

# FY26-FY28 Implementation Strategy



# Implementation Strategy

## About the 2025 Hospital and Community Health Needs Assessment Process

Lahey Hospital & Medical Center (LHMC) is a world-class, tertiary academic medical center providing comprehensive care to communities across northeastern Massachusetts and southern New Hampshire. LHMC has 333 licensed inpatient beds with more than 6,100 employees and over 1,200 clinicians on active medical staff. With close collaboration between specialties and satellites in multiple communities, LHMC offers distinctly integrated care and the most advanced services available north of Boston. LHMC is a teaching hospital and regional medical campus of University of Massachusetts' Chan School of Medicine. Lahey Medical Center, Peabody operates under the LHMC license and is a full-service, community-based hospital and medical center with 10 inpatient beds, an emergency department, as well as outpatient services, diagnostic imaging and an on-site bloodwork lab, pharmacy and more.

The Community Health Needs Assessment (CHNA) and planning work for this 2025 report was conducted between June 2024 and September 2025. It would be difficult to overstate LHMC's commitment to community engagement and a comprehensive, data-driven, collaborative, and transparent assessment and planning process. LHMC's Community Benefits staff and Community Benefits Advisory Committee (CBAC) dedicated hours to ensuring a sound, objective, and inclusive process. This approach involved extensive data collection activities, substantial efforts to engage LHMC's partners and community residents, and a thoughtful prioritization, planning, and reporting process. Special care was taken to include the voices of community residents who have been historically underserved, such as those with limited resources, individuals who speak a language other than English, and those who experience barriers and disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

LHMC collected a wide range of quantitative data to characterize the communities served across the hospital's Community Benefits Service Area (CBSA). LHMC also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data were collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs for specific communities. The data was tested for statistical significance whenever possible and compared against data at the

regional, Commonwealth and national level to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments, and other sources. Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing cohorts most at-risk and crafting a collaborative, evidence-informed Implementation Strategy (IS). Between September 2024 and February 2025, LHMC conducted 15 one-on-one and group interviews with collaborators in the community, facilitated five focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 1,500 residents, and organized a community listening session. In total, the assessment process collected information from more than 1,600 community residents, clinical and social service providers, and other key community partners.

## Prioritization and Implementation Strategy Process

Federal and Commonwealth community benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its Implementation Strategy (IS). By analyzing assessment data, hospitals can identify the health issues that are particularly problematic and rank these issues in order of priority. This data can also be used to identify the segments of the community that face health-related disparities. Accordingly, using an interactive, anonymous polling software, LHMC's CBAC and community residents, through the community listening session, formally prioritized the community health issues and cohorts that they believed should be the focus of LHMC's IS. This prioritization process helps to ensure that LHMC maximizes the impact of its community benefits resources and its efforts to improve health status, address disparities in health outcomes, and promote health equity.

LHMC's IS is designed to address the underlying social determinants of health and barriers to accessing care, as well as promote health equity. The content addresses the leading community health priorities, including activities geared toward health education and wellness (primary prevention), identification, screening, referral (secondary prevention) and disease management and treatment (tertiary prevention).

The following goals and strategies are developed so that they:

- Address the prioritized community health needs and/or populations in the hospital's CBSA.
- Provide approaches across the up-, mid-, and downstream spectrum.
- Are sustainable through hospital or other funding.
- Leverage or enhance community partnerships.
- Have potential for impact.
- Contribute to the systemic, fair, and just treatment of all people.
- Could be scaled to other BILH hospitals.
- Are flexible to respond to emerging community needs

Recognizing that community benefits planning is ongoing and will change with continued community input, LHMC's IS will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies and other issues that may arise, which may require a change in the IS or the strategies documented within it. LHMC is committed to assessing information and updating the plan as needed.

## Community Benefits Service Area

LHMC's CBSA includes the nine municipalities of Arlington, Bedford, Billerica, Burlington, Danvers, Lexington, Lowell, Lynnfield, and Peabody in Middlesex and Essex Counties in the MetroWest and Northeast portions of Massachusetts. These cities and towns are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education, and employment), and geography (e.g., urban, suburban). There is also diversity with respect to community needs. There are segments of LHMC's CBSA population that are healthy and have limited unmet health needs and other segments that face significant disparities in access, underlying social determinants, and health outcomes. LHMC 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 identity, sexual orientation, disability status, immigration status, or age. LHMC is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

LHMC's CHNA focused on identifying the leading community health needs and priority populations living and/or working within its CBSA. In recognition of the health disparities that exist for some residents, the hospital focuses the bulk of its community benefits resources on improving the health status of those who face health disparities, experience poverty, or who are marginalized due to their race, ethnicity, immigration status, disability status, or other personal characteristics. By prioritizing these cohorts, LHMC is able to promote health and well-being, address health disparities, and maximize the impact of its community benefits resources.



Beth Israel Lahey Health  
Lahey Hospital & Medical Center

## Community Benefits Service Area

- H** Lahey Hospital and Medical Center
- H** Lahey Medical Center-Peabody
- 1** Lahey Hospital and Medical Center- Outpatient Rehabilitation Services at Danvers
- 2** Lahey Outpatient Center-Lexington MRI Suite
- 3** Lahey Health Outpatient Services
- 4** Lahey Neurology Outpatient Services
- 5** Lahey Hospital and Medical Center, Departments of Allergy and Immunology & Ophthalmology

## Prioritized Community Health Needs and Cohorts

LHMC is committed to promoting health, enhancing access, and delivering the best care for those in its CBSA. Over the next three years, the hospital 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 priority cohorts within the community health priority areas.

### LHMC Priority Cohorts



Youth



Low-Resourced Populations



Older Adults



Racially, Ethnically, and Linguistically Diverse Populations



Individuals Living with Disabilities



LGBTQIA+

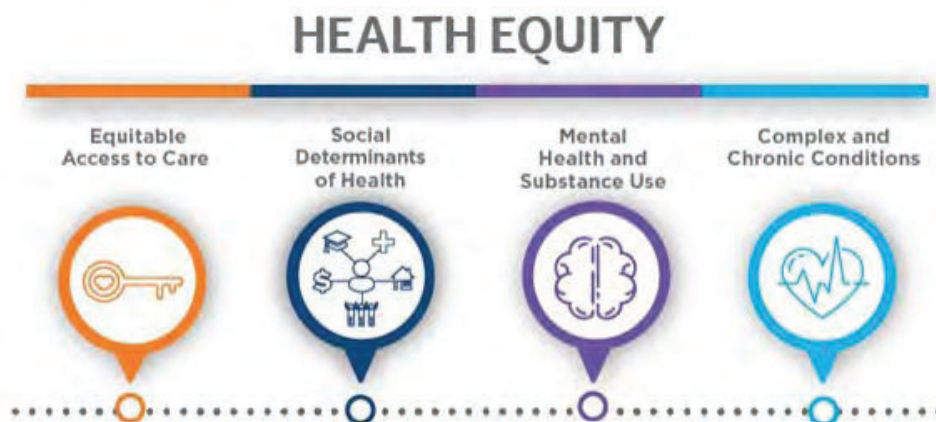
## Community Health Needs Not Prioritized by LHMC

It is important to note that there are community health needs that were identified by LHMC's assessment that were not prioritized for investment or included in LHMC's IS. Specifically, issues related to the built environment (i.e., improving roads/sidewalks and access to physical activity) were identified as community needs but were not included in LHMC's IS. While these issues are important, LHMC's CBAC and senior leadership team decided that these issues were outside of the organization's sphere of influence and investments in others areas were both more feasible and likely to have greater impact. As a result, LHMC recognized that other public and private organizations in its CBSA and the Commonwealth were better positioned to focus on these issues. LHMC remains open and willing to work with community residents, other hospitals, and other public and private partners to address these issues, particularly as part of a broad, strong collaborative.

## Community Health Needs Addressed in LHMC's IS

The issues that were identified in the LHMC CHNA and are addressed in some way in the hospital's IS are housing issues, transportation barriers, language and cultural barriers to services, food insecurity, economic insecurity, long wait times for care, health insurance and cost barriers, emergency preparedness, navigating a complex health care system, youth mental health, social isolation among older adults, lack of behavioral health providers, lack of supportive/navigation services for individuals with substance use disorder, community-based behavioral health education and prevention programs, trauma, conditions associated with aging, healthy eating/active living, community-based chronic disease education and prevention, and caregiver support.

### LHMC Community Health Priority Areas



# Implementation Strategy Details

## Priority: 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, and stem from the way in which the system does or does not function. System-level issues included full provider panels, which prevented providers from accepting new patients, long wait lists, and an inherently complicated health care system that was difficult for many to navigate.

There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forgo 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.

**Resources/Financial Investment:** LHMC expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by LHMC and/or its partners to improve the health of those living in its CBSA. Additionally, LHMC works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, LHMC supports residents in its CBSA by providing free or discounted care to individuals who are low-resourced and unable to pay for care and services. Moving forward, LHMC will continue to commit resources through the same array of direct, in-kind, or leveraged expenditures to carry out its community benefits mission.

**Goal:** Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic and economic barriers.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Expand and enhance access to health care services by strengthening existing service capacity and connecting patients to health insurance, essential medications, and financial counseling.	<ul style="list-style-type: none"> <li>All priority populations</li> </ul>	<ul style="list-style-type: none"> <li>Health insurance eligibility and enrollment assistance programs</li> <li>Expanded primary care and medical specialty care services for Medicaid covered, uninsured, and underinsured populations</li> <li>Programs and activities to support culturally/linguistically competent care and interpreter services</li> <li>Programs and activities with community health workers and peer support workers</li> <li>Emergency medical services, training, leadership, and community preparedness activities</li> </ul>	<ul style="list-style-type: none"> <li># of individuals served/enrolled</li> <li># of clinical practices supported</li> </ul>	<ul style="list-style-type: none"> <li>Community health centers</li> <li>Private, non-profit, health-related agencies</li> <li>Hospital-based activities</li> <li>Older adult services agencies</li> <li>Local primary and secondary schools</li> </ul>
Advocate for and support policies and systems that improve access to care.	<ul style="list-style-type: none"> <li>All priority populations</li> </ul>	<ul style="list-style-type: none"> <li>Advocacy activities</li> </ul>	<ul style="list-style-type: none"> <li># of policies supported</li> </ul>	<ul style="list-style-type: none"> <li>To be determined</li> </ul>

## Priority: Social Determinants of Health

The social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions influence and define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to housing, food insecurity, economic insecurity, education and other important social factors.

Information gathered through interviews, focus groups, listening session, and the 2025 LHMC Community Health Survey reinforced that these issues have considerable impacts on health status and access to care in the region, especially issues related to housing, food insecurity, nutrition, transportation, and economic instability.

**Resources/Financial Investment:** LHMC expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by LHMC and/or its partners to improve the health of those living in its CBSA. Additionally, LHMC works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, LHMC supports residents in its CBSA by providing free or discounted care to individuals who are low-resourced and unable to pay for care and services. Moving forward, LHMC will continue to commit resources through the same array of direct, in-kind, or leveraged expenditures to carry out its community benefits mission.

**Goal:** Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support programs and activities that promote healthy eating and active living by expanding access to physical activity and affordable, nutritious food.	<ul style="list-style-type: none"> <li>All priority populations</li> </ul>	<ul style="list-style-type: none"> <li>Community-based food access, nutrition support, and education programs</li> </ul>	<ul style="list-style-type: none"> <li># of people served</li> <li># of organizations/housing sites served</li> <li>% of people reporting increased consumption of healthy food</li> </ul>	<ul style="list-style-type: none"> <li>Non-profit, community-based agencies</li> <li>Elder services agencies</li> </ul>
Support programs and activities that assist individuals and families experiencing unstable housing to address homelessness, reduce displacement, and increase home ownership.	<ul style="list-style-type: none"> <li>Racially, ethnically, and linguistically diverse populations</li> <li>Low-resourced populations</li> </ul>	<ul style="list-style-type: none"> <li>Homelessness prevention and housing stability programs</li> <li>Housing assistance, navigation, and resident support activities</li> </ul>	<ul style="list-style-type: none"> <li># of people served</li> <li># of people who secured safe housing</li> </ul>	<ul style="list-style-type: none"> <li>Housing support and community development agencies</li> </ul>

**Goal:** Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
<p>Provide and promote career support services and career mobility programs to hospital employees and employees of other community partner organizations.</p>	<ul style="list-style-type: none"> <li>• All priority populations</li> </ul>	<ul style="list-style-type: none"> <li>• Career advancement and mobility programs</li> <li>• Youth employment and internship programs</li> </ul>	<ul style="list-style-type: none"> <li>• # of people served</li> <li>• # of people hired</li> <li>• # of interns engaged</li> <li>• # of programs or classes organized</li> </ul>	<ul style="list-style-type: none"> <li>• Local primary and secondary schools</li> <li>• Vocational/technical schools</li> <li>• Hospital-based activities</li> </ul>
<p>Support community/regional programs and partnerships to enhance access to affordable and safe transportation.</p>	<ul style="list-style-type: none"> <li>• Older adults</li> <li>• Individuals living with disabilities</li> </ul>	<ul style="list-style-type: none"> <li>• Subsidized transportation and rideshare assistance programs</li> </ul>	<ul style="list-style-type: none"> <li>• # of people served</li> </ul>	<ul style="list-style-type: none"> <li>• Older adult services agencies</li> <li>• Hospital-based activities</li> </ul>
<p>Advocate for and support policies and systems that address social determinants of health.</p>	<ul style="list-style-type: none"> <li>• All priority populations</li> </ul>	<ul style="list-style-type: none"> <li>• Advocacy activities</li> </ul>	<ul style="list-style-type: none"> <li>• # of policies supported</li> </ul>	<ul style="list-style-type: none"> <li>• Hospital-based activities</li> </ul>

## Priority: Mental Health and Substance Use

Anxiety, chronic stress, depression, and social isolation were leading community health concerns. There were specific concerns about the impact of mental health issues for youth and young adults, and social isolation among older adults.

In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options. Those who participated in the assessment also reflected on the difficulties individuals face when navigating the behavioral health system.

Substance use remained a major issue in the CBSA, with ongoing concern about opioids and alcohol. It was also recognized as closely connected to other community health challenges like mental health and economic insecurity.

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**Goal:** 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.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support mental health and substance use education, awareness, and stigma reduction initiatives.	<ul style="list-style-type: none"> <li>All priority populations</li> </ul>	<ul style="list-style-type: none"> <li>Behavioral health support groups</li> <li>Medication disposal programs</li> </ul>	<ul style="list-style-type: none"> <li># of people served</li> <li># of classes/groups organized</li> <li>Pounds of medication disposed</li> </ul>	<ul style="list-style-type: none"> <li>Non-profit community-based activities</li> <li>Hospital-based activities</li> </ul>
Support activities and programs that expand access, increase engagement, and promote collaboration across the health system so as to enhance high-quality, culturally and linguistically appropriate services.	<ul style="list-style-type: none"> <li>All priority populations</li> </ul>	<ul style="list-style-type: none"> <li>Health education, awareness, and wellness activities for all age groups</li> <li>Substance use and mental health screening, monitoring, counseling, and referral programs</li> <li>Crisis intervention and early response programs and activities</li> <li>Outreach, support, and navigation programs and activities</li> <li>Substance use and mental health screening, monitoring, counseling, and referral programs</li> <li>Primary care and behavioral health integration and collaborative care programs</li> </ul>	<ul style="list-style-type: none"> <li># of people served</li> <li># of referrals made</li> <li># of support groups/trainings conducted</li> <li># of clinical practices supported</li> </ul>	<ul style="list-style-type: none"> <li>Private, non-profit, health related agencies</li> <li>Children and family services agencies</li> <li>Schools</li> <li>Elder services agencies</li> <li>Hospital-based activities</li> <li>Law enforcement</li> <li>Health departments</li> </ul>
Advocate for and support policies and programs that address mental health and substance use.	<ul style="list-style-type: none"> <li>All priority populations</li> </ul>	<ul style="list-style-type: none"> <li>Advocacy activities</li> </ul>	<ul style="list-style-type: none"> <li># of policies supported</li> </ul>	<ul style="list-style-type: none"> <li>Hospital-based activity</li> </ul>



## Priority: Chronic and Complex Conditions

In the Commonwealth, chronic conditions like cancer, heart disease, chronic lower respiratory disease, and stroke account for four of the six leading causes of death statewide, and it is estimated that there are more than \$41 billion in annual costs associated with chronic disease. Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

**Resources/Financial Investment:** LHMC expends substantial resources to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through

direct and in-kind investments in programs or services operated by LHMC and/or its partners to improve the health of those living in its CBSA. Additionally, LHMC works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, LHMC supports residents in its CBSA by providing free or discounted care to individuals who are low-resourced and unable to pay for care and services. Moving forward, LHMC will continue to commit resources through the same array of direct, in-kind, or leveraged expenditures to carry out its community benefits mission.

**Goal:** Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications, and other resources.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	SAMPLE METRICS	IDENTIFIED PARTNERS
Support education, prevention, and evidence-based chronic disease treatment and self-management support programs for individuals at risk for or living with complex and chronic conditions and/or their caregivers.	<ul style="list-style-type: none"> <li>All priority populations</li> </ul>	<ul style="list-style-type: none"> <li>Fitness, nutrition, and healthy living programs and activities</li> <li>Chronic disease management, treatment, and self-care support programs</li> <li>Cancer education, wellness, navigation, and survivorship support programs</li> </ul>	<ul style="list-style-type: none"> <li># of people served</li> <li># of classes organized</li> </ul>	<ul style="list-style-type: none"> <li>Elder services agencies</li> <li>Local health departments</li> <li>Hospital-based activities</li> </ul>
Advocate for and support policies and systems that address those with chronic and complex conditions.	<ul style="list-style-type: none"> <li>All priority populations</li> </ul>	<ul style="list-style-type: none"> <li>Advocacy activities</li> </ul>	<ul style="list-style-type: none"> <li># of policies supported</li> </ul>	<ul style="list-style-type: none"> <li>Hospital-based activity</li> </ul>

## General Regulatory Information

<b>Contact Person:</b>	Michelle Snyder, Community Benefits/Community Relations Manager
<b>Date of written report:</b>	June 30, 2025
<b>Date written report was adopted by authorized governing body:</b>	September 8, 2025
<b>Date of written plan:</b>	June 30, 2025
<b>Date written plan was adopted by authorized governing body:</b>	September 8, 2025
<b>Date written plan was required to be adopted</b>	February 15, 2026
<b>Authorized governing body that adopted the written plan:</b>	Lahey Hospital & Medical Center Board of Trustees
<b>Was the written plan adopted by the authorized governing body on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed?</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<b>Date facility's prior written plan was adopted by organization's governing body:</b>	September 12, 2022
<b>Name and EIN of hospital organization operating hospital facility:</b>	Lahey Hospital & Medical Center: 04-2704686
<b>Address of hospital organization:</b>	41 Burlington Mall Rd. Boston, MA 01805

