that serve communities within the LHMC service area including mobile behavioral health urgent care programs as well as comprehensive care coordination and case management. BILH is also committed to increasing access to Behavioral Health services as part of primary care. Services include individual and group therapy for mental health and substance use issues; addiction treatment; family services; mobile crisis teams for behavioral and substance-related emergencies, and inpatient psychiatric care. Centralized bed management monitors a patient's progress through a facility or emergency department and coordinates the placement of behavioral health patients in the inpatient unit best suited to their needs based on clinical presentation and geographic location.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	To increase access to behavioral health services.
Goal Status	2,996 patients were served in FY 22.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Behavioral Health Crisis Consultation** **Health Issue: Mental Health/Mental Illness/ Substance Use Disorder**	
Brief Description or Objective	To provide 24/7/365 behavioral health crisis evaluation in the emergency department (ED) and throughout other hospital units for individuals experiencing mental health and substance use related crisis. Services are payer agnostic and provided via in-person or telehealth by a multidisciplinary team of qualified professionals, including Psychiatrists, independently licensed and Master's level clinicians, Nurse Practitioners, Registered Nurses, Certified Peer Specialists, and Family Partners. The services include initial assessments for risks, clinical stabilization, treatment initiation, care coordination, and ongoing evaluation to ensure appropriate level of care placement.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to clinical and non-clinical support services for those with mental health and substance use issues, by providing behavioral health services in the hospital.
Goal Status	A multidisciplinary team, comprised of qualified behavioral health providers, psychiatry, family partners, and peer specialists, is employed to provide behavioral health crisis consultations in the Emergency Department or medical floors of the hospital. The team served 319 patients in FY22.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington High School Wellness Day** **Health Issue: Mental Health**	
Brief Description or Objective	LHMC provides support to Burlington High School for a full day learning experience that provides wellness based workshops for all students that focus on stress reduction, connection, and self-care. This has been run in both a full day and half day model, and has no tie to academic demands/assessments.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2022 Burlington High School will provide a wellness day focused on providing students with resources for stress reduction and mental health.
Goal Status	• Number of students who participated - 850 • Number of staff who participated -80 • Number of vendors/workshops offered - 42

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington High School Adjustment Counselor** **Health Issue: Mental Health**	
Brief Description or Objective	LHMC provides support to Burlington High School for and on-site position that provides in school counseling for students based on mental health status and need. This position traditionally provides support for tier two students. This position was added in Burlington in the 2019-2020 school year.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2022 Burlington High School will provide social and emotional support services to students through the adjustment counselor services.
Goal Status	• Number of students served - 253 • Demographics of students served African American - 42

	Asian - 56 Asian, Caucasian - 3 Caucasian - 157 Native American - 9 EL - 28 IEP/504 - 32 Connections Program (substantially separate) - 24 Free/Reduced - 78 • Number of students referred for services - 25

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: LHMC Medication Disposal Program** **Health Issue: Substance Use Disorders**	
Brief Description or Objective	LHMC provides a medication disposal box 24 hours, 7 days a week medication disposal to safely dispose of expired or unwanted medication.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To increase the amount of medications collected.
Goal Status	LHMC increased the amount of medications collected by approximately 39%.
Program Goal(s)	To provide a safe and convenient way for community members to dispose of unwanted or unused medications.
Goal Status	In FY 2022, LHMC collected and disposed of over 730 lbs. of medications.
Program Goal(s)	To provide community-based medication counseling.
Goal Status	In FY 2022, LHMC pharmacists counseled approximately 25 patients in the community regarding their new paxlovid prescriptions and any drug interactions/considerations.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Outpatient Behavioral Health Services** **Health Issue: Mental Illness and Mental Health**		
Brief Description or Objective	LHMC provides a hospital-based, outpatient program for adults with complex medical and psychiatric needs in a single care setting. 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 provides 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.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide behavioral health resources and supportive services.	
Goal Status	In FY22, LHMC provided 9 virtual support groups at the Burlington and Peabody locations.	
Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Peabody High School Health Center** **Health Issue: Mental Illness and Mental Health**		
Brief Description or Objective	This program provides high-quality, comprehensive health care to students on site at Peabody High School. Services 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.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide support and funding for services at the PVMHS SHC that meet a critical, identified community need.	
Goal Status	In FY22, the SHC had the following impacts: Medical: 675 Onsite: 666	

	Telehealth: 9 Behavioral health: 1228 On-site: 1162 Telehealth: 66 Total number unduplicated patients – 313 Total number of visits where client had no insurance at time of visit and visit was not paid out of another revenue source: 139 The top 3 diagnoses were Major Depressive Disorder, Anxiety Disorder, and Immunization (new for FY22).
Program Goal(s)	The student-based health center will help to provide access to critical behavioral health services for students who are uninsured/health safety net or on MassHealth.
Goal Status	81% of total clients had either MassHealth or were uninsured/health safety net.

Program Year: Year 3	**Of X Years: Year 3**	**Goal Type: Process Goal**

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$8,522,317.00	$ -
Community-Clinical Linkages	$1,095,755.00	$ -
Total Population or Community Wide Interventions	$1,597,161.00	$1,167,145.00
Access/Coverage Supports	$890,866.00	$483,646.00
Infrastructure to Support CB Collaborations	$78,820.00	
Total Expenditures by Program Type	$12,184,919.00	$1,650,791.00
CB Expenditures by Health Need		
Chronic Disease	$7,064,921.80	
Mental Health/Mental Illness	$1,600,942.30	
Substance Use Disorders	$108,820.20	
Housing Stability/Homelessness	$97,210.10	
Additional Health Needs Identified by the Community	$3,313,024.60	
Total by Health Need	$12,184,919.00	
Leveraged Resources	$61,860.00	
Total CB Programming		
Net Charity Care Expenditures		
HSN Assessment	$5,399,263.76	
Free/Discounted Care		
HSN Denied Claims	$1,238,310.39	
Total Net Charity Care	$6,637,574.15	
Total CB Expenditures	$18,884,353.15	

Additional Information	
Net Patient Services Revenue	**$991,114,000.00**
CB Expenditure as % of Net Patient Services Revenue	**1.91%**
Approved CB Budget for FY22 (*Excluding expenditures that cannot be projected at the time of the report)	**$18,884,353.15**
Bad Debt	**$6,524,458.65**
Bad Debt Certification	**Yes**
Optional Supplement	
Comments	**In addition to the above amounts, Beth Israel Lahey Health contributed $1 million to The Latino Equity Fund and the New Commonwealth Racial Equity and Social Justice Fund in support of addressing health disparities related to hypertension, diabetes and obesity and further integration and alignment, particularly regarding stakeholder engagement and convening with the Health Equity Compact.** **LHMC also contributes PILOT payments to the Town of Burlington and City of Peabody. LHMC is also subsidizing behavioral health services outside of its community benefits service area.**

SECTION VI: CONTACT INFORMATION

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Lahey Hospital & Medical Center
Community Benefits/Community Relations
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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Form – Year 1
Note: This form is to be completed in the Fiscal Year in which the hospital completed its triennial Community Health Needs Assessment

I. **Community Benefits Process:**

1. Community Benefits in the Context of the Organization's Overall Mission:
   - Are Community Benefits planning and investments part of your hospital's strategic plan? ☒Yes ☐No
   - If yes, please provide a description of how Community Benefits planning fits into your hospital's strategic plan. If no, please explain why not.

LHMC is a member of Beth Israel Lahey Health (BILH). While LHMC oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure ensures that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – **We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity.**

2. Community Benefits Advisory Committee (CBAC)

- Members (and titles):

Brigitte Bowen-Benitich, MBA, Vice President of Surgical Services, Lahey Hospital & Medical Center
Jean Bushnell, Director, Billerica Council on Aging
Sharon Cameron, Director of Health and Human Services, City of Peabody
Stephanie Cronin, Executive Director, Middlesex 3 Coalition
Randi Epstein, Coordinator, Community Health Network Area 15
Melissa Hastings Cruz, Lahey Hospital & Medical Center Board of Trustees
Christine Healey, Director, Community Relations, Beth Israel Lahey Health
Peter Kilcommons, Corporate Controller, Lahey Hospital & Medical Center
Allison Kilcoyne, Vice President Integration, Wellness & Outreach, North Shore Community Health
Jennifer Knight, Director of Family and Community Engagement, Burlington Public Schools
Kelly Magee Wright, Executive Director, Minuteman Senior Services
Elvira Omerovic, Director, Site Operations, Beth

Israel Lahey Health Primary Care
Rick Parker, Executive Director, Burlington Resident
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

- Leadership:
Brigitte Bowen-Benitich, MBA, Vice President of Surgical Services, Lahey Hospital & Medical Center
Andy Villanueva, MD, Chief Quality Officer, Lahey Hospital & Medical Center, Lahey Hospital & Medical Center Board of Trustees

- Frequency of meetings:
The LHMC CBAC met quarterly during FY 2022 and also attended the hospital's annual Community Benefits public meeting.

3. Involvement of Hospital's Leadership in Community Benefits:
Place a checkmark next to each leadership group if it is involved in the specified aspect of your Community Benefits Process.

	Review Community Health Needs Assessment	Review Implementation Strategy	Review Community Benefits Report
Senior leadership	☒	☒	☒
Hospital board	☒	☒	☐
Staff-level managers	☒	☒	☒
Community Representatives on CBAC	☒	☒	☒

For any check above, please list the titles of those involved and describe their specific role:

At BILH, our belief that everyone deserves high-quality, affordable health care is at the heart of who we are and what drives our work with our community partners. The organizations that are now part of BILH have always been deeply committed to serving their communities. Working collaboratively with our community partners, our Community Benefits Committee (CBC) and the Community Benefits team, such commitment is shared by staff at all levels within LHMC:

Hospital Board:
- LHMC Board of Trustees – reviewed and approved its CHNA and adopted its Implementation Strategy
- LHMC Community Benefits Advisory Committee - oversaw CHNA and Implementation Strategy process

Senior Leadership:
- David Longworth, MD, President - provided input on identifying CBSA, CHNA and Implementation Strategy
- Andrew Villanueva, Chief Quality Officer - participated in prioritization process

- Brigitte Bowen-Benetich, Vice President of Surgical Services - participated in prioritization process

Staff-level Managers:

- Nancy Kasen, BILH VP of Community Benefits and Community Relations, and Community Benefits team - designed, managed and conducted CHNA, managed prioritization process, drafted Implementation Strategy

BILH Community Benefits Committee (CBC):

- BILH CBC - guided the process for the system

4. Hospital Approach to Assessing and Addressing Social Determinants of Health

- How does the hospital approach assessing community needs relating to social determinants of health? (150-word limit)

LHMC undertook a robust, collaborative and transparent assessment and planning process. The approach involved extensive quantitative and qualitative data collection and substantial efforts to engage community residents, with special emphasis on population segments often left out of assessments. The assessment was supported by LHMC's Community Benefits Advisory Committee. The Community Benefits Advisory Committee is comprised of community members, service providers, and other stakeholders that either live in and/or work in LHMC's CBSA. LHMC's Implementation Strategy (IS) reflects the hospital and the CBAC's prioritization of the following social determinants of health: healthy neighborhoods, healthy eating and active living opportunities, violence prevention, housing affordability and home ownership, workforce development and the creation of employment opportunities, and environmental sustainability.

- How does the hospital incorporate health equity in its approach to Community Benefits? (150-word limit)

LHMC and BILH are committed to health equity, the attainment of the highest level of health for all people, required focused and ongoing societal efforts to address avoidable inequalities, socioeconomic barriers to care, and both historical and contemporary injustices. Throughout LHMC's assessment process, LHMC worked to understand the needs of populations that are often disadvantaged, face disparities in health-related outcomes, and are deemed most vulnerable. LHMC's IS is rooted in health equity and was developed with a focus on reaching the geographic, demographic and socioeconomic segments of populations most at risk, as well as those with physical and behavioral health needs in the hospital's CBSA.

- How does the hospital approach allocating resources to Total Population or Community-Wide Interventions? (150-word limit)

The LHMC's IS includes a diverse range of programs and resources to addresses the prioritized needs within the LHMC Community Benefits Service Area. The majority of LHMC's community benefits initiatives are focused on cohorts and sub-populations due to identified disparities or needs. LHMC's strategies include increasing access to care through support of the Community Care Alliance, participating in the Dana Farber/Harvard Cancer Center and the Faith-Based Cancer Disparities Network, and supporting the Violence Intervention and Prevention Program in the Bowdoin/Geneva neighborhood. Additionally, LHMC collaborates with many community partners to own, catalyze and/or support total

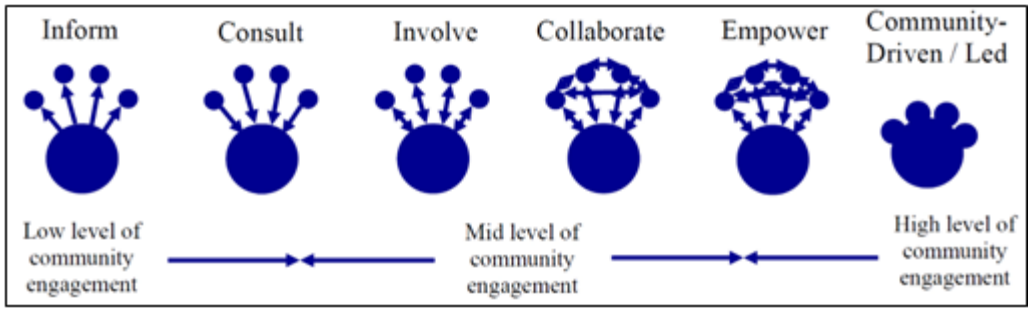
population and community-wide interventions including Sociedad Latina, The Louis D. Brown Peace Institute, Family Nurturing Center, and YMCA Training, Inc.

II. Community Engagement

1. Organizations Engaged in CHNA and/or Implementation Strategy
   Use the table below to list the key partners with whom the hospital collaborated in assessing community health needs and/or implementing its plan to address those needs and provide a brief description of collaborative activities with each partner. Note that the hospital is not obligated to list every group involved in its Community Benefits process, but rather should focus on groups that have been significantly involved. Please feel free to add rows as needed.

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
Peabody Public Health Department	Sharon Cameron, Director of Public Health	Local Health Department	CBAC Member; Participated in IS prioritization process; participated in key informant interview; helped to arrange focus group
North Shore Community Health Center	Allison Kilcoyne, Co-Chief Operating Officer	Community Health Centers	CBAC Member; participated in prioritization process
Place of Promise	Jeff Kiel, Executive Director	Social service organizations	Participated in key informant interview
Billerica Council on Aging	Jean Bushnell, Executive Director	Social service organizations	CBAC Member, participated in key informant interview, participation in IS prioritization process

2. Level of Engagement Across CHNA and Implementation Strategy
   Please use the spectrum below from the Massachusetts Department of Public Health[1] to assess the hospital's level of engagement with the community.



For a full description of the community engagement spectrum, see page 11 of the Attorney General's Community Benefits Guidelines for Non-Profit Hospitals.

A. **Community Health Needs Assessment**
   Please assess the hospital's level of engagement in developing 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 assessing community health needs	Empower	Goal was met.	Collaborate
Collecting data	Empower	Goal was met – LHMC built capacity for community residents to co-facilitate/facilitate focus groups and breakout sessions during listening sessions.	Collaborate
Defining the community to be served	Collaborate	Starting several months before launching the CHNA, LHMC worked with its CBAC to identify the community, those to be engaged and ways to engage them.	Collaborate
Establishing priorities	Empower	Working with BILH, LHMC actively engaged with the CBAC and the community to identify and select priorities.	Collaborate

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

  BILH and LHMC are committed to continuing to build our capacity to engage with the community and to foster community member capacity for facilitation and evaluation.

B. **Implementation Strategy**
Please assess the hospital's level of engagement in developing and 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	Collaborate	Goal met – community listening sessions with breakout sessions facilitated by community members, with active CBAC engagement in prioritization discussions and decisions.	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Inform	Goal met – FY 2022 was the last year of LHMC's FY 2020 – 2022 Implementation Strategy (IS) and its CBAC was informed regarding how CB resources were allocated. LHMC will collaborate with its CBAC to select programs to invest its resources in for the FY 2023 – 2025 IS.	Collaborate
Implementing Community Benefits programs	Collaborate	Goal met – FY 2022 was the last year of LHMC's FY 2020-2022 Implementation Strategy (IS). LHMC will be collaborating with the community on new and existing programs for its FY 2023-2025 IS.	Collaborate

Evaluating progress in executing Implementation Strategy	Involve	Goal met - BILH and LHMC held multiple evaluation workshops to build evaluation and data capacity of community organizations, CBAC members and community residents.	Collaborate
Updating Implementation Strategy annually	Inform	Goal met – FY 2022 was the last year of the current FY2020-2022 IS. BILH and LHMC are working to develop, track and share data on a routine basis with the CBAC.	Collaborate

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

  Click or tap here to enter text.

3. Opportunity for Public Feedback

   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 has a comprehensive Implementation Strategy (IS) to respond to identified community health priorities. LHMC engaged with the leadership team and the community to identify and select priorities for the new (FY2023-2025) IS. The IS was shared with the CBAC, the leadership team, adopted by the Board of Trustees and widely distributed.

4. Best Practices/Lessons Learned

   The AGO seeks to continually improve the quality of community engagement.

   - What community engagement practices are you most proud of? (150-word limit)

     LHMC is most proud of its committed CBAC and the long-standing relationships it has with many community-based organizations, the public health department, and other government partners. LHMC is proud of their collaboration with these and other organizations that allowed LHMC to engage with hard-to-reach cohorts. LHMC is particularly proud of how it was able to reach community members who had not previously been engaged.

   - What lessons have you learned from your community engagement experience? (150-word limit)

     Working collaboratively with other hospitals, community-based organizations, public health agencies, and area coalitions enhances the level and quality of LHMC's community engagement efforts.

III. **Regional Collaboration**

1. Is the hospital part of a larger community health improvement planning process?

   ☒Yes ☐No

- If so, briefly describe it. If not, why?

For its FY 2022 CHNA, Beth Israel Lahey Health (BILH) took the unique approach of designing and implementing a system-wide, highly coordinated CHNA and prioritization process across each of the system's 10 licensed hospitals, including LHMC, encompassing 49 municipalities and six Boston neighborhoods. While LHMC focuses its Community Benefits resources on improving the health status of those in its CBSA experiencing the significant health disparities and barriers to care, this system-wide approach enhances opportunities for collaboration and alignment with respect to addressing unmet need and maximizing impact on community health priorities. Together, BILH hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact.

2. If the hospital collaborates with any other filer(s) in conducting its CHNA, Implementation Strategy, or other component of its Community Benefits process (e.g., as part of a regional collaboration), please provide information about the collaboration below.

- Collaboration:
  LHMC worked collaboratively with each of the 9 other hospitals in the BILH system to design and implement a system-wide, highly coordinated CHNA and prioritization process across each of the system's 10 licensed hospitals.

- Institutions involved:
  - Anna Jaques Hospital
  - Beth Israel Deaconess Hospital - Milton
  - Beth Israel Deaconess Hospital - Needham
  - Beth Israel Deaconess Hospital - Plymouth
  - Beth Israel Deaconess Medical Center
  - Beverly and Addison Gilbert Hospitals
  - Lahey Hospital and Medical Center
  - Mount Auburn Hospital
  - New England Baptist Hospital
  - Winchester Hospital
- Brief description of goals of the collaboration:
  LHMC collaborated with the other 9 hospitals in the BILH system to add rigor to the hospitals' assessments and planning processes, promoting alignment across hospital efforts and strengthening relationships between and among BILH hospitals, community partners and the community-at-large.

- Key communities engaged through collaboration:
  LHMC collaborated with the other 9 hospitals in the BILH system to engage the 49 municipalities and six Boston neighborhoods who were part of the individual Community Benefits Service Areas from each of the licensed hospitals.

- If you did not participate in a collaboration, please explain why not:
  Click or tap here to enter text.