Community Benefits Report

Fiscal Year 2023

Beth Israel Lahey Health
Lahey Hospital & Medical Center

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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 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 4,000 physicians and 35,000 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's Community Benefits staff are committed to working collaboratively with its communities to address the leading health issues and create a healthy future for individuals, families and communities.

While LHMC oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure makes sure that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *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*
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- ***E**quity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.*

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

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

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

There was consensus among interviewees and focus group participants that older adults, people of color, recent immigrants, and non-English speakers faced systemic challenges that limited their ability to access health care services. While relatively small, these segments of the population were impacted by language

and cultural barriers that limited access to appropriate services, posed health literacy challenges, exacerbated isolation, and may have lead to discrimination and disparities in access and health outcomes.

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

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

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

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

Key Accomplishments for Reporting Year
The accomplishments and activities highlighted in this report are based upon priorities identified and programs contained in LHMC's FY 2022 Community Health Needs Assessment (CHNA) and FY 2023-2025 Implementation Strategy (IS):

- LHMC provided breast cancer risk assessments for over 20,000 people to identify those at high risk for the disease.
- LHMC assisted patients in FY23 who had Medicaid coverage, presented as self-paying and completed an application with a Financial Navigator, who qualified for upgraded MassHealth coverage, or otherwise required support navigating the financial components of their health care visit.
- LHMC provided 40 internships in radiology, nuclear medicine, and sonology for students at surrounding universities to strengthen the local workforce.
- LHMC continued to partner with the New Entry Sustainable Farming Project to provide weekly farmers markets at the Arlington, Burlington, and Billerica Councils on Aging. This program provides free, fresh produce every week to over 200 seniors at those locations.
- LHMC helped support the Peabody Veterans Memorial High School Student Health Center, which provided services for over 300 unique individuals.
- LHMC provided funding to the Lowell Community Health Center to support their interpreter services program. Interpretation is required in 45% of the health center's total encounters.

- LHMC provided support to the Greater Boston YMCA and the Metro North YMCA for their evidence based Enhance Fitness Program. Over 50 older adults participated in the program and 100% reported an improvement in their overall health.
- LHMC partnered with the Merrimack Valley Food Bank to provide a farmers market program at three low-income housing sites in the city of Lowell that served 554 people.

Plans for Next Reporting Year

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

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

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

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

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

- **Equitable Access to Care**
  - LHMC will work with the Lowell Community Health Center to provide support for interpreter services in order to help to provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, urgent and emerging care, particularly for those who face cultural, linguistic and economic barriers.

- **Social Determinants of Health**
  - LHMC will work with Mill City Grows, New Entry Sustainable Farming Project, and the Merrimack Valley Food Bank to provide farmers markets and community gardens to improve health and quality of life outcomes

- **Mental Health and Substance Use**
  - LHMC will work with Place of Promise to help to provide support for their community-based recovery support services to promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.

- **Complex and Chronic Conditions**
  - LHMC will continue its partnership with the Burlington Council on Aging to provide free exercise classes for older adults to build their capacity to recover and sustain healthy habits.

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 45]. The LHMC Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members who participated in LHMC's CHNA 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 in order to meet its Community Benefits obligations. Hospital senior leadership is actively engaged in the development and implementation of the LHMC's Implementation Strategy, ensuring that hospital policies and resources are allocated to support planned activities.

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

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

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

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

Community Benefits Advisory Committee (CBAC)
The LHMC Community Benefits Advisory Committee (CBAC) works in collaboration with LHMC's hospital leadership, including the hospital's governing board and senior management to support LHMC's Community Benefits mission to serve its patients compassionately and effectively, and to create a healthy future for them, their families, and 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 13th, 2022
March 21st, 2023
June 20th, 2023
September 19th, 2023

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. LHMC'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 need as well as planning, implementing, and overseeing its Community Benefits Implementation Strategy. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment (Section VII, page 45].

- A Healthy Lynnfield Coalition
- Burlington Recreation Department
- Burlington School Department
- Center for Hope and Healing
- City of Peabody
- Greater Boston YMCA
- Housing Corporation of Arlington
- Merrimack Valley Food Bank
- Metro North YMCA
- Mill City Grows
- Minuteman Senior Services
- New Entry Sustainable Farming Project
- North Shore Community Health
- North Suburban YMCA
- Place of Promise
- Saheli
- Town of Arlington
- Town of Bedford
- Town of Billerica
- Town of Burlington
- Town of Lexington
- Town of Lynnfield

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY 2022 Community Health Needs Assessment (CHNA) along with the associated FY 2023-2025 Implementation Strategy was developed over a twelve-month period from September 2021 to September 2022. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill the LHMC's need to conduct a community health needs assessment, engage the community, identify priority health issues, inventory community assets, assess impact, and develop an Implementation Strategy. However, these activities are driven primarily by LHMC's dedication to its mission, its covenant to cohorts who have been historically underserved, and its commitment to community health improvement.

As mentioned above, LHMC's most recent CHNA was completed during FY 2022. FY 2023 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 2022 CHNA approach, methods, and key findings.

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

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

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

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

The articulation of each specific community's needs (done in partnership between LHMC and community partners) is used to inform LHMC's decision-making about priorities for its Community Benefits efforts. LHMC works in concert with community residents and leaders to design specific actions to be collaboratively undertaken each year. Each component of the plan is developed and eventually woven into the annual goals and agenda for the LHMC's Implementation Strategy that is adopted by the LHMC's Board of Trustees.

Summary of FY 2022 CHNA Key Health-Related Findings

Equitable Access to Care

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

Social Determinants of Health

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

Mental Health and Substance Use

- Anxiety, chronic stress, depression, and social isolation were the leading community health concerns. The assessment identified specific concerns about the impact of mental health issues for

youth and young adults, the mental health impacts of racism, discrimination, and trauma, and social isolation among older adults. These difficulties were exacerbated by COVID-19.

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

Complex and Chronic Conditions

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

For more detailed information, see the full FY 2022 LHMC Community Health Needs Assessment and Implementation Plan Report on the hospital's website.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Equitable Access to Care **Program Name: Patient Financial Counseling** **Health Issue: Additional Health Needs as Defined by Community**		
Brief Description or Objective	LHMC employs four MassHealth-certified application counselors who can screen patients and assist them in applying for state aid. They also estimate for patients their financial responsibility (copay, deductible, coinsurance, self-pay). The financial counselors spend their time with patients discussing financial assistance and estimates and helping patients understand their insurance benefits.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Assist patients who are uninsured to assess their eligibility for and align them with state and hospital-based financial assistance programs.	
Goal Status	For FY 23 LHMC screened 17,871 patients for eligibility of which 2,103 were approved for an entitlement program. The number of patients with Health Safety Net (HSN) served at LHMC were 2,749	
Time Frame Year: Year 1	**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**		
Brief Description or Objective	LHMC offers an extensive Interpreter Services program that provides interpretation (translation) and assistance in over 60 different languages, including American Sign Language, and hearing augmentation devices for those who are hard of hearing. The Interpreter Services Department routinely also helps with facilitating access to care, helping patients understand their course of treatment, and adhering to discharge instructions and other medical regimens. LHMC also routinely translates materials such as legal consents for treatment, patient education forms, and discharges to continue to reduce barriers to care.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Provide culturally responsive care through the Interpreter Services Department.	
Goal Status	For FY 23 LHMC there were 101,449 encounters. The top 3 Languages were Spanish (40,023) encounters, Portuguese - Brazilian (9,236 encounters), Chinese - Mandarin (9,219 encounters)	
Time Frame Year: Year 1	**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**	
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. 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 23, the Lowell Community Health Center provided 176,347 sessions of interpretations (in-house interpreters = 71,779; External Language Line = 104,568) to 17,000 patients. Demographics of clients served White 22%, Black 11%, Asian 21%, Other/Unknown, 14%, Hispanic 32%. The top languages were Spanish, Portuguese, Khmer, Haitian Creole, Arabic. 50% of all patients at the Lowell Community Health Center require interpreter services. In FY 23, Lowell Community Health Center translated over 200 documents, flyers and/or forms for individual patients and general education posting on health center social media sites. Majority of materials were translated into Spanish, Portuguese, Khmer. The Health Center also translated materials targeted to Arabic, Swahili, and Vietnamese speakers. Information included: Lowell CHC SAMHSA-funded Partners in Prevention HIV/AIDs grant program; international overdose awareness; LGBTQ History Month; Happy Growth and Nutrition; FDA alert for artificial tear/lubricant eye drops; Colorectal Screening guidance; Patient Privacy notices; materials for Health Insurance renewal fairs; materials promoting My Chart (patient electronic access); promotion of new Healthy Aging Clinic.

	Via text messages to 10,000 patients, in English, Spanish, Portuguese, Khmer, Lowell Community Health Center sent a survey concerning the Sliding Fee Discount program. Survey asked patients if they considered the amount charged was reasonable. They also provided multi-lingual texting to remind patients of overdue procedures and lab services; eye glasses pickup. Lowell Community Health Center made changes to its phone messaging system by adding service and administrative department directories, in four top languages (English, Spanish, Portuguese, Khmer) Lowell Community Health Center delivered 50 episodes of its signature Khmer-language tv program, Jivit Thmei, which aired 156 times (Monday 9-10pm, Tues/Wed 10-11pm on local channel 95 and channel 26, and included information on vaccines, flu prevention and other topics from CDC and other sources.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: BILH Office of Diversity, Equity, and Inclusion** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	BILH's Diversity, Equity, and Inclusion (DEI) office develops and advocates for policies, processes and business practices that benefit the communities and our workforce. The DEI vision is to "Transform care delivery by dismantling barriers to equitable health outcomes and become the premier health system to attract, retain and develop diverse talent."
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)	Across BILH, increase BIPOC representation among new leadership (directors and above) and clinical (physicians and nurses) hires with an aim of at least 25% representation. Increase spend with diverse businesses by 25% over the previous fiscal year across the system. Expand system-wide DEI learning, in alignment with enterprise learning management solution. Support creation or expansion of local DEI committees/resource groups.

Goal Status	Across BILH there was a 25% increase in BIPOC leadership (directors and above) and clinical (physicians and nurses) hires over FY22. More than $50 million was contracted to Women and Minority-owned Business Enterprises (WMBE) in FY23. This is a 22% increase over FY22. 8 system-wide DEI trainings were conducted for all BILH staff and hospitals. LHMC is forming a Diversity, Equity and Inclusion Council to guide the hospital's efforts to nurture and sustain a diverse, equitable and inclusive organizational culture – and to make meaningful and lasting change for our patients, our employees and our communities.

Time Frame Year: Year 1	**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**	
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 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 FY23, Workforce Development will continue to encourage community referrals and hires. In FY23, Workforce Development will attend events and give presentations about employment opportunities to community partners In FY23, Workforce Development will offer paid training for community members across BILH. In FY23, Workforce Development will offer English for Speakers of Other Languages (ESOL) classes to BILH employees.

	In FY23, Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees.
Goal Status	In FY23, 225 job seekers were referred to BILH and 70 were hired across BILH hospitals. In FY23, 67 events and presentations were conducted with community partners across the BILH service area. In FY23, BILH trained total of 89 community members to Patient Care Technician or Nursing Assistant (30), Pharmacy Tech (16), Perioperative LPN (3), Medical Assistant (21), Behavioral Health roles (4) or into the Associate Degree Nursing Residency program (15). LHMC participated in offering these trainings. In FY23, 45 employees across BILH were enrolled in ESOL classes. LHMC employees participated in these classes. In FY23, 20 BILH employees attended citizenship classes, 135 BILH employees attended career development workshops and 189 BILH employees attended financial literacy classes. LHMC employees participated in these offerings.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process 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**	
Brief Description or Objective	LHMC maintains its extremely successful partnership with Minuteman Senior Services to continue to provide SHINE counselors at the Arlington and Burlington Councils on Aging and at a designated site on the LHMC campus at 41 Mall Road. The consumers served in the LHMC region received no-cost, one-on-one insurance benefits counseling provided by state-certified SHINE volunteers or staff members. LHMC is the only acute care health system serving as a SHINE counseling site in Massachusetts. The collaboration includes private, in-kind space so SHINE counselors can be accessible to the hospital community, volunteer support provided by the LHMC Volunteer Services Department, and related services.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention ☒Access/Coverage Supports ☐Infrastructure to Support Community Benefits

Program Goal(s)	Minuteman Senior Services Regional SHINE program will provide Medicare benefits counseling to 2100 individuals who reside in Burlington and Arlington during the grant cycle (seven hundred annually). Minuteman Senior Services Regional SHINE program will offer 21 (7 annually) community education presentations to people new to Medicare turning sixty-five or retiring to ensure consumers make educated health insurance decisions.	
Goal Status	In FY23 Minuteman Senior Services Regional SHINE Program served 639 consumers. Minuteman Senior Services Regional SHINE program hosted 9 community education presentation to people new to Medicare turning 65 or retiring at Arlington Adult Education, Arlington Housing Authority, Arlington Council on Aging and Burlington Council on Aging.	
Time Frame Year: Year 1	**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**	
Brief Description or Objective	This program provides high-quality, comprehensive health care to students on site at Peabody High School. Services include management of chronic illnesses such as asthma and diabetes, urgent care visits, immunizations, routine and sports physicals, health education, and confidential services, including reproductive health care and behavioral health services.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	• Provide support and funding for services at the PVMHS SHC that meet a critical, identified community need. • Provide access to critical behavioral health services for students who are uninsured/health safety net or on MassHealth. • Increase student participation by 10% in Youth Action Committee (YAC) to improve mental health by 2026. • To provide diversion in lieu of suspension to 60 students by 2026, an increase of 20%.
Goal Status	• FY23, the SHC had the following impacts: Medical: 748 Onsite: 747 Telehealth: 1 Behavioral health: 1286 Total number unduplicated patients – 377 Total number of visits where client had no insurance at time of visit and visit was not paid out of another revenue source: 112 The top 3 diagnoses were Anxiety Disorder, Adjustment disorder with mixed anxiety and depressed mood, Adjustment Disorder.

	• In FY 23, 68% of health center clients were either on MassHealth/uninsured health safety net. • In school year 22-23, the YAC led by staff had weekly meetings with a group of 15 students. This year YAC engaged the PVMHS student population in three main projects including; hat and mitten drive, Valentines Project and the Gratitude Project. PVMHS students donated winter apparel to elementary school students in need. The Valentines Project involved creating an individual valentine for each community member (student and staff) which totaled over 1700 valentines that were strung inside the cafeteria for all to see. While members of the YAC played a large role in creating these valentines, many other students volunteered their time to help with setting up the display. Lastly, the Gratitude Project invited each student and staff member to express a note of gratitude on the glass windows of the cafeteria. To ensure complete engagement of the PVMHS community, this project spanned over the course of 10 weeks. • In school year 22-23 over 35 students have been registered in and received substance use prevention educational sessions in lieu of suspension. Of these students, approximately 5% consented to nicotine replacement therapy, and six students have been referred for individual therapy within the SBHC program.

Time Frame Year: Year 1	**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**	
Brief Description or Objective	LHMC partners with Saheli to support, grow and strengthen community-based outreach, engagement and education targeted to the unique needs of the South Asian and Arab immigrant communities. The project assists immigrants through a two-pronged approach: 1) a culturally competent Community Health Worker (CHW) also trained as a DV advocate, will improve access and engagement of health and safety services to South Asian and Arab communities. CHW will assess client's needs, link households to supports, and enhance access to culturally competent care providing trauma informed and survivor-centered services tailored to the goals and needs of the survivor.; 2) CHW will provide education and engagement with medical and mental health providers, housing providers, and community leaders to raise public awareness about SA and Arab immigrant survivors challenges and improve social acculturation and health access for these households.

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)	• Upon notice of funding, Saheli will perform and complete a search for the culturally competent Community Health Worker and hire within 60 days. • Once on board, the Community Health Worker will work with the team to create two focus groups within 30 days of hire – one Arab participants and one SA participants – to help identify how and where to best engage with the target population; and at the same time, reach out to community contacts to create at least six formal agreements with referral/project partners. • Once on board, the Community Health Worker will work with the team to create two focus groups within 30 days of hire – one Arab participants and one SA participants – to help identify how and where to best engage with the target population; and at the same time, reach out to community contacts to create at least six formal agreements with referral/project partners. • Community Health Worker will outreach and engage a minimum of 35 SA/Arab households in program services and supports and track progress toward client self-designated goals and objectives. • Community Health Worker will conduct a minimum of 10 community-based educational and community meetings during the project period for community-based organizations to raise public awareness about SA and Arab immigrant challenges and approaches to success with the population.
Goal Status	• Immediately upon notice of funding, Saheli recruited and hired a part-time Community Health Worker with South Asian language capacity and have plans to add a .25FTE Arabic speaking Community Health Worker to the Outreach and Engagement team in the new year. • The Community Health Worker, together with other outreach and engagement staff members, have conducted ongoing focus groups with Arab survivors and SA survivors to help identify their needs and how to best engage with them. • The Outreach and Engagement team has led several focus group sessions in colleges to help community advocates understand the intersection of domestic violence with chronic illness and have collaborated with Tufts for Health Equity and Tufts MARCH, reaching over 50 students. Saheli has also collaborated with healthcare providers across the state from Boston Healthcare for the Homeless Program and Boston Children's Hospital, training providers on how domestic violence interacts with homelessness and on cultural competency, respectively.

- In FY23, Saheli engaged with 338 unduplicated clients throughout the region; 42 of those clients were seeking emergency supports and financial assistance.
- In FY23, Saheli's Outreach and Engagement team conducted 27 community-based public awareness and cultural education activities within our region as indicated below:
    - Total Educational & Community Meetings: 27
    - Total People Reached: 1184
    - IINE - Healthy Relationships Workshop (Attendees: 10) (Afghani Community)
    - IINE - Mental Health Workshop (Attendees: 10) (Afghani Community)
    - IINE - Know Your Rights Workshop (Attendees: 10) (Afghani Community)
    - Revere PD - Supporting Domestic Violence Survivors (Attendees: 15)
    - State House - Denim Day Lobbying (Attendees: 100 legislators)
    - Harvard Women's Center - South Asian Dating (Attendees: 10)
    - Wellesley College Asian Student Union - Power Dynamics in Dating (Attendees: 20)
    - Tufts for Health Equity - Bystander Intervention Training (Attendees: 20)
    - Tufts MARCH - How Chronic Illness Can Manifest in Racism (Attendees: 30)
    - Boston University - SAAM Vigil (Attendees: 150)
    - Revere PD - Cultural Competency Training (Attendees: 15)
    - Boston Healthcare for the Homeless Program - Supporting Survivors Who Experience
    - Homelessness (Attendees: 15)
    - MIT - Identities and Community (⅓) (Attendees: 10) (South Asian Community)
    - Volunteer Orientation (½) (Attendees: 12)
    - Volunteer Orientation (2/2) (Attendees: 18)
    - Tufts - Community Day (Attendees: 150)
    - REACH - DV Awareness (Attendees: 150)
    - NEBAF - Women's Empowerment (Attendees: 40) (Bangladeshi Community)
    - Tufts for Health Equity - How Chronic Illness Can Manifest in Racism (Attendees: 17)
    - Revere PD - DV Awareness Luncheon (Attendees: 20)
    - MIT - Intersectionality & Identifying Barriers (⅔) (Attendees: 5) (South Asian Community)

Time Frame Year: Year 1	Time Frame Duration: Year 3	Goal Type: Outcome Goal

Priority Health Need: Infrastructure to support Community Benefits Collaborations across BILH Hospitals **Program Name: Infrastructure to support Community Benefits Collaborations across BILH Hospitals** **Health Issue: Additional Health Needs as Defined by the Community**		
Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital worked together to plan, implement, and evaluate Community Benefits programs. Community Benefits staff continued to understand state and federal regulations, build community engagement and evaluation capacity, and collaborate on implementing similar programs. BILH continues to refine the Community Benefits (CB) database, as part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☒Infrastructure to Support Community Benefits
Program Goal(s)	• By September 30, 2023, BILH Community Benefits and Community Relations staff will participate in workshops to build community engagement skills and expertise. • By September 30, 2023, continue to refine a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits data to more accurately capture and quantify CB/CR activities and expenditures. • By September 30, 2023, all BILH Hospitals will launch a Community Connections newsletter on a quarterly basis to communicate community benefits activities to community partners, residents, and vested parties.	
Goal Status	• All 10 BILH Community Benefits hospitals participated in 4 community engagement workshops. • All FY23 regulatory reporting data were entered into the Community Benefits Database. The ability for community organizations to apply for grants was added in FY23. • LHMC launched and sent 2 newsletters to a mailing list of 350 organizations and individuals.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Peabody Council on Aging Transportation Program: Project Mobility** **Health Issue: Additional Health Needs as Defined by Community**		
Brief Description or Objective	LHMC provides support to the Peabody Council on Aging for their transportation project, "Project Mobility". Peabody has developed one of the largest transportation systems offered by Councils on Aging in the Commonwealth. Project Mobility provides over 30,000 rides per year for Peabody's older adults and individuals with disabilities to medical appointments, grocery stores, social services agencies, to the senior center, to the Adult Day Health Program and necessary services. The transportation service allows non-driving residents of Peabody the opportunity to remain independent in the community. Peabody has a large older adult population as the 2020 US Census identified 17,279 individuals 60 years and older living in Peabody. That represents 32% of the total population which is almost double the state average.	
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, 2023 Project Mobility will provide transportation services to over 30,000 residents of Peabody.	
Goal Status	• From October 2022 to September 2023 Project Mobility provided 32,064 rides of which 5,865 required the use of a wheelchair lift, making services more accessible to all. 6,470 rides were provided for medical appointments to 957 unduplicated individuals. At the present time 95% of clients are age 60 years and older.	
Time Frame Year: Year 1	**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**		
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	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits

	☒Total Population or Community Wide Intervention
Program Goal(s)	• In FY23, LHMC will provide clinical-based education opportunities to help strengthen the local workforce.
Goal Status	• In FY23, LHMC provided 2 internships for students in Diagnostic Ultrasound, and 2 internships for students in Vascular Ultrasound; 1 graduating intern was not hired by LHMC. LHMC Nuclear Medicine provided 3, 3-month internships for Regis College Nuclear Medicine students. One student completed 2 internships and the second student completed 1 internship. LHMC hired 1 student for a 20-hour position after graduation in Spring 2023. LHMC Diagnostic Radiology had 5 graduating second years and hired 4. LHMC Diagnostic Radiology had 6 first years from Jan. 2023 to May 2023, from May 2023 to August 2023, 8 First Years, and from Sept. 2023 to Dec. 2023, 7 second years and 6 first years.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**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**	
Brief Description or Objective	LHMC partners with Mill City Grows (MCG) to provide funding for improvements to its community-based garden program. MCG, a longtime partner of LHMC, has designed and built and now oversees 21 community and school gardens in Lowell that are used by over 6,500 Lowell residents. In this urban environment environmental challenges exist that contribute to health inequities among low-income families, elders, immigrants and refugee residents. Low-income neighborhoods are blighted by vacant, contaminated and underutilized lots containing soils with legacy heavy metals and other toxins that are remnants of Lowell's industrial past. This renders much of the open space in these neighborhoods unsuitable for recreational use with little incentive for developers to remediate the land.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	• By June 2025, establish a new community garden in the Pawtucketville neighborhood of Lowell with at least 30 new beds. • Increase parent engagement in School Garden Education by hosting 9 family garden days at Lowell Public Schools through the 2022-23 school year. MCG expect over 200 participants at these events. • Increase physical accessibility at Community Gardens by installing stone dust walkways in all community gardens, and building 7 tall, wheelchair accessible beds prior to garden opening day in 2023.

Goal Status	• Mill City Grows and project partners are establishing fundraising plans in support of the Pawtucket Farm Wildlife Sanctuary. Mill City Grows is applying for grants to support site access, building of the community garden, and developing the All-Persons Trail with design and development beginning in 2024. Mill City Grows ninth Community Garden is on track to be completed by December 31, 2024. • Due to changes in staffing and lack of response of parents to "family garden days" Mill City Grows chose to increase parent outreach by attending 8 school open houses and talked with 325 parents/guardians and children at these events. They also hosted a Harvest Day at the Farm and promoted this event by sending flyers to LPS schools. This event provided tours of the farm, arts and crafts activities, an animal presentation by Mass Audubon, and a table manned by LPS Food Services to discuss Mass Farm to School with children and parents. • In all community gardens, except one, stone dust was applied for the 2023 garden season. One garden did not receive new stone dust as it wasn't needed. Each garden has at least 2 functional wheelchair accessible beds. If gardeners request taller beds, Mill City Grows will be able to meet that request. In the 2023 survey of community gardeners showed that community gardeners were 50% more likely to be food secure than the average Lowellian. Mill City Grows also hosted the Garden Ambassador Program, which gets community gardeners involved in supporting MCG and welcoming new gardeners to the community gardens.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Merrimack Valley Food Bank Community Market Program** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	LHMC partners with the Merrimack Valley Food Bank (MVFB) to provide funding to support its Community Market Program, which serves residents of four Lowell Housing Authority (LHA) properties, offering them the opportunity to supplement their food by enjoying fresh produce at no cost. Bringing the market to the LHA properties helps residents who have difficulty traveling to a grocery store or pantry. The convenience of having fresh produce available outside one's front door may encourage individuals to eat more fresh fruits and vegetables.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits

Program Goal(s)	• Increase the number of public housing residents who utilize the Community Market and receive supplies of fresh produce. • Coordinate with Lowell Housing Authority to bring the Community Market food distribution program to at least four public housing sites in 2023.		
Goal Status	• Merrimack Valley Food Bank has increased the number of people regularly served by the markets to 553 residents, by adding two additional Community Market sites (an increase over the previous year. Of those 553 clients, 23% self-identified as Asian, 22% as Black, and 57% as white. • Merrimack Valley Food Bank is exceeding this goal by implementing Community Markets at six public housing sites. The program continues at these six sites through mid-November.		
Time Frame Year: Year 1		**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**	
Brief Description or Objective	LHMC partners with the New Entry Sustainable Farming Project to run 20-week farmers' markets at Burlington, Arlington, and Billerica Councils on Aging. Depending on location, the program served 50-80 seniors per week from June through October, and on average, participants took home 6 varieties of fresh, local produce each week.
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, 2023, the program will provide a cohort of 50-80 older adults per week in Arlington, Billerica, and Burlington with fresh fruits and vegetables. • By September 30th, 2023, participants will report feelings of reduced social isolation from participating in the market. • By September 30th, 2023, participants will report both an increase in ease of preparation and storing of fresh fruits and vegetables.

Goal Status	• The program served between 50-80 seniors per week, depending on location. There were 67 survey responses. 98% of the survey respondents stated they came more than once to the market. 74% were female; 4% Hispanic or Latino. The average age was 76 and 52% have an annual income of less than $30,000 per year. The program distributed more than 17,500 pounds of produce to the community • From the pre/post survey: 53% of 67 total survey respondents reported that the program reduced feelings of isolation. • From the pre/post survey: Of the 67 total survey respondents, 46% gained more knowledge about how to prepare produce; 68% gained more knowledge about how to store produce.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: Affordable Housing, Family Stability and Tenants Support in Arlington** **Health Issue: Housing/Homelessness**	
Brief Description or Objective	LHMC partners with the Housing Corporation of Arlington to provide an integrated set of social service programs that provide affordable housing, prevent homelessness, connect families to vital resources, and help low-income people 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)	• During 2023, establish at least 3 active and effective Tenant Councils throughout HCA's affordable housing, including training at least 12 HCA tenants as leaders who will help facilitate and lead their Councils. See at least 100 households within HCA's affordable housing portfolio participate in the Tenant Councils each year. See at least 2 additional HCA tenants join the HCA Board over the next 3 years. See at least 15 HCA tenants participate in advocacy on state and local housing and other relevant issues. • Prevent homelessness and create more stable tenancies for at least 45 unique Arlington families per year (at least 90 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 the assistance. • 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.

Goal Status	• As of end of year, 2023: Goal has shifted to create one Tenant Council throughout all properties, instead of multiple councils. Steering Committee formed with 6 leaders in it to date (not yet 12). First meeting will be held in 2024, so have not yet started seeing the wider participation of 100 households. In 2023 1 new HCA tenant joined the HCA Board of Directors • As of end of 2023: HCA provided 56 vetted households with homelessness prevention grants during calendar year 2023. In 2024 HCA will be conducting an evaluation of prior HPP participants to identify who remains stable and who may need further assistance. • At end of 2023: Total families assisted with social services (not counting homelessness prevention program recipients reported in Goal 1 or tenant council steering committee leaders) is 119.		
Time Frame Year: Year 1		**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Burlington Affordable Housing Coordinator** **Health Issue: Housing/Homelessness**			
Brief Description or Objective	LHMC collaborates with the Burlington Affordable Housing Coordinator. This position administers the affordable housing program for the Town of Burlington which provides support, referrals and assistance for those who are undergoing a period of housing instability. This program primarily serves residents of Burlington who are seniors or are experiencing homelessness.		
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	• Provide supportive services related to housing to Burlington residents such as referrals and assistance programs to those experiencing housing instability.		
Goal Status	• In FY 23, the Burlington Affordable Housing Coordinator reported 28 total encounters and was able to provide 10 referrals for additional housing services and supports. All encounters were residents who qualified as low income.		
Time Frame Year: Year 1		**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 who 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, 2023 increase the number of Burlington residents who are provided with supportive services by COA social workers. • By September 30th, 2023 provide referrals for program clients to supportive services.	
Goal Status	• The Burlington Council on Aging social workers had 3,283 encounters up from 1,962 encounters serving 621 up from 504 people (including family members or caregivers). Demographics: Social workers met with 6 African Americans, 30 Asian Americans were identified, 32 Southeast Asians, and 0 of Hispanic origin. • The social workers made 614 referrals to various agencies such as Legal Services, adult day health, housing and Minuteman Senior Services for home care services, health insurance benefits (SHINE), protective services just to name a few. Most of those referrals also stayed with the COA for ongoing case management.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington 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 30th, 2023 provide referrals and supportive services to persons with substance use disorder.

Goal Status	• Number of individuals contacted for substance use coordinator: 81
	• Number of referral who accepted services: 28
	• Demographics of people served:
	  ○ By gender male 58 & female 23
	  ○ By age 15 to 19 = 1, 20 to 39 = 52, 40 to 59 = 25, 60 and over = 3

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process 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 support on support groups, trainings for staff to enhance services, and clinical consultation services from behavioral health providers.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	• By September 30th, 2023, provide comprehensive supportive mental health services to youth and families in Burlington.
Goal Status	• 4,286 individuals were provided with services through Burlington Youth and Family Services in FY 23 • Burlington Youth and Family Services received 285 referrals from community-based organizations in FY 23 • Burlington Youth and Family Services held 6 trainings in FY 23 including topics such as Depression/Suicide, Motivational Interviewing, Step Parenting, Psychopharmacology, Domestic Violence and Teen Dating Violence • Number of support groups and individuals served through support groups: 10 groups, and 81 attended. This year's groups were all adolescent groups. They included FitGirls, Creative Self, Yoga, Rock Climbing and Hiking. The focus of the Rock Climbing and Hiking groups is to help kids develop better social skills. Clinicians intervene in real time helping them learn to use better problem solving and affect management skills.

Time Frame Year: Year 1	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 an onsite adjustment counselor to provide preventative and supportive services for students identified to be at high-risk for mental health disorder.
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, 2023 Burlington High School will provide social and emotional support services to students through the adjustment counselor services.
Goal Status	• This role was restructured for the 22/23 SY. The focus was on less overall students and students need to qualify for a higher level of intervention services. o Number of students served - 85 o Demographics of students served o African American - 22 o Asian - 10 o Asian, Caucasian - 1 o Caucasian - 36 o EL - 4 o IEP/504 - 2 o Connections Program (substantially separate) - 10 o Free/Reduced - 17 o Number of students referred for services - 7 (included above)

Time Frame Year: Year 1	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.: 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 Staff on culturally-sensitive approaches to support BIPOC and 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 June 30, 2023, 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. The staff will be trained in Cognitive Processing Therapy (CPT) by June 30, 2023; TF-CBT by June 30, 2024; and EMDR technique by June 30, 2025. • By March 1, 2023, CHH will hire a program evaluator to conduct a needs assessment with survivors in underserved communities and in collaboration with other mental health service providers in the Greater Lowell Community, to assess barriers and opportunities in providing support groups to survivors in Spanish, Portuguese, Khmer, English-speaking community and Male Survivors of sexual assault. The needs assessment report will be completed by September 30, 2023. • By September 1, 2023, CHH Survivor Services team will reopen 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 December 30, 2025, 30 support groups will be held and have supported at least 200 survivors.
Goal Status	• Progress: during this reporting period, the staff at Center for Hope and Healing have worked with a consultant to provide clinical supervision and resilience practice with counselor staff. Held quarterly, the resilience practice supports staff in building resilience, accountability and commitment toward their wellness are they are providing direct services to survivors. • Progress: Currently working on the needs assessment by identifying community partners, and community members, and formulating assessment questions to be conducted by December 2023.

	• In the first year, Center for Hope and Healing was able to serve 98 survivors in the community through over 48 sessions of various support groups and Healing series, including: o Providers Hispanohablantes (4 sessions) for Spanish speakers o Tudo Bem Mesmo (8 sessions) for Portuguese Speaker o Construyendo Puentes (8 Sessions) for Spanish speakers o Radical Self-Care Support Group (8 sessions) for English Speakers o Food For Thought: Community Discussion with Khmer Community Members/survivors (1 session) o Food for Thought: Community Discussion with Khmer Community Members/Intergenerational survivors, Khmer New Year Edition (1 session) o Food for Thought: Community Discussion: Planting Seed in Our Community, (1 session) o Cultivating Hope, English Support Group (10 sessions) o Support group for Portuguese Speaking Providers, quarterly meeting (4 sessions) o Construyendo Puentes, Cohort 2, (3 sessions – ongoing until December)

Time Frame Year: Year 1	**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. Place of Promise provides adult long-term residential addiction recovery. 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 FY2023, 45 men/women will be served in the Level I and II program • 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

	• 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 (1/1/23 – 9/30/23, partial year): 38 served. On a partial-year basis Place of Promise has exceeded this goal. • Result (1/1/23 – 9/30/23, partial year): Of the 38 served during this time period, 32 attained medical insurance, been seen by a Primary Care Physician, and had a care plan established (84%). On a partial-year basis Place of Promise has exceeded this goal. • Result (1/1/23 – 9/30/23, partial year): Of the 38 served during this time period, 31 have gotten the necessary ID's (82%). On a partial-year basis, Place of Promise has exceeded this goal.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Collaborative Care Model** **Health Issue: Mental Health/Mental Illness**	
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 30th, 2023 provide services to increase access to behavioral health services.
Goal Status	• In FY 23, 6 practices served 3179 individuals.

Time Frame Year: Year 1	**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**			
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 crisis. Services are payer agnostic and provided via in-person or telehealth by a multidisciplinary team of qualified professionals, including Psychiatrists, independently licensed and Master's level clinicians, Nurse Practitioners, Registered Nurses, Certified Peer Specialists, and Family Partners. The services include initial assessments for risks, clinical stabilization, treatment initiation, care coordination, and ongoing evaluation to ensure appropriate level of care placement.		
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	• By September 30th, 2023, 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 140 individuals at Lahey Peabody in FY23.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Outpatient Behavioral Health Services** **Health Issue: Mental Illness/Mental Health**		
Brief Description or Objective	LHMC provides a hospital-based, outpatient program for adults with complex medical and psychiatric needs in a single care setting. Services include 24-hour emergency care, individualized/family therapy, stress management, and many other programs designed to enhance access to behavioral health resources in the community. LHMC provides nine support groups between the two hospital sites that help to provide counseling and support for individuals undergoing cancer treatment as well as other chronic diseases, such as ALS, COPD, and kidney disease.	
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits

Program Goal(s)	• By September 30th, 2023 provide behavioral health resources and supportive services to patients and community members
Goal Status	• In FY 23, 95 Telepsychiatry services were provided through BILH Behavioral Services to the City of Lowell • In FY 23 Lahey Clinic Hospital provided 11 sessions of a support group for survivors of trauma. On average there were 3-4 participants per session. Total number of participants for the year was 31. Lahey Clinic Hospital also sent out 20 information packets per month to 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

Time Frame Year: Year 1	**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, 2023 Burlington High School will provide a wellness day focused on providing students with resources for stress reduction and mental health.
Goal Status	• In FY 23, 870 students from Burlington High School participated in Wellness Days, with an additional 80 staff of Burlington Public Schools who also participated. 45 vendors participated and offered workshops focusing on stress reduction, mental health, and sharing available community resources. • Number of staff who participated -806 • Number of vendors/workshops offered - 45

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Burlington Diabetes Care Program** **Health Issue: Chronic Disease**		
Brief Description or Objective	LHMC partners with the Town of Burlington to support the Burlington Diabetes Care Program. This program provides assistance for Town of Burlington Employees who have a diagnosis of pre-diabetes or are diabetic. The program provides those who are identified with an annual foot exam, eye exam, and an A1C analysis, among other support services, every six months with no copays for participants. This program is intended to help offset the cost of these services to help to avoid serious chronic conditions often associated with diabetes and pre-diabetes.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	• By September 30th, 2023 the Burlington diabetes care coordinator will work to Improve A1c3 of 25% of participants. • By September 30th, 2023 the Burlington diabetes care coordinator will provide education, support, and intervention for persons with diabetes.	
Goal Status	• In FY 23, 42% of program participants had a reduction in A1C and 38% of program participants maintained a healthy A1C of 6.5 or below • In FY 23 of 95 Members with diabetes, 34 enrolled in the program and 14 were adherent with 17 Adherent in last 12 months • Demographics of people served: o Eligible 46% female/54% male o Enrolled 23% female/47% male o Adherent 40% female/42% male	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Cooking Up Good Health** **Health Issue: Chronic Disease**		
Brief Description or Objective	LHMC provides free nutrition and cooking classes to community members through its Cooking Up Good Health series. Participants learn different culinary tips and nutrition information about meals, snacks, sides, and desserts.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits

Program Goal(s)	• By September 30th, 2023 100% of attendees will report more confidence in using healthier ingredients when cooking a meal.		
Goal Status	• In FY 23, over twelve classes,100% of program participants reported being more confident in using healthier ingredients when cooking a meal. 71 individuals were served by these classes.		
Time Frame Year: Year 1		**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **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, 2023 the Council on Aging will provide support through the Memory Café to 15 participants per class		
Goal Status	• In FY 23, 60 individuals were served by this program, with an age range of 45-65+.		
Time Frame Year: Year 1		**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **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)	• By September 30th, 2023 the Council on Aging will provide opportunities for community members to participate in group exercise classes at no cost to them.
Goal Status	• In FY23, LHMC provided funding to the Burlington Council on Aging for a Senior Stretch program for a 52 week exercise program. Overall, the classes served 359 older adults in Burlington with 71% of participants identifying as female and 29% as male. 23% of the total participants were Asian, 46% White and 31% did not report their race/ethnicity.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Metro North YMCA Enhance Fitness Classes** **Health Issue: Chronic Disease**	
Brief Description or Objective	LHMC partners with the Metro North YMCA to provide Enhance Fitness Classes. Enhance Fitness is an evidence-based health intervention offsetting the effects of aging and chronic illness as well as minimizing fall risk. Participants work on cardio and muscular strength, balance, flexibility, and stability, all while engaging in a supportive social community.
Program Type	☐ Direct Clinical Services ☐Access/Coverage Supports ☐Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☒Total Population or Community Wide Intervention
Program Goal(s)	• To Increase participation in the Enhance Fitness program by 80% (20 people) by April 1, 2023. • To increase the number of external referrals to Enhance Fitness by 10 people by collaborating with a minimum of 2 referral partners by February 1st, 2023. • To positively affect the lives of older adults by delivering the Enhance Fitness Program resulting in an average 50% improvement in fitness tests and self-rated improvement in health and wellness as evidenced from the pre and post assessments.
Goal Status	• The YMCA increased the number of participants served from 37 in FY 22 to 62 to FY 23. • In FY23, the YMCA succeeded in collaborating with two referral partners but, due to the changes in the class structure and leadership, did not reach the goal of 10 additional referrals. • Given the staff changes and having to merge the Enhance Fitness class with the Senior Fitness class in the interim, it was difficult to conduct the

	assessments for participants and therefore measure their progress. Additionally, at the end of the program once things were back on track, only a few participants showed up for their final assessments, most of whom hadn't had their initial assessments. Given that the YMCA now has the Health & Wellness Coordinator and are back to the 16-week session format versus drop-in style, they anticipate being able to track this data more robustly going forward.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Greater Boston YMCA Enhance Fitness Classes** **Health Issue: Chronic Disease**	
Brief Description or Objective	LHMC partners with the Greater Boston YMCA to provide Enhance Fitness Classes. Enhance Fitness is an evidence-based health intervention offsetting the effects of aging and chronic illness as well as minimizing fall risk. Participants work on cardio and muscular strength, balance, flexibility, and stability, all while engaging in a supportive social community.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	• Establish and maintain enrollment in the Enhance Fitness program (capacity=15 in year one, 25-30 in years 2 and 3) running classes year-round. • Maintain at least 70% attendance, and graduate participants once they achieve the established benchmarks. Conduct "Fit Checks" every 16 weeks and demonstrate measurable improvement in established functional fitness measures. • Expand the Enhance Fitness program from a rolling roster of 15 participants (new participants come in as people graduate) to a rolling roster of 25-30 participants. The National Enhance Fitness program requires providing a second instructor for this larger group, which allows for one instructor to lead the class, and the second instructor to help support participants with safety and or modifications as needed.
Goal Status	• The YMCA was able to exceed this goal by enrolling 32 participants in 2023 and also changed the enrollment process to 16-week launches rather than year-round enrollment.

	• In FY 23, the YMCA was able to hold a 78% attendance rate, and have graduated all 32 participants. • The YMCA is working towards this goal in FY 24 there is interest from older adults in the community,but are continuing to work on solidifying more staff to run additional classes. The goal is ensure the classes have a safe instructor to participant ratio.

Time Frame Year: Year 1	Time Frame Duration: Year 3	Goal Type: Process Goal

Priority Health Need: Chronic/Complex Conditions and Risk Factors **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 ☐Access/Coverage Supports ☐Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☒Total Population or Community Wide Intervention
Program Goal(s)	• By September 30th, 2023 LHMC will conduct 48 classes of Tai Ji for the community and conduct one abbreviated summer session of 10 classes.
Goal Status	• 17 participants started the program in October 2022; 16 completed the program (attended at least 75% of the sessions) and 1 did not complete the program; ages ranged from 65 to 80 years of age: 13 females and 4 males. Participants reported increased balance, increase strength, and overall physical improvement from participation.

Time Frame Year: Year 1	Time Frame Duration: Year 3	Goal Type: Process Goal

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Bone Health and Osteoporosis Prevention Program** **Health Issue: Chronic Disease**	
Brief Description or Objective	LHMC conducts a Bone Health and Osteoporosis Prevention program to help patients understand a diagnosis of osteopenia and/or osteoporosis, discusses treatment measures to improve bone health after a fracture, provides education on the types of exercises necessary to promote bone health and prevent falls, provides

	information on a healthful diet with important nutrients that contribute to bone health, and aims to reduce the burden of fragility fractures for the individual and community.
Program Type	☐ Direct Clinical Services ☐Access/Coverage Supports ☒Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐Total Population or Community Wide Intervention
Program Goal(s)	• By September 30th, 2023 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 Orthopaedic Specialty Classes".
Goal Status	• LHMC provided 6 classes with a total of 40 participants in FY23. 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 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Oncology Nurse Navigator and Supportive Services for Cancer Patients** **Health Issue: Chronic Disease**	
Brief Description or Objective	LHMC provides oncology navigation services for patients with a cancer diagnosis. RNs with oncology-specific clinical knowledge work with newly diagnosed cancer patients by offering individualized support and assistance with coordinated care through a holistic and collaborative approach that includes communication and coordination with the patient's family and/or caregivers along with a multidisciplinary team consisting of physicians, nurse practitioners, oncology nurses, and social workers.
Program Type	☐ Direct Clinical Services ☐Access/Coverage Supports ☒Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐Total Population or Community Wide Intervention
Program Goal(s)	• By September 30th, 2023 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 23 Oncology Navigators assisted 10-15 patients per day and provided referral and supportive services.		
Time Frame Year: Year 1		**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **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. LHMC is also a long-standing partner and provides support to the American Cancer Society on many community-based prevention activities.		
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	• By September 30th, 2023 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 23, LHMC completed 21,029 risk assessments for 20,553 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 1		**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$9,230,794	$ 0
Community-Clinical Linkages	$1,211,249	$12,692
Total Population or Community Wide Interventions	$1,168,794	$584,287
Access/Coverage Supports	$3,145,851	$533,133
Infrastructure to Support CB Collaborations	$76,609	$0
Total Expenditures by Program Type	$14,833,297	$1,130,072
CB Expenditures by Health Need		
Chronic Disease	$5,844,562	
Mental Health/Mental Illness	$2,429,711	
Substance Use Disorders	$1,237,733	
Housing Stability/Homelessness	$65,804.40	
Additional Health Needs Identified by the Community	$5,255,485	
Total by Health Need	$14,833,297	
Leveraged Resources	$171,567	
Total CB Programming	$15,004,864	
Net Charity Care Expenditures		
HSN Assessment	$5,366,306	
Free/Discounted Care	$476,236	
HSN Denied Claims	$1,135,356	

Total Net Charity Care	$7,177,797.94	
Total CB Expenditures	$22,182,761.94	

Additional Information	
Net Patient Services Revenue	$1,098,564,774
CB Expenditure as % of Net Patient Services Revenue	2.02%
Approved CB Budget for FY24 (*Excluding expenditures that cannot be projected at the time of the report)	$22,182,761.94
Bad Debt	$6,682,828
Bad Debt Certification	Yes
Optional Supplement	
Comments	LHMC also contributes a PILOT payment to the Town of Burlington. LHMC is subsidizing behavioral health services outside of its CBSA

SECTION VI: CONTACT INFORMATION

Michelle Snyder, Community Benefits/Community Relations
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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

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

I. **Community Benefits Process:**

- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? Yes
    - If so, please list updates:
    - Susan Moffatt-Bruce, MD, PhD, President Lahey Hospital & Medical Center joined the committee; Tim Liesching, MD Chief Medical Officer, Lahey Hospital & Medical Center replaced Andy Villanueva; Rosemary DeSousa, Burlington Public Schools replaced Jennifer Knight, Director of Family and Community Engagement, Burlington Public Schools; Greg Schmergel, LHMC Board of Trustees replace Melissa Hastings-Cruz, LHMC Board of Trustees; Ryan Ribero Rodriguez, North Shore Community Health replaced Allison Kilcoyne, North Shore Community Health; Erica Schwartz, Executive Director of Housing Corporation of Arlington joined the CBAC

II. **Community Engagement**

a. Organizations Engaged in CHNA and/or Implementation Strategy

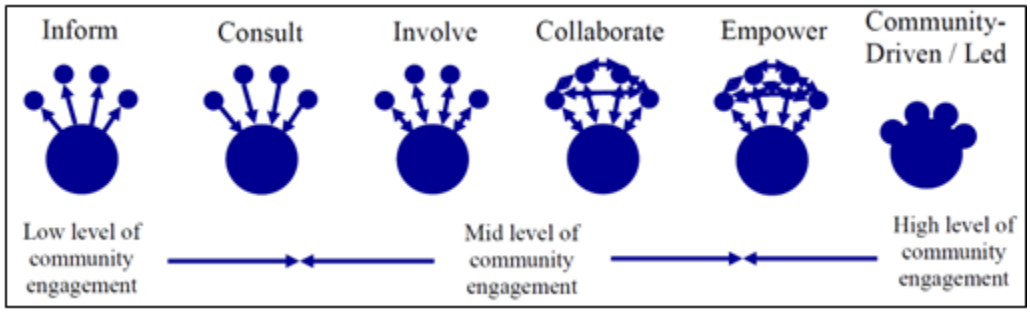
If there have been any updates to the key partners with whom the hospital collaborates, please indicate in the table below. Please feel free to add rows as needed.

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
Center for Hope and Healing	Mana Kheang, Director of Grants and Partnerships	Social service organizations	LHMC partners with Center for Hope and Healing to provide a three-year grant for support group services for historically underserved communities in Lowell
Saheli	Priya Murali, Executive Director	Social service organizations	LHMC partners with Saheli to provide funding for a three-year grant for a Community Health Worker to serve families of South Asian and Middle Eastern descent
Lowell Community Health Center	Karen Myers	Community Health Centers	LHMC provides funding for a three-year grant to help to

			provide interpretation services for the Lowell Community Health Center
Housing Corporation of Arlington	Erica Schwartz, Executive Director	Housing organizations	LHMC provides funding for a three-year grant for supportive housing services and includes the executive director on the CBAC

b. Level of Engagement Across CHNA and Implementation Strategy

Please use the spectrum below from the Massachusetts Department of Public Health[1] to assess the hospital's level of engagement with the community 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. **Implementation Strategy**

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

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing	Collaborate	Goal was met – In FY 23 LHMC collaborated with	Collaborate

filer's plan to address significant needs documented in CHNA		CBAC members to prioritize and allocate grant funding to address health needs identified in the CHNA	
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Collaborate	Goal was met – IN FY 23 LHMC engaged with it's CBAC in an RFP process to allocate three-year grants to community organizations addressing health needs identified in the LHMC Implementation Strategy	Collaborate
Implementing Community Benefits programs	Collaborate	Goal was met – LHMC engaged the CBAC in the review process for RFP's for three-year grant funding in alignment with the Implementation Strategy	Collaborate
Evaluating progress in executing Implementation Strategy	Collaborate	Goal was met – LHMC and BILH have engaged grantees in a regular data tracking system to provide mid-year and annual progress on community benefits programs	Collaborate
Updating Implementation Strategy annually	Consult	Goal was met – BILH and LHMC have worked to update and engage the CBAC in tracking data for community beneits programs on a regular basis	Consult

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

c. Opportunity for Public Feedback

Did the hospital hold a meeting open to the public (either independently or in conjunction with its CBAC or a community partner) at least once in the last year to solicit community

feedback on its Community Benefits programs? If so, please provide the date and location of the event. If not, please explain why not.

LHMC hosted it's annual public meeting via zoom on September 19th, 2023l

III. Updates on Regional Collaboration

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

No updates

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

No updates