Community Benefits Report

Fiscal Year 2025

Beth Israel Lahey Health
Lahey Clinic

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SECTION I: SUMMARY AND MISSION STATEMENT

Lahey Hospital & Medical Center (LHMC) is a member of Beth Israel Lahey Health (BILH). The BILH network of affiliates is an integrated health care system committed to expanding access to extraordinary patient care across Eastern Massachusetts and Southern New Hampshire and advancing the science and practice of medicine through groundbreaking research and education. The BILH system is comprised of academic and teaching hospitals, a premier orthopedics hospital, primary care and specialty care providers, ambulatory surgery centers, urgent care centers, community hospitals, homecare services, outpatient behavioral health centers, and addiction treatment programs. BILH's community of clinicians, caregivers and staff includes approximately 5,900 physicians and 36,000 employees.

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 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 Community and Health Impact 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 *WE CARE:*

- ***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.*

The mission of LHMC is to serve our patients compassionately and effectively, and to create a healthy future for them and their families. Our mission is supported by our commitment to personalized, excellent care for patients; a workforce committed to individual accountability, mutual respect, and collaboration; and a commitment to maintaining our financial health. The

Medical Center is also committed to being active in the community as well. Service to community is at the core and an important part of our mission. We have a covenant to care for the underserved and to work to change disparities in access to care. We know that to be successful we need to learn from those we serve.

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 Needs Assessment (CHNA) process as well as in the development, implementation, and oversight of the hospital's three-year Implementation Strategy (IS);

- **Engaging and learning from residents** throughout LHMC's Community Benefits Service Area (CBSA) in all aspects of the Community Benefits process, with special attention focused on engaging diverse perspectives, from those, patients and non-patients alike, who are often left out of similar assessment, planning and program implementation processes;

- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to understand unmet health-related needs and identify communities and population segments disproportionately impacted by health issues and other social, economic and systemic factors;

- **Implementing community health programs and services** in LHMC's CBSA that address the underlying social determinants of health, barriers to accessing care, as well as promote equity to improve the health status of those who are often disadvantaged, face disparities in health-related outcomes, experience poverty, and have been historically underserved;

- **Promoting health equity** by addressing inequities and ensuring that all patients are welcomed and received with respect and have access to culturally responsiveness care; and

- **Facilitating collaboration and partnership within and across sectors** (e.g., state/local public health agencies, health care providers, social service organizations, businesses, academic institutions, community health collaboratives, and other community health organizations) to advocate for, support, and implement effective health policies, community programs, and services.

The following annual report provides specific details on how LMHC is honoring its commitment and includes information on. LHMC's CBSA, community health priorities, priority cohorts, community partners, and detailed descriptions of its Community Benefits programs and their impact.

Priority Cohorts

LHMC's CBSA includes Arlington, Bedford, Billerica, Burlington, Danvers, Lexington, Lowell, Lynnfield, and Peabody. In FY 2025, 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 (February 2018). 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 2026 - 2028 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 upon LHMC's FY 2025 CHNA, the community characteristics that were thought to have the greatest impact on health status and access to care in its CBSA were issues related to age, race/ethnicity, language, gender identity, immigration status, household composition, and economic security. There was consensus among interviewees, focus groups, and community listening session participants that people of color, recent immigrants, and non-English speakers were more likely to have poor health status and face systemic challenges accessing needed services than white, English speakers who were born in the United States. These segments of the population are impacted by language and cultural barriers that limit access to appropriate services, pose health literacy challenges, exacerbate isolation, and may lead to discrimination and disparities in access and health outcomes.

For its FY 2026 – 2028 IS, LHMC will work with its community partners, with a focus on Arlington, Bedford, Billerica, Burlington, Danvers, Lexington, Lowell, Lynnfield, and Peabody, 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 improving the health status of the following priority cohorts:

- Youth
- Low-Resourced Populations
- Individuals Living with Disabilities
- Older Adults
- Racially, Ethnically and Linguistically Diverse Populations
- LGBTQIA+

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 FY 25 CHNA and FY 26-FY 28 IS were approved and adopted, respectively, by the LHMC's Board of Trustees during the fiscal year ended September 30, 2025. That CHNA and IS will inform the Community Benefits mission and activities of LHMC for the fiscal years ending September 30, 2026; September 30, 2027; and September 30, 2028.

This report covers LHMC's fiscal year ending September 30, 2025. The previous FY 22 CHNA and accompanying FY 23-FY 25 IS were approved by the LHMC Board before September 30, 2022 and informed the LHMC's Community Benefits initiatives for the fiscal years ending September 30, 2023; September 30, 2024; and September 30, 2025. 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, 2022.

Program accomplishments include:

- LHMC supported 4,816 patients through 6,664 financial counseling encounters, resulting in 815 charity care approvals, 485 MassHealth approvals, and Health Safety Net access for 3,441 uninsured individuals.
- The Peabody Veterans Memorial High School Health Center delivered 933 medical visits and 850 behavioral health visits to 343 students, expanding access to onsite care and early intervention.
- Through partnerships with local organizations, LHMC delivered more than 17,500 pounds of fresh produce to older adults, supported 658 community gardeners, and distributed 1,700 pounds of food to Lowell youth.
- The Housing Corporation of Arlington provided 23 homelessness prevention grants and supported 300+ families with stabilization services, while Citizens Inn connected over 120 families with SNAP and essential resources.
- LHMC delivered evidence-based programs—including Enhance Fitness, Bone Health education, A Matter of Balance, and Tai Ji Quan—showing measurable improvements in mobility, falls prevention, and participant engagement.
- LHMC provided internships and clinical training placements across radiology, nuclear medicine, and diagnostic ultrasound, supporting workforce readiness and strengthening the clinical talent pipeline.

Plans for Next Reporting Year

In FY 2025, 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. In response to the FY 2025 CHNA, LHMC will focus its FY 2026 - 2028 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 2025 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 2025 CHNA and creating its FY 2026 - 2028 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 2025 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that for LHMC's FY 2026 - 2028 IS, it should work with its community partners 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 continue to focus on improving the health status, addressing disparities in health outcomes, and promoting health equity for its priority cohorts, which include youth; low-resourced populations; individuals living with disabilities; older adults; racially, ethnically and diverse populations and LGBTQIA+.

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 2026 – 2028 IS.

- **Equitable Access to Care**
    - LHMC will partner across its CBSA to reduce financial, logistical, and cultural barriers to care—including financial counseling, subsidized primary and specialty care at primary care practices, SHINE Medicare benefits counseling, and the Peabody High School Health Center. These programs collectively improve affordability, navigation, and access for thousands of residents annually

- **Social Determinants of Health**
  - LHMC will continue to address food security, housing stability, and workforce development through community-based partnerships and multiple internship programs. These collaborations expand access to fresh produce, stabilize households, and strengthen local career pathways

- **Mental Health and Substance Use**
  - LHMC will work to strengthen mental health and substance use supports through partners including the Burlington Council on Aging, Burlington Youth & Family Services, Burlington High School, the Torigian Family YMCA, Place of Promise, and BILH Behavioral Health initiatives. Together, these programs expand counseling, youth mental-health supports, substance use outreach, long-term recovery services, and community-wide training.

- **Complex and Chronic Conditions**
  - LHMC and its partners provide evidence-based fitness, falls-prevention, chronic disease management, and cancer screening programs—including Enhance Fitness, A Matter of Balance, Bone Health education, diabetes care, and breast-cancer risk assessments. These programs improve mobility, reduce fall risk, support chronic disease self-management, and enhance early detection.

Hospital Self-Assessment Form

Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), the LHMC Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 66). The LHMC Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members and asked them to submit the form to the AGO website.

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 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 Community and Health Impact 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 *WE CARE:*

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- ***E**quity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.*

The LHMC Community Benefits program is spearheaded by the Community Benefits and Community Relations Manager, who has direct access to 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 Community and Health Impact 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 LHMC'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 18, 2024
March 26, 2025
June 25, 2025
September 17, 2025

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 (IS) 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. Lahey Hospital & Medical Center's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of LHMC's mission.

LHMC currently supports numerous 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 joins in assessing community needs 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 66).

- Arlington Council on Aging
- A Healthy Lynnfield Coalition
- Billerica Council on Aging
- Bunker Hill Community College
- Burlington Council on Aging
- Burlington Recreation Department
- Burlington School Department
- Center for Hope and Healing
- City of Peabody
- Community Teamwork, Inc.
- Greater Lowell Health Alliance
- Greater Boston YMCA
- Lowell Community Health Center
- Housing Corporation of Arlington
- Massachusetts College of Pharmacy and Health Sciences
- Merrimack Valley Food Bank
- Metro North YMCA
- Middlesex Community College
- Mill City Grows
- Minuteman Senior Services
- New Entry Sustainable Farming Project
- North Shore Community Health
- North Suburban YMCA
- Peabody Council on Aging
- Peabody High School
- Place of Promise
- Regis College
- 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 2025 Community Health Needs Assessment (CHNA) along with the associated FY 2026-2028 Implementation Strategy was developed over a fifteen-month period from June 2024 to September 2025. 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 2025. FY 2025 Community Benefits programming was informed by the FY 2022 CHNA and aligns with LHMC's FY 2023 – FY 2025 Implementation Strategy. The following is a summary description of the FY 2025 CHNA approach, methods, and key findings.

Approach and Methods

The FY 2025 assessment and planning process was conducted in three phases between June 2024 and September 2025, 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. 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.

Through the FY 2025 Community Health Needs Assessment process, LHMC conducted 15 interviews with key collaborators in the community, facilitated 5 focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 1,500 residents, and organized a community listening session.

The articulation of each specific community's needs (done in partnership between Lahey Hospital & Medical Center 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 2025 CHNA Key Health-Related Findings

Equitable Access to Care

- Interviewees, focus groups, and listening session participants 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 stemmed from the ways in which the system did or did not function. System-level issues included full provider panels, which prevented providers from accepting new patients, long wait lists, and an inherently complicated health care system that was 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 housing, food insecurity, economic insecurity, education, 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, surveys, and the listening session reinforced 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, transportation and economic stability.

Mental Health and Substance Use

- Anxiety, chronic stress, depression, and social isolation were leading community health concerns. There were specific concerns about the impact of mental health issues for youth and young adults; trauma experienced by immigrants, migrants, and refugees, and social isolation among older adults.
- In addition to the overall burden and prevalence of mental health issues, residents identified a need for assistance navigating a complex behavioral health system, as it can be overwhelming for individuals experiencing mental health challenges. Providing navigation assistance ensures people can access the right services at the right time, improving continuity of care and health outcomes.
- Youth mental health was a concern in the CBSA, including the prevalence of chronic stress, anxiety, and behavioral issues. These conditions were exacerbated throughout the pandemic, because of isolation, uncertainty, remote learning, and family dynamics.

Complex and Chronic Conditions

- Chronic conditions like cancer, heart disease, chronic lower respiratory disease, and stroke account for four of the six leading causes of death statewide, and it is estimated that there are more than $41 billion in annual costs associated with chronic disease. 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 2025 LHMC Community Health Needs Assessment Report and Implementation Strategy on the hospital's website.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Equitable Access to Care **Program Name: Financial Assistance Counseling** **Health Issue: Additional Health Needs as Defined by Community (Access to Care)**		
Brief Description or Objective	Significant segments of the community population living within the hospital's CBSA, particularly low-resourced populations, face significant barriers to care. The hospital's Financial Assistance Program offers emergency and other medically necessary services at low or no cost to qualified patients (when qualifying family income is at or below 400% of the Federal Poverty Level). The hospital's Financial Counseling staff screen people and assist them in applying for all eligible financial assistance programs.	
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 assist patients throughout the BILH Systems who are uninsured and under insured to obtain eligibility for and align them with state financial assistance and hospital-based financial assistance programs. This includes MassHealth, MassHealth ACOs, Health Connector, Pharmacy Programs, and Hospital Charity programs.	
Goal Status	For FY25, staff screened 4,816 patients for eligibility programs of which 815 were enrolled in the charity care discount program. Of these patients, 815 were enrolled in MassHealth and 3,441 uninsured patients utilized the Health Safety Net.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Interpreter Services** **Health Issue: Additional Health Needs as Defined by Community (Access to Care)**		
Brief Description or Objective	An extensive body of research illustrates the health disparities and differences in health care access and utilization that exist for diverse individuals/cohorts and foreign-born populations. Language barriers pose significant challenges to providing effective and high-quality health and social services. To address this need, and in recognition that language and cultural barriers are major difficulties to accessing health and social services and navigating the health system, LHMC offers free interpreter services for non-English speaking, limited-English speaking, deaf and hard-of-hearing patients. These services are provided in person; by phone using a portable speaker phone to connect patients, their care team and an interpreter; and through video-based remote interpreter service using a computer to connect patients with an interpreter. Professional interpretation services in hundreds of languages are available 24/7.	
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 access to interpretation and translation services at no cost to Lahey patients.	
Goal Status	In FY 25 there were 165,502 encounters; top 3 languages were Spanish, Portuguese-Brazilian, and Chinese-Mandarin	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable 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 (Access to Care)**			
Brief Description or Objective	LHMC supports the Lowell Community Health Center with funding to offset the cost of 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)	Deliver on-demand interpretation and follow-up services for patients, in all languages.		
Goal Status	In FY 25, the Lowell Community Health Center provided 214,567 sessions of interpretations (in-house interpreters = 87,972 in 12 different languages; External Language Line = 126,595) to over 21,500 patients. The top languages continue to be Spanish, Portuguese, Khmer, Haitian-Creole and Pashto.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal(s)	Ensure community and patient access to evidence-based, culturally tailored education on COVID-19 prevention and other health concerns by delivering as many as 7,000 interpreter-assisted sessions/month, all sources.		
Goal Status	In FY 25, Lowell Community Health Center translated over 70 documents, flyers and/or forms for individual patients and general education postings on health center social media sites. The majority of materials were translated into Spanish, Portuguese, Khmer, with others translated for Arabic, Swahili, and Pashto speakers.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Equitable Access to Care **Program Name: BILH Workforce Development** **Health Issue: Additional Health Needs as Defined by Community (Access to Care)**		
Brief Description or Objective	BILH is strongly committed to workforce development programs that enhance the skills of its diverse employees and provide career advancement opportunities. BILH offers incumbent employees "pipeline" programs to train for professions such as Patient Care Technician, Central Processing Technician and an associate degree Nurse Resident. BILH's Employee Career Initiative provides career and academic counseling, academic assessment, and pre-college and college-level science courses to employees at no charge, along with tuition reimbursement, competitive scholarships and English for Speakers of Other Languages (ESOL) classes. BILH is also committed to making employment opportunities available to qualified community residents through training internships conducted in partnership with community agencies and hiring candidates referred by community programs.	
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)	In FY25, Workforce Development will establish and maintain clinical affiliation agreements with vocational technical high schools to hire young people from the community for cooperative education paid and unpaid internships in nursing assistant, medical assistant, and other hospital-specific positions.	
Goal Status	In FY25, Workforce Development established/maintained 11 clinical affiliation agreements with vocational technical high schools, which resulted in the hiring of 55 high school students in paid cooperative education placements and 20 into unpaid clinical placements. LHMC participated in offering these trainings.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Workforce Development will offer paid trainings for community members across BILH.	
Goal Status	In FY25, BILH trained total of 97 community members to pipeline programs, including Patient Care Technician/ Nursing Assistant, Pharmacy Tech, Medical Assistant, CPT, Surg Tech, Research Admin, Endoscopy Tech, and the Associate Degree Nursing Residency program. LHMC participated in offering these trainings.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Workforce Development will hire interns hired after internships and place in BILH hospitals	

Goal Status	In FY25, 36 interns were hired permanently in BILH hospitals.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Workforce Development will offer internships in BILH hospitals to community members over the age of 18.	
Goal Status	In FY25, 131 community members placed internships across BILH hospitals to learn valuable skills.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Workforce Development will offer English for Speakers of Other Languages (ESOL) classes to BILH employees	
Goal Status	In FY25, 126 employees across BILH were enrolled in ESOL classes.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees.	
Goal Status	In FY25, 12 BILH employees attended citizenship classes, 102 BILH employees attended career development workshops, and 138 BILH employees attended financial literacy classes.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Workforce Development will offer employees career development services.	
Goal Status	In FY25, 831 BILH employees received career development services.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Workforce Development will attend events and give presentations about employment opportunities to community partners.	
Goal Status	In FY25, 42 events and presentations were conducted with community partners across the BILH Community Benefits Service Area.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Workforce Development will continue to encourage community referrals and hires.	
Goal Status	In FY25, 306 job seekers were referred to BILH and 79 were hired across BILH hospitals.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Patient Care Coordination** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	LHMC provides patient care coordination services to help patients navigate the health system by scheduling appointments, coordinating referrals, and addressing logistical or communication barriers. By streamlining these steps and providing proactive outreach, they make it easier and faster for patients to access timely, appropriate care.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	In FY25, the Patient Care Coordinator will help to increase navigation for patients to services within the hospital.	
Goal Status	In FY 25, the Patient Care Coordinator provided 216 new patients with care coordination to 11 services within the hospital.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Addressing BILH Patient Health Disparities** **Health Issue: Additional Health Needs as Defined by Community**		
Brief Description or Objective	BILH Health Equity division sits within the Office of Community and Health Impact. BILH's Health Equity team's focus is on addressing health disparities to ensure equitable health outcomes across the patient populations served by BILH.	
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)	Meet or exceed goal of 69.6% of BILH patients 18-85 years of age with a diagnosis of both diabetes and hypertension who meet control targets for both conditions (HbA1c <= 9.0% AND BP < 140/90 mmHg criteria) during the measurement period ending September 30, 2025	
Goal Status	Goal Met: 70.4% of the focus population met the control targets for both conditions (HbA1c <= 9.0% AND BP < 140/90 mmHg criteria) during the measurement period through September 2025	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcome Goal**
Program Goal(s)	Meet or exceed goal of 74.8% of BILH patients 18-85 years of age with a diagnosis of hypertension whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period ending September 30, 2025	
Goal Status	Goal Met: 75% of the focus population had blood pressure that was adequately controlled (< 140/90 mmHg) during the measurement period	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcome Goal**
Program Goal(s)	Meet or exceed goal of 76.5% of BILH patients 18-85 years of age diagnosed with diabetes (Type 1 and Type 2) who had a hemoglobin A1c (HbA1c) level of <= 9.0% during the measurement period ending September 30, 2025	
Goal Status	Goal Met: The average percentage, of the identified population above, whose hemoglobin A1c (HbA1c) level was <= 9.0% during the measurement period was 78.4% which exceeded the target average goal of 76.5%	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcome Goal**

Priority Health Need: Equitable Access to Care **Program Name: Serving Health Information Needs of Everyone (SHINE)** **Health Issue: Additional Health Needs as Defined by the Community (Access to Care)**		
Brief Description or Objective	LHMC maintains its partnership with Minuteman Senior Services to continue to provide SHINE counselors at the Arlington and Burlington Councils on Aging. 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.	
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 2025, the SHINE counselor will help to provide referrals, assessments, and assistance to individuals in the LHMC community benefits service area.	
Goal Status	Serving Health Information Needs of Everyone (SHINE) experienced a staff transition in April 2025. This was an opportunity to review and update the position description to include 5 hours of weekly onsite benefits counseling at Winchester Center for Cancer Care 5 hours at Arlington Housing Authority and 5 hours dedicated to Lahey Hospital patients/families and patient financial assistance staff. The role was enhanced to include assisting patients with accessing private foundation and pharmaceutical resources including the Healthwell Foundation, PAN Foundation, NeedyMeds, and various rare disease funds. The position also provides MassHealth application assistance to people who are low-income, disabled, and dual eligible for Medicare and Medicaid. SHINE also modified its data collection to capture healthcare costs savings based on benefits applications submitted and cost reductions resulting from insurance plan changes. SHINE improved its ability to serve non-English-speaking recruiting/training counselors who speak Mandarin, Hindi, Spanish, and Portuguese coupled with use of an agency interpreting service for other languages. In Burlington, specifically, SHINE 141 consumers were referred by LHMC or who contacted MSS for support. The Medicare Benefits Specialist also submitted 29 Medicare Savings Program applications for Burlington consumers which represents a cash savings of $87,000	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	Minuteman Senior Services will provide Medicare Benefits Counseling to 650 individuals who reside in Arlington, Burlington and Winchester annually throughout the grant cycle	
Goal Status	Minuteman Senior Services provided Medicare Benefits Counseling to 900 individuals who reside in Arlington, Burlington and Winchester in FY25, achieving its goal of serving 650 beneficiaries.	

Time Frame Year: Year 3	Time Frame Duration: Year 3	Goal Type: Process Goal

Priority Health Need: Equitable Access to Care **Program Name: Peabody Veterans Memorial High School Student-based Health Center** **Health Issue: Additional Health Needs as Defined by the Community (Access to Care)**		
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 Peabody Veteran's Memorial High School Student-based Health Center that meet a critical, identified community need.	
Goal Status	In FY25, the Student-based Health Center had the following impacts: 933 Medical visits (an increase of 80 visits from FY24), 850 Behavioral Health visits (an increase of 139 visits from FY24) and 343 unique clients. 71% of clients were either insured by MassHealth or uninsured, through the Health Safety Net.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
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	In FY25, of the 89 students who were referred to the student-based Health Center for behavioral health services, 16 patients declined or screened out, and 4 patients already had outside behavioral health providers. Providers were able to establish care with the rest through either individual therapy or group therapy. The health center was able to hire a second behavioral health clinician, at the end of October 2025, however the first clinician left North Shore Community Health at the end of May 2025.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Saheli's Community Health Outreach, Engagement and Education** **Health Issue: Additional Health Needs as Defined by the Community (Access to Care)**		
Brief Description or Objective	LHMC partners with Saheli to support, grow and strengthen community-based outreach, engagement and education to communities within its community benefits service area. The project assists residents of these communities through a two-pronged approach: 1) a culturally proficient community health worker also trained as a domestic violence advocate, will improve access and engagement of health and safety services to community residents. The community health worker assesses the client's needs, links households to support, and enhances access to culturally competent care providing trauma informed and survivor-centered services tailored to the goals and needs of the survivor. The community health workers also provide education and engagement with medical and mental health providers, housing providers, and community leaders to raise public awareness about survivors' challenges and improve social acculturation and health access.	
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 2025, Saheli will provide outreach and engagement services to increase cultural awareness for clinicians and the community.	
Goal Status	Outreach and Engagement Services: • Conducted 6 prevention education and public awareness workshops in focus communities. • Engaged with 16 new partners and collaborators through community-based outreach and provide training about trauma-informed culturally appropriate services for South Asian and Middle Eastern or North African (MENA) immigrant survivors and their children. • Reached 514 people in community-based prevention education outreach events and activities. • Saheli has worked with a range of partners to develop training curriculum and materials for providers and stakeholders targeted to the unique cultural characteristics and needs of target populations.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	By September 2025, Saheli will provide supportive housing services to program participants through the community health outreach worker.	
Goal Status	• Increased number of survivors who contacted for services by 50%.	

	• Helped 67 survivors stabilize their housing and/or secure permanent housing. • 303 clients received case management and supportive services. • 44 clients received one-on-one therapeutic counseling. • 44 clients participated in group therapy sessions. • 29 clients obtained employment and/or enrolled in training/education programs. • 26 survivors participated in economic empowerment program, set educational and employment goals and attend financial literacy education. • 59 survivors received legal and/or immigration services.

Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Community Benefits Administration and Infrastructure **Program Name: Community Benefits Administration & Infrastructure** **Health Issue: Chronic Disease, Mental Health/Mental Illness, Housing Stability/Homelessness, Substance Use, Additional Health Needs (Food Insecurity and Access to Care)**		
Brief Description or Objective	Community Benefits and Community Relations staff implement programs and services in our Community Benefits Services Area, encourage collaborative relationships with other providers and government entities to support and enhance community health initiatives, conduct Community Health Needs Assessments and address priority needs and ensure regulatory compliance and reporting. Additionally, Community Benefits and Community Relations staff at BILH hospitals work together and across institutions to plan, implement, and evaluate Community Benefits programs.	
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions	☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits
Program Goal(s)	Implement effective and efficient programs that support the community health needs of the Community Benefits Service Area.	
Goal Status	LHMC supported and implemented 32 programs and granted over $300,000 to local organizations in FY25.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	Offer evaluation capacity workshops to partner organizations and grantees to better understand impact.	
Goal Status	BILH offered five (5) evaluation workshops in FY25 focusing on data collection, analysis, interpretation, reporting and storytelling, with 96% of attendees reporting increased knowledge.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: LHMC Internship Programs** **Health Issue: Additional Health Needs as Defined by Community (Workforce Development)**			
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)	In FY25, LHMC will provide clinical-based education opportunities to help strengthen the local workforce.		
Goal Status	In FY25, LHMC provided 2 internships for students in Diagnostic Ultrasound. LHMC Nuclear Medicine provided 2, 3-month internships for Regis College Nuclear Medicine students. LHMC Radiologic Technology program had 8 graduating second years, 6 were hired. LHMC Radiologic Technology had 6 first years. LHMC also added one online program to the portfolio in Diagnostic Radiology and provided a summer practicum.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Social Determinants of Health **Program Name: LHMC Transportation Program** **Health Issue: Additional Health Needs as Defined by Community (Transportation)**		
Brief Description or Objective	LHMC offers a variety of services to help reduce transportation-related barriers and increase access to care, including providing free parking vouchers to older adults.	
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)	In FY25, LHMC will work to reduce barriers to healthcare access for older adults by offering free parking to support easier, more reliable access to care.	
Goal Status	In FY25, LHMC provided 19,696 parking validations for older adults.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Mill City Grows Community Gardens Program** **Health Issue: Additional Health Needs as Defined by Community (Access to Healthy Food)**		
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 households with incomes below the federal poverty level, older adults, and foreign-born persons. Historically underserved 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 will increase produce consumption because of community gardening.	
Goal Status	In FY25, 217 households participated in MCG's Community Garden program throughout Lowell and 95% reported eating more fruits and vegetables (compared to 86% in 2022).	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal	75% of youth participants in school-based programming will experience new foods and 60% will state a willingness to incorporate these foods into their diet.	
Goal Status	Surveys from 197 youth indicate positive outcomes; 98% enjoyed the program and tried new foods during the program. 94% of them would try these new foods again.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal	By June 2025, establish a new community garden in the Pawtucketville neighborhood of Lowell with at least 30 new beds.	
Goal Status	In May 2025, over 30 volunteers and MCG staff-built garden beds in the Pawtucket Farm Wildlife Sanctuary (PFWS) Community Garden which has 20 beds currently, with additional accessible beds being added in 2026.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Program Goal	By September 30th, 2025, enroll 450 gardeners in 8 gardens.	
Goal Status	Mill City Grows added a ninth garden in 2025 with 20 active beds, and 658 gardeners were active in the program with 90% of garden beds enrolled.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	In FY25, Mill City Grows will increase community members' sense of social connections and increase the sense of shared space in the community gardens.	
Goal Status	Social connections continue to be a priority for the Community Garden team and gardener surveys indicate: • 90% are getting more outdoor exercise • 90% actively used/visited their garden bed • 97% have formed social relationships with fellow gardeners • 80 people participated in Garden Education workshops during the grant period.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	Mill City Grows will improve access to fresh, local food for Lowell youth through afterschool programs, widening the variety of produce and veggies offered to students.	
Goal Status	632 youth brought home 1,700 lbs of food home via after school programs at 5 Lowell Public schools, including Mobile Markets and cooking classes.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Merrimack Valley Food Bank (MVFB) Community Market Program** **Health Issue: Additional Health Needs as Defined by Community (Access to Healthy Food)**		
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 Lowell Housing Authority 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 ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	In FY25, Merrimack Valley Food Bank will hold a free "farmer's market" - style food distribution at nine public housing sites in Greater Lowell, monthly/ The market will distribute over 25,000 pounds of fresh, minimally-processed fresh fruits and vegetables, to support residents' health and well-being make food distribution accessible by delivering and distributing food at a central location within each housing complex. MVFB will also provide certified assistance with SNAP (Supplemental Nutrition Assistance Program) applications and renewals, for residents at each site and achieve positive evaluation of this program by residents and by public housing site managers.	
Goal Status	MVFB added an additional site in Lowell (City View Towers) to the Community Market in 2025 bringing the total markets to nine and increased distribution of culturally familiar fruits and vegetables, as appropriate for each site through June-November, serving 442 residents over 25,000 pounds of food. Food distribution was accessible at each site at a convenient location for resident, providing help for those with disabilities, and resident choice of food. MVFB also offered certified assistance with SNAP (Supplemental Nutrition Assistance Program) applications and renewals and added SNAP application/renewal assistance at each Community Market.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Council on Aging Farmers Market Program** **Health Issue: Additional Health Needs as Defined by Community (Access to Healthy Food)**		
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 older adults per week from June through October. On average, participants took home 6 varieties of fresh, local produce each week.	
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, 2025, participants will report an increase in their daily intake of fruits and vegetables.	
Goal Status	97 program participants (55%) completed the 2025 Season's survey. Arlington had 4 participants complete the survey, Billerica had 49 and Burlington had 44, all with a mean age of 78 years old. Survey results showed that 89.9% ate a greater variety of fruits and/or vegetables, 85.52% increased their daily intake of fruits and vegetables, and 87.13% ate better quality produce. A weekly newsletter featuring nutritional information and recipes for fruits and vegetables was created and distributed with the produce.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	By September 30th, 2025, the program will provide fresh fruits and vegetables to a cohort of 50-80 older adults per week in Arlington, Billerica, and Burlington.	
Goal Status	Arlington COA received produce for 60 recipients from New Entry for 20 weeks. The produce bags weighed 3-7 lbs. and valued $17.50 each including 2-3 lbs. gleaned produce per week added for 17 weeks at no cost. Over 20 weeks, 1,200 produce shares were distributed for a total of 6,000 pounds. Burlington COA received produce for 50 recipients from New Entry for 20 weeks. The produce bags weighed 3-7 lbs. and valued $15 each including 2-3 lbs. gleaned produce per week added for 17 weeks at no cost. Over 20 weeks, 1,000 produce shares were distributed for a total of 5,000 lbs. The Billerica COA received produce from New Entry for 65 recipients for 20 weeks. The produce bags weighed 3-7 lbs. and valued $15 each including 2-3 lbs. gleaned produce per week added for 17 weeks at no cost. Over 20 weeks, 1,300 produce shares were distributed for a total of 6,500 lbs. Total pounds provided through Farmers Markets = 17,500 lbs. Total produce shares served through Farmers Markets = 3,500	

	Total people served through Farmers Markets = 175

Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: Cooking Up Good Health** **Health Issue: Additional Health Needs as Defined by Community**		
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 nutritional 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)	By September 30th, 2025 LHMC will provide nutrition education for 10 participants per session.	
Goal Status	In FY 25, LHMC held twelve classes attended by an average of 10 people per class.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Affordable Housing, Family Stability and Tenant Support in Arlington** **Health Issue: Housing/Homelessness**	
Brief Description or Objective	LHMC partners with the Housing Corporation of Arlington (HCA) to provide an integrated set of social service programs that provide affordable housing, prevent homelessness, connect families to vital resources, and help people with incomes below the federal poverty level develop as leaders so that they may advocate for themselves and their 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)	By October 2025, the HCA Tenant Council will increase the number of active households.
Goal Status	In October 2025 the Tenant Council held its second accountability session with members of HCA's property management firm. The first session led to improvements in the policy for notifying tenants when management needs to access an apartment for a non-emergency reason. This session focused on the next set of priority tenant concerns. Property management agreed to: • Provide written information for tenants regarding trash pick up days and what to do if the private trash collection vendor does not come • Return all calls and emails within 2 business days • Notify all residents via mail or by posting notices on apartment doors when there are changes in property management staff or to the maintenance staff. • Provide a written summary of internal protocols so that tenants are aware of how things work, such as for the process for responding to work orders, and completing annual tenant income recertification. These new agreements and policies will be combined into one document for all tenants and management staff to access. Between May 2025 and October 31st, 44 total households were active with the Tenant Council activities, bringing the total number of households who have been active to date up to 50. Between May and October, HCA held 5 coffee hours, which are casual conversations in the homes of tenants, who invite their neighbors from their building to attend. There is no strict agenda, but opportunities to get involved with the Tenant Council are shared.

	9 HCA tenants completed a Resident Training presented by the Mel King Institute. All participants reported increased learning and felt better prepared to help engage, organize, and lead their fellow tenants. Since the start of the 3-year grant period, 4 HCA tenants and one low-resourced tenant who is not in HCA's housing joined the HCA board.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	Prevent homelessness and create more stable tenancies for at least 45 unique Arlington families per year (at least 135 over 3 years) who are at near-term risk of homelessness through the provision of homelessness prevention grants. At least 80% of grantees will remain stable in their homes for at least 18 months after they have received assistance.	
Goal Status	In the 6 months between May 2025 and October 2025, HCA made 23 Homelessness Prevention grants, providing a total of $51,359 in grants that supported back rent, security deposit or moving expenses to help families who were very low-resourced and at risk of losing housing to remain stably and housed. From January 2023 through October 2025, a total of $279,463 in grants was provided to 136 households. Approximately 85% of grantees who have received a grant at least 18 months prior have remained in stable housing. Other grantees have returned for more assistance. In some cases, HCA has provided additional financial assistance. In all cases, HCA provided other kinds of services to help families get back to stability.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	Support an additional 100 families per year who are seeking help in resolving urgent financial, housing, employment, or other issues through the provision of direct social services and referrals to ensure they do not fall into facing the risk of homelessness. provision of direct social services and referrals, to ensure they do not fall into facing the risk of homelessness.	
Goal Status	Between May 1, 2025 and October 31, 2025, HCA provided direct social services and referrals to 48 households (not counting those who also received an HPP grant). Assistance ranged from: getting on HCA's waiting list or other waiting lists for affordable housing; applying for RAFT rental assistance when funds needed exceeded HCA's Homelessness Prevention Program guidelines; applying for SNAP food benefits; getting a referral to use the Arlington EATS food pantry; applying for unemployment benefits; applying for social security or disability benefit; hoarding or in-home safety services, negotiating with landlords to delay or prevent eviction; referrals for employment services, fuel assistance, legal /eviction services, senior services from the Arlington Council on Aging, and assistance transferring	

	housing voucher benefits to the other adult in the household after the voucher holder passed away. HCA reached a total of 242 families over the 3 years, not including HPP clients.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Community Teamwork Inc. (CTI) Secure Jobs Program** **Health Issue: Housing/Homelessness**		
Brief Description or Objective	LHMC, through its Community-based Health Initiative, is supporting the Secure Jobs Program at CTI. The program provides job readiness skills training, eliminates barriers to employment and connects families with suitable employers in jobs with defined career paths. The program provides job training, job search services and a year of stabilization services for participants. In addition to providing clients with personalized employment services, Secure Jobs staff works with the client to remove barriers to success by linking participants with childcare resources, transportation to and from training programs, helping navigate options for people who have challenges with CORIs, and providing skills training, job readiness training, and job search services spiritual and mental wellness.	
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)	Participants increase in ability to maintain a budget for at least three months	
Goal Status	This goal is in progress: Secure Jobs is working on creating budgeting timelines with the clients who secured a HomeBase voucher and safe housing. This past year, many families had the barrier of not just finding a job but also a home.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	Participants increase their employability through job readiness as demonstrated by the reduction or elimination of barriers, acquisition of soft and hard job skills, and/or training.	
Goal Status	Fifty five (55) participants have been enrolled in the program and weree employed. One of the most common barriers was language; 44 participants enrolled in ESOL classes and 48 completed a training.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	Participants increase their employability through job readiness as demonstrated by the reduction or elimination of barriers, acquisition of soft and hard job skills, and/or training.	
Goal Status	Forty-eight (48) clients completed a training that led to employability.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	Secure Jobs Graduates increase their income in the first year of employment.	
Goal Status	Seven (7) clients increased their income.	

Time Frame Year: Year 2	Time Frame Duration: Year 3	Goal Type: Outcome Goal
Program Goal(s)	Secure Jobs graduates maintain employment for 90 days.	
Goal Status	Of the 55 clients who secured employment, 48 had maintained their job for 90 days.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	Secure Jobs graduates obtain safe and affordable housing that they can maintain with their income.	
Goal Status	Twenty-four families (24) secured housing.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	Secure Jobs participants increase in ability to establish and maintain savings accounts	
Goal Status	This has been a challenge for the program. Most of the Haitian Immigrants send money back to their families remaining in Haiti. This upcoming year, CTI will continue to provide financial education, financial coaching to assist the families in knowing how important saving is.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	Secure Jobs graduates obtain sustainable employment in the first year	
Goal Status	Fifty-five (55) clients secured employment	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: The Resource Center at Citizens Inn** **Health Issue: Housing/Homelessness**	
Brief Description or Objective	To support increased access to economic access for individuals to maintain stabilized housing, Lahey supports the Resource Center at Citizens Inn, which offers direct services and referrals aimed at removing the barriers to housing and food security. Citizens Inn has been supporting families to successfully transition to stable housing for over 41 years and have learned that families who are homeless or food insecure face many other barriers to stability, and that homelessness prevention requires a comprehensive approach. The Resource Center addresses obstacles to financial security by offering a range of direct services and referrals, including SNAP assistance (food stamps), digital access (internet hotspots), English as a Second Language classes, support to obtain drivers' licenses for qualified immigrants, financial literacy and counseling, access to health services and referrals to housing, rental, and utilities assistance.

	It is designed to be a community resource, open to all in need, to connect individuals and families to 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)	In FY25, Citizens Inn's housing stabilization team will offer case management to families exiting its emergency shelters and partner with Peabody Housing Authority, Eliot Services and North Shore Community Action Programs to assist participants in finding or maintaining housing.
Goal Status	In FY25, over 30 families that exited shelter were provided services from the stabilization team with monthly checkups to ensure the families are maintaining their new housing situation. Citizens Inn also partnered with the Peabody Housing Authority to support families at risk of eviction to maintain housing by assisting them with resources including applications to utilities and rental assistance (RAFT) and utilities assistance. Citizens Inn also continued its partnership with Eliot Community Health Services to refer individuals who were chronically unhoused for mental health services and housing assistance.
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	The Resource Center will provide supportive services for clients focused on comprehensive services and referrals tailored to the needs of individuals and families experiencing homelessness, food insecurity, and economic instability.
Goal Status	Citizens Inn partnered with the Peabody School System to help families achieve food security and raise awareness of available resources. In FY25, the Resource Center connected over 120 families with SNAP benefits. They also created a new position, Community Outreach Specialist to assist with both direct services (SNAP benefits, digital access and literacy, driver's license support) and referrals to housing, employment, fuel assistance, and legal aid, among others. They assisted over 300 families with direct services and/or referrals. and offered English as a Second Language classes focused on employment readiness for participants in the Emergency Assistance Family Shelter. Classes were lead in English twice a week, with participants whose primary languages included Spanish, Haitian Creole, Portuguese, and Arabic. Citizens Inn also launched a Food as Medicine pilot program in partnership with North Short Community Health, who offered on-site virtual visits with a healthcare provider on Friday mornings.
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington Council on Aging Outreach Workers** **Health Issue: Mental Illness and Mental Health**		
Brief Description or Objective	LHMC partners with the Burlington Council on Aging on social workers that provide outreach to older adults within 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)	By September 30th, 2025 provide referrals for program clients to supportive services.	
Goal Status	Outreach workers had 4,672 encounters in FY25, an increase from 4,116 encounters in FY24. There was also an increase in the number of people served from 818 in FY25 from 691 in FY24. (including family members or caregivers). Social workers made 796 referrals in FY25, an increase from 679 referrals in FY24. Referrals were made 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 outreach workers for ongoing case management.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington Police Department Substance Use Coordinator** **Health Issue: Substance Use**			
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)	By September 31st, 2025, provide referrals and supportive services to persons with substance use disorder.		

Goal Status	• Number of individuals contacted for substance use coordinator: 16
	• Number of referrals who accepted services: 13
	• Demographics of people served:
	  o By gender male 6 & female 10
	  o By age 15 to 19 = (1), 20 to 39 = (8), 40 to 59 = (4), 60+ = (3)
	
	The substance use coordinator left in August 2024 so essentially there was no substance use coordinator for FY2025. New staff absorbed as much of this role as possible, taking on substance use referrals from the department as needed.
	
	In addition, staff toured multiple recovery facilities in the area and attended community meetings with stakeholders in the addiction and recovery field to be able to learn about the resources available for our community. The substance use case numbers would have been higher had there been a substance coordinator for the full year.		

Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Greater Lowell Health Alliance: ស្មារតី Empowered Cambodian Elders Promoting Whole-self Wellness** **Health Issue: Mental Illness/Mental Health**		
Brief Description or Objective	LHMC, through its Community-based Health Initiative, supports increased access to mental health and supports through the Khmer Older Adult Action Group (KOAAG)/Seniors in Action (SIA), which engages older adults as paid community ambassadors to identify community needs and implement interventions. The program will be led by Cambodian outreach workers and the KOAAG will operate under an empowerment model, with community norms, meeting procedures, and group initiatives being determined by the KOAAG. The primary driving force behind this project will be the inherent value in community convening to reduce isolation, support empowerment, and create self-determining communities through honoring the cultural linkages of spiritual and mental wellness.	
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)	The KOAAG/SIA will maintain at least 8 consistently active members who are representative of their elder Khmer peers who attend at least 1 meeting monthly.	
Goal Status	11 members attended monthly meetings	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	Between June 2024 and June 2025, the KOAAG/SIA will host at least 4 community events, trainings, or educational sessions, or produce and distribute at least 3 Khmer-language resources (flier, brochure, video, etc.) for the elder Cambodian community that address mental health and/or the factors that drive mental health needs in the Cambodian community.	
Goal Status	3 community trainings were held and 4 community events were hosted (Preleugn Remembrance, Pride, SEA Waterfest, Health Fair/vaccine clinic) with an estimated community reach of 6700 individuals.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	Elder Asian participants in the 2025 Community Health Needs Assessment will report an increase in reporting that there are opportunities for them to engage in their community and make their voices heard (Q. 26, 2022 Baseline: 38.5%), that their overall mental health is better than the year before (Q.27, 2022 Baseline: 26.6%), and a decrease in the percent of participants reporting not being able to afford mental health care (Q.35,2022 Baseline: 6.4%).	

Goal Status	Reporting better mental health: 30.1% in 2022, 34% in 2025; Self-reported MH issues: 32% in 2022, 40.4% in 2025; Unable to access MH services: 14.3% in 2022, 14.4% in 2025. Reported metrics include a short form of both the DeJong Loneliness Scale and the Lubben Social Network Scale. Participants completed the scales at the start of the project and repeated them at the end of year 1. The results showed a 13.6% decrease in loneliness and a 23.4% increase in social networks, suggesting meaningful impacts on participant mental wellbeing.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Torigian Family YMCA Youth Mental Health and Substance Use Prevention Program** **Health Issue: Mental Illness/Mental Health**		
Brief Description or Objective	LHMC, through its Community-based Health Initiative, supports the Torigian YMCA's Association Behavioral Analyst position, which provides in-house support to the increasing number of youth exhibiting mental health and behavioral support needs across the Association's childcare programs. A part-time Teen Mentor/Program Director also support teens at the Torigian Y and direct them towards targeted activities. The YMCA also provides financial assistance to low-resourced families to enable their children to attend childcare programs in order to help to increase access to critical social-emotional skills.	
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)	Financial assistance will be provided by the YMCA to ensure the 40% of YMCA families who are low-resourced are able to access Y programs and services, including the behavioral health supports.	
Goal Status	$89,979 in financial assistance was distributed from May to October for families to attend childcare programs (Y Academy and Camp).	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	The Behavioral Analyst will provide mental and behavioral health support and referrals to the over 1,000 youth across the Torigian Family YMCA childcare programs.	
Goal Status	796 individuals have been provided with mental and behavioral health support and referrals. The YMCA added a Youth & Family Social Worker at the end of August to fulfill the mental and behavioral health support role and also promoted the former Camp Director to a Senior Director of Youth Development role to fulfill theTeen Director role to support teen programming. Additionally, the YMCA hired an Inclusion Specialist to support the over 600 campers served in the summer.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	60 YMCA staff will be trained in Youth Mental Health First Aid in Year 2 so that they are able to identify, understand, and respond to signs of mental health and substance use challenges among children and adolescents ages 12-18.	
Goal Status	50 additional staff have been trained in (110 total) in Youth Mental Health First Aid	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington Youth & Family Services** **Health Issue: Mental Illness/Mental Health**		
Brief Description or Objective	LHMC partners with Burlington Youth & Family Services to provide funding to support residents of the Town with comprehensive mental health services for youth and families.	
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, 2025, Burlington Youth and Family Services will provide comprehensive supportive mental health services to youth and families in Burlington.	
Goal Status	• Number of annual visits: 3,235 • Number of referrals: 281 • Number of trainings: 4 • Number of support groups and individuals served through support groups: 12 groups, and 120 attended.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington High School Adjustment Counselor** **Health Issue: Mental Illness/Mental Health**		
Brief Description or Objective	LHMC partners with Burlington High School to provide support for an onsite adjustment counselor for preventative and supportive services for students identified to be at high risk for mental health disorders.	
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, 2025 Burlington High School will provide social and emotional support services to students through the adjustment counselor services.	
Goal Status	71 students were provided referrals and access to emotional support services through the adjustment counselor in FY25.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: The Center for Hope and Healing, Inc (CHH): Reducing Barriers for Underserved Sexual Assault Survivors** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	This program is designed to provide capacity-building to Center for Hope and Healing (CHH) staff on culturally sensitive approaches to support historically underserved survivors of sexual assault and to fund culturally relevant resources and supplies for in-person support groups including Khmer, English, Spanish, Portuguese and male survivors.	
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 1, 2025, the CHH Survivor Services team will host 12-week in-person support groups (5 groups) such as Spanish, Portuguese, Khmer, English, and Male Survivors. The 5 support groups will be held twice a year - in the Spring and Fall. By the end of the grant period, 30 support groups will be held and have supported at least 200 survivors.	

Goal Status	During this reporting period, CHH served 51 survivors in the community through various support groups and Healing series and provided 114.92 hours of direct services through 6 support groups and 30 sessions, including: • Cultivating Hope, support group for English-speaking survivors (7 sessions) Tudo Bem Mesmo?, support group for Portuguese-speaking survivors (6 sessions) • GLADLY, group for youth who identify as LGBQ/T+ (9 sessions) • Healing Circles: Construyendo Puentes, Spanish-speaking support group (3 sessions) • Healing Circle: Surviving to Thriving (Survivor-led support group), (4 sessions)		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal(s)	The Survivor Services Manager will hire a Vicarious Trauma consultant to deliver a 12-week program to provide techniques and support to CHH's 6 counselor staff.		
Goal Status	CHH has worked closely with its consultant to provide weekly clinical supervision to its counselor staff. Clinical supervision is also held monthly with all staff. The consultant also provided Resilience Session trainings to support all staff in building resilience, accountability and commitment toward their wellness by providing direct services to survivors. This Resilience Practice is being held quarterly. This consultant provided trauma training in August 2025 to all-staff and a group of survivors (separately) focused on identifying various approaches to group therapy, skill building around hosting healing spaces, grounding and self-regulation as facilitators, and after care when sessions are increasingly challenging. The goal was to better equip them to facilitate group spaces themselves.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Place of Promise Long-Term Residential Addiction Recovery Program** **Health Issue: Substance Use**			
Brief Description or Objective	LHMC partners with Place of Promise to provide support for their adult long-term residential addiction recovery program. One-on-one counseling sessions include medical and clinical counseling, chronic illness management, and mental health counseling. The goal of the program is to prepare residents with the tools and skills to return to their homes and communities to live productive lives free from addictions, and to provide them with ongoing support when needed.		
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)	In FY2025, 45 men/women will be served in the Level I and II program.		
Goal Status	Result (10/1/23 – 9/30/25): 45 Served		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	
Program Goal(s)	Within 10 months of program start, 50% of Residents will be I-9 Ready (i.e., necessary documentation to enter work force or attend school)		
Goal Status	Result (10/1/24 – 9/30/25): Of the 45 served during this time period, 37 have gotten the necessary ID's (82%).		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	
Goal Status	Within 3 months of program start, 75% of Residents will have attained medical insurance, been seen by Primary Care Physician, and have a care plan established.		
Program Goal(s)	Result (10/1/24 – 9/30/25): Of the 45 individuals (84%) served during this time period, 38 attained medical insurance, had been seen by a Primary Care Physician, and had a care plan established.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Behavioral Health Navigation - City of Peabody Department of Social Services** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	To support increased access to mental health and substance use services and supports, LHMC participated with other BILH hospitals to pilot community-based Behavioral Health Navigator grant programs, including one with the Peabody Department of Social Services. The project aims to connect Peabody residents with a bilingual Care Coordinator who will conduct outreach to individuals during the grant period and provide referrals, providing case management and service connections for 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 June 2027, recipients of community educational activities will demonstrate increased knowledge and awareness of available behavioral health services and support.	
Goal Status	In FY25, the navigator participated in 17 community education events, has identified 12 partner organizations they are actively working with, and has had 28 partner meetings with the goal of raising awareness.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	By June 2027, the community-based Behavioral Health Navigator model will demonstrate success in connecting individuals experiencing mental health and/or substance use issues from the selected priority cohort(s) to appropriate behavioral health referral, screening, assessment and treatment services and supports.	
Goal Status	In FY25, 31 individuals were referred to the program through a variety of sources, including the Peabody Policy Department, acquaintances, and local social service agencies. Those individuals were screened and provided with referrals to numerous agencies including SNAP benefits, behavioral health providers and insurance benefits.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Facilitating Access to Behavioral Health Services and Supports** **Health Issue: Mental Health/Mental Illness and Substance Use**			
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)	By September 2025, provide services to increase access to behavioral health services.		
Goal Status	In FY25, 95 women and 218 children were provided 5,470 bed days in the Hart House.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal(s)	To increase access to mental health services by expanding the Collaborative Care Model (CoC) to additional communities throughout the community benefits service area.		
Goal Status	Provided CoC at 6 primary care practices within LHMC CBSA serving over 2,900 patients.		
Time Frame Year: Year 3	**Time Frame Duration: 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 and Substance Use**			
Brief Description or Objective	LHMC, along with all hospitals in the BILH system, provides 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 crises. 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)	By September 30th, 2025, 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 247 individuals at Lahey Peabody and 846 in Lahey Burlington in FY25.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Trauma Support Group** **Health Issue: Mental Illness/Mental Health**		
Brief Description or Objective	LHMC provides a free, monthly support group for individuals and their families who are recovering from a traumatic injury to help them in their recovery, resilience-building, and identifying resources for support.	
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 to patients and community members	
Goal Status	LHMC provided 11 sessions of a support group for survivors of trauma. On average there were 1-4 participants per session. The total number of participants for the year was 17. LHMC also sent out 21 information packets per month to our Trauma Survivors. The packets included an invitation to join the support group as well as information on the programs offered by the Trauma survivors Network. This year LHMC began utilizing the Epic Portal, MyChart, for patient communication. Those patients who did not have access to my Chart were mailed the information packets.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: LHMC Medication Disposal Program** **Health Issue: Substance Use**			
Brief Description or Objective	LHMC provides a 24 hour a day, 7 days a week medication disposal kiosk 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)	By September 30th, 2025, LHMC will provide a free, accessible disposal box for community residents to safely dispose of expired or unused medications.		
Goal Status	In FY 25, LHMC collected and safely disposed of 1,160 pounds of medications.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington High School Wellness Day** **Health Issue: Mental Illness/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, 2025, 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 - 863 • Number of staff who participated -144 • Number of vendors/workshops offered - 152 session offered	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: BILH Behavioral Health Access Initiative** **Health Issue: Substance Use Disorder, Mental Health/Mental Illness and Additional Health Needs (Access to Care)**		
Brief Description or Objective	To support increased access to mental health and substance use services and supports, LHMC participated with other BILH hospitals to pilot Behavioral Health Navigator grant programs, offer Mental Health First Aid (MHFA) trainings, provide behavioral health navigation and digital literacy trainings to BILH physical health navigators and amplify anti-stigma messaging, resources and supports.	
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒ Total Population or Community-Wide Interventions	
Program Goal(s)	Offer Mental Health First Aid (MHFA) training to community residents and BILH staff across the BILH Community Benefits Service Area (CBSA).	
Goal Status	More than 146 community residents and BILH staff attended one of 11 MHFA trainings (9 Adult and 2 Youth, with 1 of the Adult trainings conducted in Spanish) provided across the BILH CBSA, of which 53% (78) completed all pre- and post-training requirements to receive Mental Health First Aid certification.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	Increase knowledge and awareness of available behavioral health services and support among clinical and non-clinical staff who provide patients/clients with physical and/or social determinants of health navigation services.	
Goal Status	Two (2) Behavioral Health Navigation and Digital Literacy workshops were conducted in FY25 with 13 participants, including RNs, CHWs/Navigators, Social Workers and a Housing Case Manager. In the program evaluation, 82% of participants felt confident to help navigate patients to appropriate behavioral health care and 70% felt confident to guide patients to web-based apps to help them meet their behavioral health needs.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Burlington Diabetes Care Program** **Health Issue: Chronic Disease**	
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 ☒Access/Coverage Supports ☐Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐Total Population or Community Wide Intervention
Program Goal(s)	By September 30th, 2025, provide education, support, and intervention for persons with diabetes.
Goal Status	Demographics of people served: • Eligible 49% female 51% male • Enrolled 21% female 55% male • Adherent 44% female 50% male Number of people served: • 86 members with diabetes • 33 members enrolled in the program • 19 members adherent in the program High Risk Population: • 16 members identified as high risk • 14 members enrolled in the program • 11 members adherent in the program Changes perceived as a result of the program through survey responses: • 80% agree - I have a better understanding of how to manage my diabetes • 80% agree - I am feeling healthier • 80% agree - My A1C has improved • 80% agree - I am testing my blood sugar more regularly • 80% agree - I am taking my diabetes medication more regularly • 40% agree - I am keeping in touch with my doctor more often Percentage of clients achieving individual goals: • 80% - Improve Diet • 80% - Lose Weight

	• 40% - More active lifestyle • 60% - Manage Stress • 40% - Regular contact with my doctor • 40% - Adherence to prescribed medication

Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	By September 30th, 2025, the program will improve A1c3 of 25% of participants.	
Goal Status	Percent improvement A1C: • 53% of the program participants that shared their initial A1c vs most recent had a reduction in A1C • 36% of program participants maintained a healthy A1C of 6.5 or below	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Burlington Council on Aging Memory Cafe** **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)	By September 30th, 2025 the Council on Aging will provide support through the Memory Cafe to 15 participants per class.	
Goal Status	64 clients were served by this program in FY 25, generally 30 participants per class.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Burlington Council on Aging Exercise Classes** **Health Issue: Chronic Disease**		
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 FY25, LHMC provided funding to the Burlington Council on Aging for a Senior Stretch program for a 52-week exercise program. Overall, the classes served 308 older adults in Burlington for a total of 13,226 sessions.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: YMCA Enhance Fitness Classes** **Health Issue: Chronic Disease**		
Brief Description or Objective	LHMC partners with the Greater Boston and Metro North YMCAs 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, 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)	By May 30th, 2025, certify two additional instructors to increase program sustainability and offer an offsite instructor available by the second program session.	
Goal Status	Two additional instructors were hired and trained to run the program by May 30, 2025.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	To increase participation in the Enhance Fitness program by 5 new unique (non-recurrent) participants by September 30, 2025.	
Goal Status	16 new unique participants were served by this program since FY24.	

Time Frame Year: Year 3	Time Frame Duration: Year 3	Goal Type: Outcome Goal
Program Goal(s)	To positively affect the lives of older adults by delivering the Enhance Fitness Program resulting in an average 75% improvement in participant mobility by the end of 16-week sessions.	
Goal Status	67% of participants demonstrated improvement in physical assessments from September 2024 to June 2025.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal(s)	By September 1st, bring programming off-site to Chelsea Jewish with a goal of serving 25 individuals.	
Goal Status	25 individuals were served through a partnership with Chelsea Jewish, although they preferred to bring the seniors to the YMCA facility for the classes. Metro North YMCA also held a successful event in the fall to reach different communities.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	To decrease the number of repeat participants in the program, graduating them to more advanced classes.	
Goal Status	5 program participants graduated from the prior session to additional classes.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Tai Ji Quan: Moving for Better Balance** **Health Issue: Chronic Disease**		
Brief Description or Objective	Tai Ji Quan: Moving for Better Balance is an evidenced-based fall prevention program designed to help and improve balance as well as core strength. The program combines elements of Tai Ji with sensory and motor balance training to increase strength, improve balance & function. The program is for individuals who are able to ambulate within the community (with or without an assistive device), stand without hand support, and possess the cognitive ability to safely understand directions. The class meets 2X/week for 1 hour for 24 weeks for a total of 48 sessions.	
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, 2025, LHMC will conduct 48 classes of Tai Ji for the community.	
Goal Status	Nine participants began the program in October 2024. Of those, seven completed the full 46-session program by attending at least 75% of sessions. One participant did not complete the program, and another withdrew due to	

	medical issues. Participants ranged in age from 65 to 81, and the group included seven females and two males. A spring session was started and 17 sessions were completed; 4 participants participated but the program was discontinued due to anticipated decrease in participation over the summer months.

Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Bone Health & Falls Prevention Programs** **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)	By September 30th, 2025, LHMC will 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 Orthopedic Specialty Classes. QR codes were added to the flyers for easy and efficient self-registration. Nursing contact hours were awarded to nurses who attended the two-hour Bone Health Education session to expand patient education by knowledgeable healthcare professionals.
Goal Status	LHMC provided 5 classes with a total of 28 participants in FY25. 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 the 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.

Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: A Matter of Balance** **Health Issue: Chronic Disease**		
Brief Description or Objective	LHMC provides A Matter of Balance (MOB) which is specifically designed to reduce fear of falling and increase activity levels among older adults. The program includes eight two-hour classes presented to 8-12 participants and led by trained coaches. This program sets goals for increasing activity levels, encourages small changes to reduce fall risks at home, and teaches exercises to increase strength and balance.	
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 20th, 2025, LHMC will offer two sessions of A Matter of Balance Falls Prevention Program.	
Goal Status	LHMC offered two sessions of A Matter of Balance in FY 25. 100% of program participants reported a decreased risk of falls. Two coaches classes were held in October 2024 and January 2025 with a total of ten new coaches added to support community-based Matter of Balance programs.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **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 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)	By September 30, 2025, LHMC will 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 FY 25, Oncology Navigators assisted 10-15 patients per day and provided referral and supportive services.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Cancer Programs Screening and 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.		
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, 2025, LHMC will identify persons who may be at a higher risk for breast cancer and provide screening follow-ups to their physicians		
Goal Status	In FY 25, LHMC completed 11,313 risk assessments for 11,071 unique individuals. 13% of patients screened were identified as having a high lifetime risk of breast cancer and 27% were identified as having a high-risk mutation.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

SECTION V: EXPENDITURES

Item/Description	Amount
CB Expenditures by Program Type	
Direct Clinical Services	9,093,205
Community-Clinical Linkages	$1,131,337
Total Population or Community Wide Interventions	$1,856,344
Access/Coverage Supports	$3,344,940
Infrastructure to Support CB Collaborations	$90,244
Total Expenditures by Program Type	$15,516,070
CB Expenditures by Health Need	
Chronic Disease	$5,754,334
Mental Health/Mental Illness	$3,299,470
Substance Use Disorders	$519,485
Housing Stability/Homelessness	$227,306
Additional Health Needs Identified by the Community	$5,715,476
Total Expenditures by Health Need	$15,516,070
Leveraged Resources	
Total Leveraged Resources	$197,417
Net Charity Care Expenditures	
HSN Assessment	$6,649,474
Free/Discounted Care	N/A
HSN Denied Claims	$3,039,786
Total Net Charity Care	$9,689,260
Total CB Expenditures	$25,402,747

Additional Information	
Net Patient Services Revenue	$1,264,384,458
CB Expenditure as % of Net Patient Services Revenue	1.79%
Approved CB Budget for FY26 (*Excluding expenditures that cannot be projected at the time of the report)	$20,882,376

Bad Debt	**$7,114,388**
Bad Debt Certification	**Yes**
Optional Supplement	
Comments	LHMC is subsidizing behavioral health services outside of its CBSA.

SECTION VI: CONTACT INFORMATION

Michele Craig
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Burlington, MA 01803
617-334-2454
michele.craig@bilh.org

SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update 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:

While Lahey Hospital & Medical Center oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Community and Health Impact 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 WE CARE:

Wellbeing - We provide a health-focused workplace and support a healthy work-life balance
Empathy - We do our best to understand others' feelings, needs and perspectives
Collaboration - We work together to achieve extraordinary results
Accountability - We hold ourselves and each other to behaviors necessary to achieve our collective goals
Respect - We value diversity and treat all members of our community with dignity and inclusiveness
Equity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.

The mission of LHMC is to serve our patients compassionately and effectively, and to create a healthy future for them and their families. Our mission is supported by our commitment to personalized, excellent care for patients; a workforce committed to individual accountability, mutual respect, and collaboration; and a commitment to maintaining our financial health. The Medical Center is also committed to being active in the community as well. Service to community is at the core and an important part of our mission. We have a covenant to care for the underserved and to work to change disparities in access to care. We know that to be successful we need to learn from those we serve

2. **Community Benefits Advisory Committee (CBAC):**
   - Members (and titles): Jean Bushnell, Resident, Town of Bedford Sharon Cameron, Executive Director, Peabody Health Department Stephanie Cronin, Executive Director, Middlesex 3 Coalition Michele Craig, Director of Community Benefits, Beth Israel Lahey Health Paulina Do, Resident, City of Lowell Ryan Ribeiro-Rodriguez, Chief Operations Officer, North Shore Community Health, Inc. Gloria Wojtaszek, Family and Community Engagement, Burlington Public Schools Kelly Magee-Wright, Executive Director, Minuteman Senior Services Elvira Omerovic, Director of Site Operations, Beth Israel Lahey Health Primary Care Rick Parker, Executive Director, Greater Burlington Chamber of Commerce; Michelle Snyder, Community Benefits and Community Relations Manager, Lahey Hospital & Medical Center; Susan Moffatt-Bruce, MD, PhD, President, Lahey Hospital & Medical Center, Lahey Hospital & Medical Center Board of Trustees; Erica Schwartz, Executive Director, Housing Corporation of Arlington; Renata Ivniskaya, Nursing Director, Residential Services, Northeast Arc; Brian Quigley, Ambulatory Transplant Worker, Lahey Hospital & Medical Center; Lauren Knowles, Director of Interprofessional Education, Instructor of Medicine, UMass Chan-Lahey Medical School
   - Leadership: Susan Moffatt-Bruce, MD, PhD, President¸ Dwayne Oxley, Interim Chief Financial Officer Randy Howard Jr., FACHE, Senior Vice President & Chief Operating Officer; Sheri Keitz, MD, PhD, Chair, Department of Medicine; John K. Lew, Vice President, Human Resources Business Partners; Scott James, DNP, MBA, RN, NEA-BC, Senior Vice President, Chief Nursing Officer; Jeffry Marx, MD, Chief Medical Officer, Chief Value Officer; Anne Mosenthal, MD, FACS, Chief Academic Officer; Julia Parrillo, Vice President, Philanthropy; Steve Stain, MD, Chair, Department of Surgery
   - Frequency of meetings: Quarterly

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:

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:

Hospital Board:
Lahey Hospital & Medical Center's Board of Trustees – reviewed and approved its CHNA and adopted its Implementation Strategy.

Community Benefits Advisory Committee - oversaw CHNA and Implementation Strategy process.

Senior Leadership:

- Susan Moffatt-Bruce, MD, PhD, President: Serves as the chair of the CBAC and participated in the approval process.
- Jeffrey Marx, MD, Chief Medical Officer: serves on the CBAC
- Nancy Kasen, Vice President of Community Benefits and Community Relations, and Community Benefits team: designed, directed and oversaw the CHNA and IS, managed prioritization process, drafted Implementation Strategy
- Michelle Snyder, Manager of Community Benefits and Community Relations: led Lahey Hospital & Medical Center's community engagement efforts
- BILH Board of Trustees Community Benefits Committee (CBC): guided the process for the system

4. <u>Hospital Approach to Assessing and Addressing Social Determinants of Health</u>

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

Lahey Hospital & Medical Center 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 similar efforts. The assessment was supported by Lahey Hospital & Medical Center's Community Benefits Advisory Committee (CBAC). The CBAC is comprised of community members, service providers, and other stakeholders who live and/or work in Lahey Hospital & Medical Center's CBSA. Lahey Hospital & Medical Center's Implementation Strategy (IS) reflects the hospital and the CBAC's prioritization of the following social determinants of health: economic stability, education, food security and nutrition, housing, and transportation.

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

Lahey Hospital & Medical Center and BILH are committed to health equity, the attainment of the highest level of health for all people. Throughout the assessment process, Lahey Hospital & Medical Center worked to understand the needs of all populations in the Community Benefits Service Area, including those who have been historically underserved. Health equity is an overarching lens applied to all four pillars within the Lahey Hospital & Medical Center's Implementation Strategy. The Implementation Strategy is designed to address the underlying social determinants of health and barriers to accessing care

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

Lahey Hospital & Medical Center's Implementation Strategy includes a range of programs and resources to address the prioritized needs within the hospital's Community Benefits Service Area. The majority of Lahey Hospital & Medical Center's community benefits initiatives are focused on cohorts and geographies based on identified needs. Additionally, Lahey Hospital & Medical Center collaborates with many community partners to own, catalyze and/or support total population and community-wide interventions.

5. Maternal Health Focus

- How does your organization assess maternal health status in the Community Needs Assessment Process? (150-word limit)

Lahey Hospital & Medical Center's Community Health Needs Assessment (CHNA) process includes comprehensive collection and review of primary and secondary data sources. Secondary data sources include the Center for Health Information Analysis (CHIA), Community Health Equity Survey (CHES), County Health Rankings, MA DPH, National Center for Health Statistics and U.S. Census Bureau. The hospital's data table has a section for Maternal and Child Health/Reproductive Health which includes infant mortality rate (%) and low birth weight (%). In addition to secondary data capture and review, throughout the CHNA Lahey Hospital & Medical Center engages with the community to collect primary data via a survey, focus groups and listening sessions to directly enable community residents to identify priorities.

- How have you measured the impact of your Community Benefits programs and what challenges have you faced in this measurement?

LHMC is a member of Beth Israel Lahey Health, which, as a system is working to address maternal health equity. Beth Israel Lahey Health established its Maternal Health Quality and Equity Council (MHQEC) in September of 2023. The Council's objective is to improve maternal health outcomes and eliminate inequities in care, with an overarching aim to reduce the occurrence of maternal morbidity and mortality. The

Council is comprised of representatives from all of the BILH hospitals providing maternity services, as well as BILH leadership, including BILH Health Equity system leadership. BILH's Vice President of Health Equity serves as the Executive Sponsor. Additionally, BILH established a health equity goal beginning in FY 25 – a year over year improvement in maternal transfusion rate (the goal is to reduce disparities in maternal transfusion rates measured at the system level).

- Do you need assistance identifying community-based organizations doing maternal health work in your area?

Lahey Hospital & Medical Center's maternal health work will continue to be guided by the BILH MHQEC and the hospital looks forward to spreading this work and collaborating with its myriad of long-standing community partners in pursuit of maternal health equity.

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.

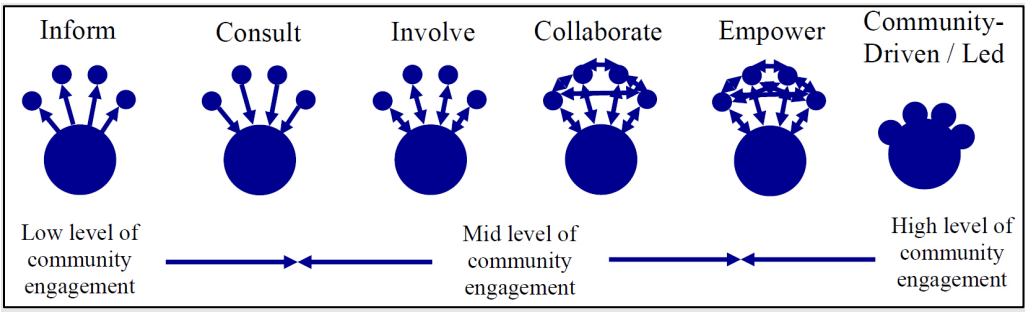
Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
Greater Lowell Health Alliance	Hannah Tello, Director of Evaluation	Social service organizations	The Greater Lowell Health Alliance (GLHA) is a nonprofit that brings together healthcare providers, community organizations and civic leaders to improve health and well-being in the Greater Lowell region. It coordinates community health planning, awards grants, and supports

			programs that address priority health issues. Lahey partnered with GLHA to collaborate on a shared community outreach strategy for focus groups and interviews in Lowell.
Housing Corporation of Arlington	Erica Schwartz, Executive Director	Housing organizations	Housing Corporation of Arlington is a nonprofit community development corporation that creates and manages affordable housing in Arlington, MA, while providing services and support to help low-income families achieve stable, sustainable housing. Lahey partnered with HCA to conduct a focus group with low-resourced individuals, and the executive director is a CBAC member.
North Shore Community Health	Katie Attia, Director of School-based Health Centers	Community Health Center	Lahey partners with North Shore Community Health to help to provide funding to support the student-based health center at Peabody High School. Lahey partnered with the school-based health center on a focus group to hear firsthand from youth about the health needs and issues affecting them. A representative from North Shore Community Health also is a member of Lahey's CBAC.
Peabody Health Department	Sharon Cameron, Director	Local health department	Lahey is a long-time partner of the Peabody Health Department and supports the funding for their community-based behavioral health navigator and many other programs. Lahey partnered with the director of the health department on outreach into the Spanish and Portuguese-speaking communities through faith-based organizations. The director of the health department is also a member of the CBAC.

2. Level of Engagement Across CHNA and Implementation Strategy
   Please use the spectrum below from the Massachusetts Department of Public Health[1] to

[1] "Community Engagement Standards for Community Health Planning Guideline," Massachusetts Department of Public Health, available at: http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-

assess the hospital's level of engagement with the community in implementing its plan to address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.



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	Involve	Goal was met	Involve
Collecting data	Involve	Goal was met	Involve
Defining the community to be served	Collaborate	Goal was met	Collaborate
Establishing priorities	Collaborate	Goal was met	Collaborate

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

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.

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

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 was met	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Consult	Goal was met	Consult
Implementing Community Benefits programs	Collaborate	Goal was met	Collaborate
Evaluating progress in executing Implementation Strategy	Collaborate	Goal was met	Collaborate
Updating Implementation Strategy annually	Consult	Goal was met	Consult

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

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.

   In FY25, Lahey Hospital & Medical Center held four CBAC meetings, a community listening session and an annual meeting that were broadly advertised to the public. Additionally, four newsletters were distributed to inform the community about the Community Health Needs Assessment and Implementation Strategy process, including opportunities for input, and other Community Benefits updates.

   The LHMC CBAC met on the following dates:

   December 18, 2024
   March 26, 2025
   June 25, 2025
   September 17, 2025

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)

Lahey Hospital & Medical Center 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. Lahey Hospital & Medical Center is proud of its collaboration with these and other organizations that allow for meaningful community engagement. Increased focus was placed on reaching communities typically not engaged in assessments, as such, Lahey Hospital & Medical Center saw a significant increase in community surveys from the following populations: Black/African American, Hispanic/Latino, Asian and Non-English speakers.

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

Working collaboratively with other hospitals, community-based organizations, public health agencies, residents, and area coalitions enhances the level and quality of Lahey Hospital & Medical Center's community engagement efforts.

III. Regional Collaboration

1. Are Community Benefits planning and investments part of your hospital's strategic plan? ☒Yes ☐No
    a. **If so, briefly describe it. If not, why?**

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
    - Institutions Involved
    - Brief description of goals of collaboration
    - Key communities engaged through collaboration. If you did not participate in a collaboration, please explain why not:

For its FY 2025 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 11 licensed hospitals, including Lahey Hospital & Medical Center. While Lahey Hospital & Medical Center focuses its Community Benefits resources on improving the health status of those in its CBSA experiencing significant 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.

In an effort to minimize the burden on community members, Lahey Hospital & Medical Center collaborated with the Greater Lowell Health Alliance, which was concurrently conducting its own community health needs assessment. This partnership allowed both organizations to align and streamline focus groups and interviews within the City of Lowell.