Community Benefits Report

Fiscal Year 2024

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*
- ***C**ollaboration - We work together to achieve extraordinary results*
- ***A**ccountability - We hold ourselves and each other to behaviors necessary to achieve our collective goals*
- ***R**espect - We value diversity and treat all members of our community with dignity and inclusiveness*
- ***E**quity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.*

At LHMC, 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 led to discrimination and disparities in access and health outcomes.

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

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

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

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

Key Accomplishments for Reporting Year
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 14,000 people to identify those at high risk for the disease.
- LHMC assisted patients in FY24 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 internships in radiology, sonology, and nuclear medicine 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 reported an improvement in their overall health.
- LHMC partnered with the Merrimack Valley Food Bank to provide a farmers market program at three public housing sites in the city of Lowell and town of Billerica.

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; and LGBTQIA+ populations.

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 continue to work with Saheli to provide support for community-based navigation services for domestic survivors and their families.

- **Social Determinants of Health**
  - LHMC will continue to 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, quality of life outcomes and increase access to healthy foods.

- **Mental Health and Substance Use**
  - LHMC will work with the Greater Lowell Health Alliance to promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health needs among Cambodian older adults.

- **Complex and Chronic Conditions**
  - LHMC will continue to support programs designed to increase mobility for older adults through its partnership with the Greater Boston and Metro North YMCA to support their Enhance Fitness programs.

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 56). The LHMC Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team

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

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

While LHMC oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief 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 the 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 the 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 19, 2023
March 27, 2024
June 26, 2024
September 25, 2024 (annual meeting)

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 needs as well as planning, implementing, and overseeing its Community

Benefits Implementation Strategy. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment (Section VII, page 56).

- Arlington Council on Aging
- A Healthy Lynnfield Coalition
- Billerica Council on Aging
- Bunker Hill Community College
- Burlington Council on Aging
- Burlington Recreation Department
- Burlington School Department
- Center for Hope and Healing
- City of Peabody
- Community Teamwork, Inc.
- Greater Lowell Health Alliance
- Greater Boston YMCA
- Lowell Community Health Center
- Housing Corporation of Arlington
- Massachusetts College of Pharmacy and Health Sciences
- Merrimack Valley Food Bank
- Metro North YMCA
- Middlesex Community College
- Mill City Grows
- Minuteman Senior Services
- New Entry Sustainable Farming Project
- North Shore Community Health
- North Suburban YMCA
- Peabody Council on Aging
- Peabody High School
- Place of Promise
- Regis College
- Saheli
- Town of Arlington
- Town of Bedford
- Town of Billerica
- Town of Burlington
- Town of Lexington
- Town of Lynnfield

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY 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 2024 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: Financial Assistance Counseling** **Health Issue: Additional Health Needs as Defined by Community (Access to Care)**		
Brief Description or Objective	Significant segments of the community population living within the hospital's CBSA, particularly low-resourced and BIPOC populations, face significant barriers to care. The hospital's Financial Assistance Program offers emergency and other medically necessary services at low or no cost to qualified patients (when qualifying family income is at or below 400% of the Federal Poverty Level). The hospital's Financial Counseling staff screen people and assist them in applying for all eligible financial assistance programs.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To assist patients throughout the BILH Systems who are uninsured and under insured to obtain eligibility for and align them with state financial assistance and hospital-based financial assistance programs. This includes MassHealth, MassHealth ACOs, Health Connector, Pharmacy Programs and Hospital Charity programs.	
Goal Status	In FY 24 LHMC screened 7,051 for eligibility programs of which 794 patients were enrolled into a MassHealth program. 486 were approved for a hospital charity discount program. 3,514 patients without insurance utilized the Health Safety Net.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Interpreter Services** **Health Issue: Additional Health Needs as Defined by Community (Access to Care)**	
Brief Description or Objective	An extensive body of research illustrates the health disparities and differences in health care access and utilization that exist for diverse individuals/cohorts and foreign-born populations. Language barriers pose significant challenges to providing effective and high-quality health and social services. To address this need, and in recognition that language and cultural barriers are major difficulties to accessing health and social services and navigating the health system, LHMC offers free interpreter services for non-English speaking, limited-English speaking, deaf and hard-of-hearing patients. These services are provided in person; by phone using a portable speaker phone to connect patients, their care team and an

	interpreter; and through video-based remote interpreter service using a computer to connect patients with an interpreter. Professional interpretation services in hundreds of languages are available 24/7.
Program Type	☐ Direct Clinical Services ☒Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population or Community Wide Intervention
Program Goal(s)	Provide culturally responsive care through the Interpreter Services Department.
Goal Status	In FY 24 there were 225,176 encounters; top 3 languages were Spanish, Portuguese-Brazilian, and Chinese-Mandarin

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Lowell Community Health Center Keys to Health Equity Project: Language Supports** **Health Issue: Additional Health Needs as Defined by Community (Access to Care)**	
Brief Description or Objective	LHMC supports the Lowell Community Health Center with funding to offset the cost of their interpreter services program. Nearly 40% of Lowell CHC patients are best served in languages other than English, this grant will strengthen the health center's capacity to deliver on-demand language services for more than half of their 35,000 patients.
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒Total Population or Community Wide Intervention
Program Goal(s)	Deliver on-demand interpretation and follow-up services for patients, in all languages.
Goal Status	In FY 24, the Lowell Community Health Center provided 206,099 sessions of interpretations (in-house interpreters = 84,728 in 12 different languages; External Language Line = 121,371) to over 20,000 patients. Demographics of clients served White 30%, Black 10%, Asian 20%, Other/Unknown, 9%, Hispanic 31%. The top languages were Spanish, Portuguese, Khmer, Haitian-Creole and Pashto. 50% of all patients at the Lowell Community Health Center require interpreter services.
Program Goal	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 24, 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. Most materials were translated into Spanish, Portuguese, Khmer. The Health Center also translated materials targeted to Arabic, Swahili, and Pashto speakers. Information included: Prenatal packet Hand hygiene, Flu and Covid vaccine clinics, Health benefits MassHealth cards, PSK-rack cards, Migrants Welcome Packet, BHS and Vision reach out letters, Lab changes, Patient Parking Communication, New Pharmacy Materials, Patient Walk-in Center-Feeling Ill?, Severe weather Communication, Expanding News, LGBTQ, Indigenous People Day, Welcome signs, Staff Access Signs. Outreach text messages were sent to over 15,000 patients, in English, Spanish, Portuguese for bi-annual Infectious Disease visits, Breast Cancer Screening and FIT Reminders.		
Time Frame Year: Year 2		**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 (Workforce Development)**		
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.	
Goal Status	Across BILH there was an 18% increase in BIPOC leadership (directors and above) and clinical (physicians and nurses) hires.	
Program Goal(s)	Increase spend with diverse businesses by 25% over the previous fiscal year across the system.	
Goal Status	More than $70 million was contracted to Women and Minority-owned Business Enterprises (WMBE) in FY24. This represents a 28% increase over FY23.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: BILH Workforce Development** **Health Issue: Additional Health Needs as Defined by Community (Access to Care)**	
Brief Description or Objective	BILH is strongly committed to workforce development programs that enhance the skills of its diverse employees and provide career advancement opportunities. BILH offers incumbent employees "pipeline" programs to train for professions such as Patient Care Technician, Central Processing Technician and an associate degree Nurse Resident. BILH's Employee Career Initiative provides career and academic counseling, academic assessment, and pre-college and college-level science courses to employees at no charge, along with tuition reimbursement, competitive scholarships and English for Speakers of Other Languages (ESOL) classes. BILH is also committed to making employment opportunities available to qualified community residents through training internships conducted in partnership with community agencies and hiring candidates referred by community programs.

Program Type	☐ Direct Clinical Services ☐Access/Coverage Supports ☐Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒Total Population or Community Wide Intervention
Program Goal(s)	• In FY24, Workforce Development will continue to encourage community referrals and hires. • In FY24, Workforce Development will attend events and give presentations about employment opportunities to community partners • In FY24, Workforce Development will offer employees career development services. • In FY24, Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees. • In FY24, Workforce Development will offer English for Speakers of Other Languages (ESOL) classes to BILH employees. • In FY24, Workforce Development will hire interns hired after internships and place in BILH hospitals • In FY24, Workforce Development will offer paid training for community members across BILH. • In FY24, Workforce Development will establish clinical affiliation agreements with vocational technical high schools to hire young people from the community for cooperative education paid and unpaid internships in nursing assistant, medical assistant, and other hospital-specific positions.
Goal Status	• In FY24, 412 job seekers were referred to BILH and 111 were hired across BILH hospitals. • In FY24, 33 events and presentations were conducted with community partners across the BILH service area. • In FY24, 1,044 BILH employees received career development services. • In FY24, 14 BILH employees attended citizenship classes, 15 BILH employees attended career development workshops and 207 BILH employees attended financial literacy classes. LHMC employees participated in these offerings. • In FY24, 82 employees across BILH were enrolled in ESOL classes. LHMC employees participated in these classes. • In FY24, Workforce Development will offer internships in BILH hospitals to community members over the age of 18.

	• In FY24, 107 community members placed in internships across BILH hospitals to learn valuable skills. LHMC participated in offering these internships. • In FY24, 37 interns were hired permanently in BILH hospitals. Lahey participated in these hirings. • In FY24, BILH trained a total of 99 community members to Patient Care Technician or Nursing Assistant (41), Pharmacy Tech (22), Medical Assistant (29), Behavioral Health roles (3) or into the Associate Degree Nursing Residency program (4). LHMC participated in offering these trainings. • In FY24, Workforce Development established 10 clinical affiliation agreements with vocational technical high schools, which resulted in the hiring of 47 high school students in paid cooperative education placements and 11 in unpaid clinical placements. LHMC participated in offering these trainings.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Facilitating Primary and Specialty Care Access** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	Throughout LHMC's Community Benefits Service Area the hospital subsidizes primary care services provided by BILH Primary Care.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	Provide access to primary and specialty care for uninsured and underinsured patients	
Goal Status	In FY24, LHMC provided primary and specialty care in 6 practices in its CBSA	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Gender Health Program** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	LHMC provides gender-affirming care for both medical and surgical services in a safe and affirming environment. Working with the Patient Care Coordinator, individuals are assisted with finding the correct LHMC specialists and providers to help affirm their gender identity. The program currently has over 650 patients. In addition to caring for gender diverse patients, the program aims to increase cultural awareness and competency across LHMC, as gender diverse patients engage with all services and departments to create a more inclusive environment for patients and staff.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	Increase opportunities for gender-affirming care.	
Goal Status	In FY24, 199 new patients were provided navigation to access gender affirming care within 11 services within the hospital.	
Time Frame Year: Year 2	**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 (Access to Care)**	
Brief Description or Objective	LHMC maintains its partnership with Minuteman Senior Services to continue to provide SHINE counselors at the Arlington and Burlington Councils on Aging. The consumers served in the LHMC region received no-cost, one-on-one insurance benefits counseling provided by state-certified SHINE volunteers or staff members.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention ☒Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Minuteman Senior Services (MSS) Regional SHINE program will provide Medicare benefits counseling to 2100 individuals who reside in Burlington, Arlington and Winchester, MA 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	MSS provided 579 individuals residing in Arlington, Burlington and Winchester with Medicare benefits counseling, public benefits screening, and plan/cost comparisons. 373 individuals resided in Arlington and Winchester or received treatment at Winchester Cancer Center. Sixty-four individuals who received support in Arlington or Winchester were below low-income subsidy ($1903 individual $2505 couple with assets of up to $17,220 individual $34,360 couple). All low-income/asset individuals received public benefits screening and/or health / pharmacy benefits application support. Minuteman Senior Services SHINE did not reach the goal of 700 counseling sessions due, in part, to retirement of the Burlington COA SHINE counselor who typically served 100+ consumers annually. This particular goal will be reviewed and updated to reflect current resources.
Program Goal	Minuteman Senior Services will perform 150 pre and post specific consumer assessments.
Goal Status	MSS performed 276 electronic consumer assessment surveys to SHINE consumers in eighteen communities who received services in the report period 11/15/23 – 11/15/24. In Arlington, Burlington and Winchester 27 surveys were completed. Five consumers in the BILH service area required further information regarding meal delivery, homecare, or transportation. MSS contacted these consumers and connected three people eligible to home delivered meals, one person was referred to transportation resources and one did not meet homecare eligibility. MSS hosted eleven community education workshops. Workshops were held at Winchester Council on Aging, Winchester and Arlington Housing Authorities and Arlington Adult

	Education. Topics included: Medicare Savings Program, Medicare Preventative Benefits, New to Medicare and Understanding IRMAA. SHINE education focused on audiences that were new to Medicare, low-income and people with disabilities.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Peabody Veterans Memorial High School Student-based Health Center** **Health Issue: Additional Health Needs as Defined by the Community (Access to Care)**	
Brief Description or Objective	This program provides high-quality, comprehensive health care to students on site at Peabody High School. Services include management of chronic illnesses such as asthma and diabetes, urgent care visits, immunizations, routine and sports physicals, health education, and confidential services, including reproductive health care and behavioral health services.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal	Provide support and funding for services at the Peabody Veterans Memorial High School Student-based Health Center that meet a critical identified community need.
Goal Status	In FY24, the Student-based Health Center had the following impacts: 853 Medical visits (which is an increase of almost 100 visits from FY23), 711 Behavioral Health visits, and 360 unique clients. The student-based Health Center offered school clearance and immunization visits for children who attended Peabody Public Schools and had no PCPs listed, 63 patients were ages 4- 14 and below. In FY 24, 68% of health center clients were people who were either insured by MassHealth or are uninsured through the Health Safety Net (HSN).
Program Goal	The student-based Health center will help to provide access to critical behavioral health services for students who are uninsured/health safety net or on MassHealth
Goal Status	In FY 24, 71% of Student-based Health Center clients were persons who are either insured by MassHealth/HSN or were uninsured for their visits. Of the 80 students who were referred to our student-based Health Center for behavioral health services, 15 patients declined or screened out, 8 patients were referred to outside providers our single provider was able to establish care with the rest through either individual therapy or group therapy.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Saheli's Community Health Outreach, Engagement and Education** **Health Issue: Additional Health Needs as Defined by the Community (Access to Care)**	
Brief Description or Objective	LHMC partners with Saheli to support, grow and strengthen community-based outreach, engagement and education developed to meet the unique needs of residents of the South Asian and Middle Eastern and North African (MENA communities within its community benefits service area. The project assists residents of these communities through a two-pronged approach: 1) a culturally proficient community health worker also trained as a domestic violence advocate, will improve access and engagement of health and safety services to South Asian and Middle Eastern and North African residents. The community health worker assesses the client's needs, links households to support, and enhances access to culturally competent care providing trauma informed and survivor-centered services tailored to the goals and needs of the survivor. The community health workers also provide education and engagement with medical and mental health providers, housing providers, and community leaders to raise public awareness about South Asian and Middle Eastern and North African survivors' challenges and improve social acculturation and health access for these populations.
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 housing services to program participants through the community health outreach worker.
Goal Status	In FY 2024 Saheli's Outreach and Engagement team, specifically the Community Health Worker and Outreach Coordinator, supported by this grant, continue to provide outreach, education and engagement services targeting South Asian and Middle Eastern and North African survivors of domestic violence and their children. Notable achievements have included reaching, engaging, and supporting over 300 survivors in the region, and partnering with dozens of new service providers and community leaders. In addition, cultural sensitivity educational workshops have helped many direct care providers in medical, educational and community service settings to better understand the unique characteristics of the populations we serve and to provide more responsive services. Other notable achievements include: • Increasing number of survivors who contacted Saheli for services by 50%. • Helping 23 survivors stabilize their housing and/or secure permanent housing. • 220 clients received case management and supportive services. • 33 clients received one-on-one therapeutic counseling. • 31 clients participated in group therapy sessions.

	• 20 clients obtained employment and/or enrolled in training/education programs. • 25 survivors participated in economic empowerment program, set educational and employment goals and attended financial literacy education. • 54 survivors received legal and/or immigration services.
Program Goal	Provide outreach and engagement services to increase cultural awareness for clinicians and the community at-large.
Goal Status	Outreach and Engagement Services • Conducted 8 prevention education and public awareness workshops in focus communities. • Engaged with 8 new partners and collaborators through community-based outreach and provide training about trauma-informed culturally appropriate services for South Asian and Middle Eastern and North African survivors and their children. • Reached 300 people in community-based prevention education outreach events and activities. Saheli has worked with a range of partners to develop training curriculum and materials for providers and stakeholders targeted to the unique cultural characteristics and needs of target populations.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Community Benefits Administration and Infrastructure **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	Community Benefits and Community Relations staff implement programs and services in our Community Benefits Services Area, encourage collaborative relationships with other providers and government entities to support and enhance community health initiatives, conduct Community Health Needs Assessments and address priority needs and ensure regulatory compliance and reporting. Additionally, Community Benefits and Community Relations staff at BILH hospitals work together and across institutions to plan, implement, and evaluate Community Benefits programs. In FY24, the staff worked collaboratively to begin the Community Health Needs Assessment, sharing community outreach ideas and support, and helping to distribute the community survey and identify key community residents for interviews and focus groups.	
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions ☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits	
Program Goal(s)	Implement effective and efficient programs that support the community health needs of the Community Benefits Service Area.	
Goal Status	LHMC supported and implemented 32 programs and granted over $300,000 to local organizations in FY 24	
Program Goal(s)	Offer evaluation capacity workshops to partner organizations and grantees to better understand impact.	
Goal Status	BILH offered two evaluation workshops to 30 organizations and grantees. 100% of organizations and grantees who attended were Satisfied or Very Satisfied with the workshops and 90% stated it was directly relevant to their role in their organization.	
Time Frame Year: Year 2	**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 (Transportation)**		
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 30, 2024 Project Mobility will provide transportation services to over 30,000 residents of Peabody.	
Goal Status	From October 1st, 2023-September 30th, 2024, Project Mobility provided 33,346 rides of which 6,791 required the use of a wheelchair lift, making services more accessible to all. At the present time, 95% of all riders are 60 years of age or older.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: LHMC Internship Programs** **Health Issue: Additional Health Needs as Defined by Community (Workforce Development)**			
Brief Description or Objective	LHMC is committed to collaborating with partners to strengthen the local workforce by supporting job training and internship programs. Every year, through the Radiology Job Training Program, students from surrounding colleges and universities are given the opportunity to receive hands-on clinical experience in radiation, breast imaging, CT scan, nuclear medicine, and ultrasound technologies. Internships range from 6 months to 2 years and interns are supervised and educated by LHMC staff members. LHMC partners with Bunker Hill Community College, Middlesex Community College, Massachusetts College of Pharmacy and Health Science, and Regis College on this program.		
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits	
Program Goal(s)	In FY24, LHMC will provide clinical-based education opportunities to help strengthen the local workforce.		
Goal Status	In FY24, LHMC provided 1 internship for a student in Diagnostic Ultrasound. LHMC Nuclear Medicine provided 2, 3-month internships for Regis College Nuclear Medicine students. LHMC Diagnostic Radiology had 8 graduating second years, 4 were hired. LHMC Diagnostic Radiology had 6 first years.		
Time Frame Year: Year 2	**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 (Access to Healthy Food)**	
Brief Description or Objective	LHMC partners with Mill City Grows (MCG) to provide funding for improvements to its community-based garden program. MCG, a longtime partner of LHMC, has designed and built and now oversees 21 community and school gardens in Lowell that are used by over 6,500 Lowell residents. In this urban environment environmental challenges exist that contribute to health inequities among households with incomes below the federal poverty level, older adults, and foreign-born persons. Historically underserved neighborhoods are blighted by vacant, contaminated and underutilized lots containing soils with legacy heavy metals and other toxins that are remnants of Lowell's industrial past. This renders much of the open space in these neighborhoods unsuitable for recreational use with little incentive for developers to remediate the land.

Program Type	☐ Direct Clinical Services ☐Access/Coverage Supports ☐Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☒Total Population or Community Wide Intervention
Program Goal(s)	50% of participants increase produce consumption because of community gardening.
Goal Status	• 86% of members report eating more fruits and vegetables because of their participation (compared to 61% in 2022). • 16% of gardeners experience food insecurity, compared with the city-wide average of 35%.
Program Goal	Enroll 450 gardeners in 8 gardens.
Goal Status	591 gardeners were active in the program with 90% of garden beds enrolled.
Program Goal	Mill City Grows will improve access to fresh, local food for Lowell youth in our afterschool programs, widening the variety of produce tried and veggies enjoyed.
Goal Status	552 youth brought home 1,472 lbs of food home via after school programs at 5 Lowell Public schools, including Mobile Markets and cooking classes.
Program Goal	Develop parent engagement with Mill City Grows programs via school-based projects; in 2024 we offered cooking classes targeting high-needs families.
Goal Status	25 individuals (youth, caregivers, educators) participated in cooking classes at an elementary school with a newly built school garden during the 2023-24 school year.
Program Goal	By June 2025, establish a new community garden in the Pawtucketville neighborhood of Lowell with at least 30 new beds.
Goal Status	12 community members participated in a collaborative Community Garden Planning process in 2024 which resulted in a finalized schematic design that incorporates 40 raised beds with permaculture spaces that focus on pollinators and minimizing wildlife disturbance.
Program Goal	75% of youth participants in school-based programming will experience new foods and 60% will state a willingness to incorporate these foods into their diet.
Goal Status	• 552 youth brought home 1,472 lbs of food home via after school programs at 5 Lowell Public schools, including Mobile Markets and cooking classes. • 83% of youth participants tried new foods and 81% reported they would eat these new foods again

Program Goal	Increase community members' sense of social connections and increase the sense of shared space in the community gardens.
Goal Status	• 20% increase in social connections formed via the community garden (95% in 2023 vs. 74% in 2022) • 57 people participated in Garden Education workshops during the grant period. • 12 community members participated in a collaborative Community Garden Planning process.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Merrimack Valley Food Bank (MVFB) Community Market Program** **Health Issue: Additional Health Needs as Defined by Community (Access to Healthy Food)**	
Brief Description or Objective	LHMC partners with the Merrimack Valley Food Bank (MVFB) to provide funding to support its Community Market Program, which serves residents of four Lowell Housing Authority (LHA) properties, offering them the opportunity to supplement their food by enjoying fresh produce at no cost. Bringing the market to the Lowell Housing Authority properties helps residents who have difficulty traveling to a grocery store or pantry. The convenience of having fresh produce available outside one's front door may encourage individuals to eat more fresh fruits and vegetables.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Increase the number of residents of public housing who utilize the Community Market and who receive supplies of fresh produce for their consumption, to sustain their health and well-being.
Goal Status	Merrimack Valley Food Bank has increased the number of people they serve with the Community Market, by adding an additional site in Billerica (four sites in Lowell, and one in Billerica, supported by LHMC). Merrimack Valley Food Bank served 15% more residents in Lowell and Billerica than in 2023.
Program Goal	Coordinate with the Lowell Housing Authority to bring the Community Market program to residents of at least four Lowell Housing Authority housing sites.

Goal Status	Merrimack Valley Food Bank is bringing Community Market food distribution to four Lowell Housing Authority sites: North Common Village, South Common Village, Francis Gatehouse, and Centralville Gardens. In addition, Merrimack Valley Food Bank expanded the Community Market to Billerica, with a Community Market at the Greenwood/McCarthy complex, in coordination with the Billerica Housing Authority.
Program Goal	Distribute at each housing site, from July through November, fresh produce and other healthy food supplies to residents of the Lowell Housing Authority who come to the Community Market
Goal Status	Merrimack Valley Food Bank extended the Community Market to begin in June instead of July, adding another food distribution to all Community Market sites, and added a site in Billerica as well.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Council on Aging Farmers Market Program** **Health Issue: Additional Health Needs as Defined by Community (Access to Healthy Food)**	
Brief Description or Objective	LHMC partners with the New Entry Sustainable Farming Project to run 20-week farmers' markets at Burlington, Arlington, and Billerica Councils on Aging. Depending on location, the program served 50-80 older adults per week from June through October. On average, participants took home 6 varieties of fresh, local produce each week.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	By September 30th, 2024, the program will provide a cohort of 50-80 older adults per week in Arlington, Billerica, and Burlington with fresh fruits and vegetables.
Goal Status	The Arlington COA received produce for 60 recipients from New Entry for 20 weeks. The produce bags weighed 3-7 lbs. and were valued at $15 each including 2-3 lbs. gleaned produce per week added for 17 weeks at no cost. Over 20 weeks, 1200 produce shares were distributed with a total weight of produce distributed this year to Arlington COA of 6000 lbs. Burlington COA received produce for 50 recipients from New Entry for 20 weeks this year. The produce bags weighed 3-7 lbs. and were valued at $15 each including 2-3 lbs. gleaned produce per week added for 17 weeks at no cost. Over 20 weeks, 1000 produce shares were distributed. The total weight of produce distributed this year to Burlington COA was 5000 lbs.

	Billerica COA received produce from New Entry for 65 recipients for 20 weeks this year. The produce bags weighed 3-7 lbs. and were valued at $15 each including 2-3 lbs. gleaned produce per week added for 17 weeks at no cost. Over 20 weeks, 1300 produce shares were distributed. The total weight of produce distributed this year to Billerica COA was 6500 lbs. Total pounds provided through LHMC Farmers Market = 17500 lbs. Total produce shares served through LHMC Farmers Market= 3500 Total people served through LHMC Farmers Market= 175
Program Goal	By September 30th, 2024, participants will report an increase in their daily intake of fruits and vegetables.
Goal Status	79 program participants completed the 2024 season's survey. Arlington had 11 participants complete the survey, Billerica had 39 and Burlington had 29. The mean age was 77 years old (minimum was 61 years old and maximum was 96 years old). Of those who completed the survey: 85% ate a greater variety of fruits and/or vegetables, 82% increased their daily intake of fruits and vegetables, and 86% ate better quality produce.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: Cooking Up Good Health** **Health Issue: Additional Health Needs as Defined by Community**		
Brief Description or Objective	LHMC provides free nutrition and cooking classes to community members through its Cooking Up Good Health series. Participants learn different culinary tips and nutritional information about meals, snacks, sides, and desserts.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	By September 30th, 2024, LHMC will provide nutrition education for 10 participants per session.	
Goal Status	In FY 24, LHMC held twelve classes attended by an average of 10 people per class.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Affordable Housing, Family Stability and Tenant Support in Arlington** **Health Issue: Housing/Homelessness**		
Brief Description or Objective	LHMC partners with the Housing Corporation of Arlington (HCA) to provide an integrated set of social service programs that provide affordable housing, prevent homelessness, connect families to vital resources, and help people with incomes below the federal poverty level develop as leaders so that they may advocate for themselves and their community.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	• During 2024, 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. • At least 100 households within HCA's affordable housing portfolio will participate in the Tenant Councils each year. • At least 2 additional HCA tenants will join the HCA Board over the next 3 years. • At least 15 HCA tenants participate in advocacy on state and local housing and other relevant issues.	

Goal Status	• This goal shifted to be to create one Tenant Council throughout HCA's portfolio. • HCA worked with tenants who were interested in a leadership role to establish the Tenant Council Steering Committee. That group has hosted three Tenant Council meetings to date, with increased attendance at each subsequent meeting. The Steering Committee is supported by HCA staff to set the Tenant Council meeting agendas, facilitate meetings, conduct outreach for meetings and develop plans and goals based on what the larger tenant constituency is concerned about. The Tenant Council is now developing a set of requests from property management related to the top issue that has emerged, which is around how communication flows (or doesn't) between management and tenants. They have also started fundraising to create a fund to augment HCA's HPP grants, which would provide very small grants to assist with needs like taking a Lyft, childcare or other unexpected but urgent or highly needed expenses. They have also started a private HCA Tenants Facebook group in order to share ideas and resources. Turnout for each Tenant Council meeting has increased slightly each time, showing greater momentum. The Steering Committee is now 5 people, with one other potentially interested in joining. • 28 households out of 150 HCA apartments have attended at least one Tenant Council meeting to date. More than this have also responded to the annual tenant survey conducted online each year (that survey has the option to be anonymous, so HCA don't know fully who might have completed it who has not attended a meeting). HCA is significantly shy of its initial goal of 100 households and does not expect to meet it within the grant period. However, building this from new – especially given HCA's poor property management history and the mistrust and apathy it created – is challenging, but the momentum and interest is clear and growing. This work remains very successful, will continue to engage more households, and will continue to have a real and positive impact. HCA expects to see perhaps a total of 50 households participate during the grant period, which represents 30% of total households. • HCA is about to formally engage the Mass Association of Community Development Corporations (CDC) to provide a specially tailored tenant association training for HCA tenants, to start in February 2025. The program will be open to any interested HCA tenant, but we intend to ensure that all 5 of our Steering Committee members attend. The training can accommodate a maximum of 15 participants, and we are aiming to enroll at least 12. The members of the steering committee have each

	received experiential training to date through their increasing leadership within the Council and the coaching they receive from the Civic Engagement Coordinator and indirectly from the Executive Director and a local volunteer, both of whom provide coaching to the Civic Engagement Coordinator based on their years of community organizing. This more formal training will build on their increased skills to date. • As of the last report HCA had surpassed the goal to engage at least 15 tenants or social service clients in advocacy but continues that work. HCA engaged tenants in advocating for several housing related bills at the state level including Tenant Opportunity to Purchase Act (TOPA), and the Zero Carbon Renovation Fund. This engagement included taking 2 HCA tenants and one former social services client to the statehouse for the Mass Association of CDCs Lobby Day, engaging 2 other HCA tenants (and some HCA Board members) in a Zoom call with staff of Arlington's State Senator to advocate for TOPA, and having attendees at the annual Walk for Affordable Housing (including tenants and social service clients) sign postcards in support of TOPA and the Community Investment Tax Credit expansion bill. In coming months HCA will be heavily engaging tenants in the town's Master Plan update process.
Program Goal	Prevent homelessness and create more stable tenancies for at least 45 unique Arlington families per year (at least 135 over 3 years) who are at near-term risk of homelessness through the provision of homelessness prevention grants. At least 80% of grantees will remain stable in their homes for at least 18 months after they have received assistance.
Goal Status	In FY 24, HCA provided 42 households with Homelessness Prevention grants, totaling $79,793. Between the start of the grant period (Jan 2023) and October 31, 2024, HCA provided a total of 96 grants. They are on track to meet this goal of 135 families over the 3-year grant period. The evaluation plans were delayed but HCA will be evaluating this program during the first half of 2025 with a team of Tufts Urban and Environmental Policy graduate students, which will enable them to understand how many of the grantees do remain stable in their homes, and for how long. That evaluation will include intensive outreach and surveying of prior grantees. Since the end of COVID era benefits in spring 2023, HCA has seen an increase in households who return within a year for more assistance. However, it seems that most households do remain stable after receiving this grant for at least 18 months, or at least they are not returning to HCA for assistance.
Program Goal	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	In FY 24, the number of households HCA provided with social services (not counting homelessness prevention program recipients reported in Goal 1 or tenant council steering committee leaders) is 78.	
Time Frame Year: Year 2	**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 Town of Burlington to provide funding to support an 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 24, the Town of Burlington reported 33 encounters and 16 referrals to housing services to residents who qualify as low-resourced.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Community Teamwork Inc. (CTI) Secure Jobs Program** **Health Issue: Housing/Homelessness**		
Brief Description or Objective	LHMC, through its Community-based Health Initiative, is supporting the Secure Jobs Program at CTI. The program provides job readiness skills training, eliminates barriers to employment and connects families with suitable employers in jobs with defined career paths. The program provides job training, job search services and a year of stabilization services for participants. In addition to providing clients with personalized employment services, Secure Jobs staff works with the client to remove barriers to success by linking participants with childcare resources, transportation to and from training programs, helping navigate options for people who have challenges with CORIs, and providing skills training, job readiness training, and job search services spiritual and mental wellness.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Create a 3-year logic model and evaluation plan for development and implementation of the program.	
Goal Status	Grantee worked with an external evaluator to develop logic model and evaluation plan and are in the process of beginning their programs.	
Program Goal	Participants increase their employability through job readiness as demonstrated by the reduction or elimination of barriers, acquisition of soft and hard job skills, and/or training.	
Goal Status	Currently, 46 participants have been enrolled in the program; 33 out of those 46 have been employed. One of the most common barriers is language; CTI have 6 participants enrolled in English as a Second Language (ESOL) classes and 5 are enrolled in further language development trainings.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: The Resource Center at Citizens Inn** **Health Issue: Housing/Homelessness**	
Brief Description or Objective	To support increased access to economic access for individuals to maintain stabilized housing, Lahey supports the Resource Center at Citizens which offers direct services and referrals aimed at removing the barriers to housing and food security. Citizens Inn has been supporting families to successfully transition to stable housing for over 41 years and have learned that families who are homeless or food insecure face many other barriers to stability, and that homelessness prevention requires a comprehensive approach. The Resource Center addresses obstacles to financial security by offering a range

	of direct services and referrals, including SNAP assistance (food stamps), digital access (internet hotspots), English as a Second Language classes, support to obtain drivers' licenses for qualified immigrants, financial literacy and counseling, access to health services and referrals to housing, rental, and utilities assistance. It is designed to be a community resource, open to all in need, to connect individuals and families to resources.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	The Resource Center will provide supportive services for clients focused on comprehensive services and referrals tailored to the needs of individuals and families experiencing homelessness, food insecurity, and economic instability.
Goal Status	Citizens Inn partners with the Peabody School System to help families achieve food security and raise awareness of available resources. In FY24, they connected over 100 families with SNAP benefits. A Digital Navigator assists immigrants eligible to obtain a MA driver's license under the Work and Family Mobility Act (WFMA), to remove barriers to employment and access to services, FY24 Citizens Inn assisted 121 individuals with the process of applying for a driver's license, with 55 successfully obtaining their driver's licenses. This program has been instrumental in removing barriers to employment for participants. In FY24 they offered English as a Second Language classes on Wednesday nights with an average of 15 students a week with a total roster of 65. Classes were lead in English as participants have home languages of: Spanish, Haitian Creole, Portuguese, Albanian and Arabic. Citizens Inn also partnered with Metro Credit Union to offer Financial Literacy classes in Spanish- assisting 35 participants and staff held office hours monthly on the third Thursday of each month for individual one-to-one financial counseling and met with over 20 individuals to discuss money saving options, household budgets, and investing/divesting options. MASSHIRE kept office hours one Monday per month to connect food pantry clients with the MA unemployment office and job training.
Program Goal	In FY24 Citizens Inn's housing stabilization team will offer case management to families exiting its emergency shelters and partnered with Peabody Housing Authority, Eliot Services and North Shore Community Action Programs to assist participants in finding or maintaining housing.
Goal Status	In FY24, 13 families that exited shelter were provided services from the stabilization team with monthly checkups to ensure the families are maintaining their new housing situation.

	Citizens Inn also partnered with the Peabody Housing Authority to support families at risk of eviction maintain housing by assisting them with resources including applications to utilities and rental assistance (RAFT) and utilities assistance. Citizens Inn launched a formal partnership with Eliot Community Health Services to refer chronically unhoused individuals for mental health services and housing assistance. In FY24, they referred 10 chronically homeless individuals to Eliot for case management, mental health assistance, and housing and referred an additional four individuals to NSCAP for housing assistance.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington Council on Aging Outreach Workers** **Health Issue: Mental Illness and Mental Health**		
Brief Description or Objective	LHMC partners with the Burlington Council on Aging on social workers that provide outreach to older adults within the town. Staff regularly meet with individuals on a variety of issues and provide support, guidance and referrals to services, helping to bridge the gaps for groups who are disproportionately affected by barriers to care.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2024, provide supportive services for older adults in Burlington.	
Goal Status	Number of encounters for outreach workers: The Burlington Council on Aging social workers had 4,116 encounters up from 3,283 encounters serving 699 up from 621 people (including family members or caregivers). Demographics of people served: 2 African Americans, 16 Asian Americans, 14 Southeast Asians, and 2 persons of Hispanic origin.	
Program Goal	By September 30, 2024 provide referrals for program clients to supportive services.	
Goal Status	The social workers made 679 referrals to various agencies such as Legal Services, adult day health, housing and Minuteman Senior Services for home care services, health insurance benefits (SHINE), and protective services. Most of those referrals also stayed with the COA for ongoing case management.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington Police Department Substance Use Coordinator** **Health Issue: Substance Use**		
Brief Description or Objective	LHMC partners with the Burlington Police Department to provide a substance use coordinator. The coordinator provides essential outreach to persons identified by police as having substance use issues. The position provides support and referrals for those individuals and coordinates between multiple town and community agencies to ensure they receive essential services.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2024, provide referrals and supportive services to persons with substance use disorder.	
Goal Status	• Number of individuals contacted for substance use coordinator: 77 • Number of referrals who accepted services: 35 • Demographics of people served: o By gender male 31 & female 46 o By age 15 to 19 = (2), 20 to 39 = (45), 40 to 59 = (24), 60 and over = (6) • In FY2024, the Mental Health Clinician (MHC) assisted 191 individuals/families; a 25% increase since 2022. Most of the referrals (60%) came from regular police calls for service. There were 58 referrals from outside of the agency and 19 walk-ins/calls from citizens. The MHC also serves on many committees and maintains communication with various departments and agencies, public and private, across the community.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Khmer Older Adult Action Group** **Health Issue: Mental Illness/Mental Health**		
Brief Description or Objective	LHMC, through its Community-based Health Initiative, supports increased access to mental health and supports through the Khmer Older Adult Action Group (KOAAG), which engages older Cambodian adults as paid community ambassadors to identify community needs and implement interventions. The program will be led by Cambodian outreach workers and the KOAAG will operate under an empowerment model, with community norms, meeting procedures, and group initiatives being determined by the KOAAG. The primary driving force behind this project will be the inherent value in community convening to reduce isolation, support empowerment, and create self-determining communities through honoring the cultural linkages of spiritual and mental wellness.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Create a 3-year logic model and evaluation plan for development and implementation of the program.	
Goal Status	KOAAG worked with an external evaluator to develop logic model and evaluation plan and are in the process of beginning their programs.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Torigian Family YMCA Youth Mental Health and Substance Use Prevention Program** **Health Issue: Mental Illness/Mental Health**	
Brief Description or Objective	LHMC, through its Community-based Health Initiative, supports the Torigian YMCA's hiring of an Association Behavioral Analyst to provide in-house support to the increasing number of youth exhibiting mental health and behavioral support needs across the Association's childcare programs. A part-time Teen Mentor/Program Director will also be hired to support teens at the Torigian Y and direct them towards targeted activities. Finally, the YMCA will provide financial assistance to economically disadvantaged families to enable their children to attend childcare programs, where they will build critical social-emotional skills that will help prevent substance use and mental or behavioral challenges from occurring down the line. Grant funds will also help support the purchase of social-emotional learning supplies and sensory toolkits for childcare 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)	Create a 3-year logic model and evaluation plan for development and implementation of the program.	
Goal Status	The YMCA worked with an external evaluator to develop logic model and evaluation plan and are in the process of beginning their programs.	
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 to provide funding to support residents of the Town with comprehensive mental health services for youth and families.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2024, provide comprehensive supportive mental health services to youth and families in Burlington.	
Goal Status	Number of annual visits: 4,146 Number of referrals: 270 Number of trainings: 4 Number of support groups and individuals served through support groups: 10 groups, and 103 attended.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington High School Adjustment Counselor** **Health Issue: Mental Illness/Mental Health**		
Brief Description or Objective	LHMC partners with Burlington High School to provide support for an onsite adjustment counselor for preventative and supportive services for students identified to be at high-risk for mental health disorders.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2024, Burlington High School will provide social and emotional support services to students through the adjustment counselor services.	
Goal Status	Number of students served - 80 Demographics of students served • African American - 27 • Asian - 9 • Asian, Caucasian - 1 • Caucasian - 32 • English Learners - 7 • Individualized Education Program/504 - 3 • Connections Program (substantially separate) – 11 • Free/Reduced - 22 • Number of students referred for services - 9 (included above)	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: The Center for Hope and Healing, Inc (CHH): Reducing Barriers for Underserved Sexual Assault Survivors** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	This program is designed to provide capacity-building to Center for Hope and Healing (CHH) staff on culturally sensitive approaches to support 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)	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.
Goal Status	CHH has worked closely with its consultant to provide weekly clinical supervision to its counselor staff. Clinical supervision is also held monthly with all staff. The consultant also supports CHH in providing Resilience Session to support all staff in building resilience, accountability and commitment toward their wellness are they are providing direct services to survivors. This Resilience Practice is being held quarterly.
Program Goal	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.
Goal Status	CHH started the community health needs assessment in collaboration with its community partners. The assessment will be completed by March 2025.
Program Goal	By September 1, 2024, CHH Survivor Services team will host 12-week in-person support groups (5 groups) such as Spanish, Portuguese, Khmer, English, and Male Survivors. The 5 support groups will be held twice a year - in the Spring and Fall. By December 30, 2025, 30 support groups will be held and have supported at least 200 survivors.

Goal Status	In this second year, CHH was able to serve 78 survivors in the community through various support groups and Healing series. During this reporting period, CHH was able to provide 186 hours of direct services through 6 support groups and 50 sessions, including: • Cultivating Hope, support group for English-speaking survivors (14 sessions) • Tudo Bem Mesmo?, support group for Portuguese-speaking survivors (held twice and had a total of 16 sessions) • Black Girls Rock, support group for high-school age girls (8 sessions) • Food for Thought Healing Series, (3 sessions) • Healing Circles: Construyendo Puentes, Spanish-speaking support group (7 sessions) • Healing Circle: Surviving to Thriving (Survivor-led support group), (2 sessions)

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Place of Promise Long-Term Residential Addiction Recovery Program** **Health Issue: Substance Use**	
Brief Description or Objective	LHMC partners with Place of Promise to provide support for their adult long-term residential addiction recovery program. One-on-one counseling sessions include medical and clinical counseling, chronic illness management, and mental health counseling. The goal of the program is to prepare residents with the tools and skills to return to their homes and communities to live productive lives free from addictions, and to provide them with ongoing support when needed.
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	In FY 24, 45 men/women will be served in the Level I and II program.
Goal Status	Result (10/1/23 – 9/30/24): 46 Served
Program Goal	Within 3 months of the program's start, 75% of residents will have attained medical insurance, been seen by Primary Care Physician, and have a care plan established.
Goal Status	Result (10/1/23 – 9/30/24): Of the 46 served during this time, 40 attained medical insurance, were seen by a Primary Care Physician, and had a care plan established (87%).

Program Goal	Within 10 months of program start, 50% of residents will be I-9 Ready (i.e., necessary documentation to enter work force or attend school)	
Goal Status	Result (10/1/23 – 9/30/24): Of the 46 served during this time, 43 have gotten the necessary ID's (93%).	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Facilitating Access to Behavioral Health Services and Supports** **Health Issue: Mental Health/Mental Illness and Substance Use**		
Brief Description or Objective	BILH Behavioral Services provides a number of different programs and services that serve communities within the LHMC service area including mobile behavioral health urgent care programs as well as comprehensive care coordination and case management. BILH is also committed to increasing access to Behavioral Health services as part of primary care. Services include individual and group therapy for mental health and substance use issues; addiction treatment; family services; mobile crisis teams for behavioral and substance-related emergencies, and inpatient psychiatric care. Centralized bed management monitors a patient's progress through a facility or emergency department and coordinates the placement of behavioral health patients in the inpatient unit best suited to their needs based on clinical presentation and geographic location.	
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	By September 30th, 2024, provide services to increase access to behavioral health services.	
Goal Status	• In FY24, 2,708 patients were served in 7 practices in LHMC's CBSA. • FY24 5,704 initial and follow-up psychological evaluations were conducted by the Emergency Services team • In FY24, 78 women and 141 children were provided with 4,905 bed days in HART House	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Behavioral Health Crisis Consultation** **Health Issue: Mental Health/Mental Illness and Substance Use**		
Brief Description or Objective	LHMC, along with all hospitals in the BILH system, provides 24/7/365 behavioral health crisis evaluation in the emergency department (ED) and throughout other hospital units for individuals experiencing mental health and substance use related crises. Services are payer agnostic and provided via in-person or telehealth by a multidisciplinary team of qualified professionals, including Psychiatrists, independently licensed and master's level clinicians, Nurse Practitioners, Registered Nurses, Certified Peer Specialists, and Family Partners. The services include initial assessments for risks, clinical stabilization, treatment initiation, care coordination, and ongoing evaluation to ensure appropriate level of care placement.	
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	By September 30th, 2024, 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 sites in Burlington and Peabody. In FY24, the team provided 40 screens in Burlington and 171 in Peabody.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Trauma Support Group** **Health Issue: Mental Illness/Mental Health**		
Brief Description or Objective	LHMC provides a free, monthly support group for individuals and their families who are recovering from a traumatic injury to help them in their recovery, resilience-building, and identifying resources for support.	
Program Type	☐ Direct Clinical Services ☒Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	Provide behavioral health resources and supportive services to patients and community members	

Goal Status	In FY 24 LHMC provided 11 sessions of a support group for survivors of trauma. On average there were 3-4 participants per session. The total number of participants for the year was 20. LHMC also sent out 25 information packets per month to our Trauma Survivors. The packets included an invitation to join the support group as well as information on the programs offered by the Trauma survivors Network	
Time Frame Year: Year 2	**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, 2024, Burlington High School will provide a wellness day focused on providing students with resources for stress reduction and mental health.	
Goal Status	• Number of students who participated - 850 • Number of staff who participated -140 (everyone participates differently, not everyone runs a session) • Number of vendors/workshops offered - 156 session offerings	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: BILH Behavioral Health Access Initiative** **Health Issue: Substance Use Disorder, Mental Health/Mental Illness and Additional Health Needs (Access to Care)**		
Brief Description or Objective	To support increased access to mental health and substance use services and supports, LHMC participated with other BILH hospitals to pilot Behavioral Health Navigator grant programs, offer Mental Health First Aid (MHFA) trainings, provide behavioral health navigation and digital literacy trainings to BILH physical health navigators and amplify anti-stigma messaging, resources and supports.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	Support Grantees in creating a 3-year logic model and evaluation plan for development and implementation of their Behavioral Health Navigator program.	
Goal Status	All four grantees worked with both BILH Director of Evaluation and Data and external evaluator to develop logic model and evaluation plan and are in the process of hiring and onboarding their Behavioral Health Navigator.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	Offer Mental Health First Aid (MHFA) training to community residents and BILH staff across the BILH Community Benefits Service Area (CBSA).	
Goal Status	More than 350 community residents and BILH staff attended one of 21 MHFA training courses provided across the BILH CBSA, of which 75% (274) completed all pre- and post-training requirements to receive Mental Health First Aid certification.	
Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**
Program Goal(s)	Increase knowledge and awareness of available behavioral health services and support among clinical and non-clinical staff who provide patients/clients with physical and/or social determinants of health navigation services.	
Goal Status	28 BILH, Community Health Center and Community Behavioral Health Center staff were trained. Trainees reported a 35% increase in identifying the essential elements of the behavioral health treatment systems of care; a 49% increase in feeling confident they can navigate patients to the appropriate level of behavioral health care, including outpatient, self -help, hotlines, and helplines; a 26%increase in feeling comfortable using different ways to promote patient engagement and activation; and a 37% increase in explaining the process of referrals to agencies.	
Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Burlington Diabetes Care Program** **Health Issue: Chronic Disease**		
Brief Description or Objective	LHMC 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 30, 2024, the Burlington diabetes care coordinator will work to improve A1c3 of 25% of participants.	
Goal Status	50% of the program participants that shared their initial A1c vs most recent had a reduction in A1C 34% of program participants maintained a healthy A1C of 6.5 or below	
Program Goal	By September 30, 2024, the Burlington diabetes care coordinator will provide education, support, and intervention for persons with diabetes.	
Goal Status	Number of people served: • 99 members with diabetes • 34 members enrolled in the program • 20 members adherent in the program High Risk Population: • 19 members identified as high risk • 15 members enrolled in the program • 10 members adherent in the program Demographics of people served: • Eligible 48% female 53% male • Enrolled 48% female 48% male • Adherent 44% female 40% male	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Burlington Council on Aging Memory Cafe** **Health Issue: Chronic Disease**		
Brief Description or Objective	LHMC partners with the Burlington Council on Aging to provide a monthly Memory café. The Memory Café provides activities and support for people with cognitive impairment as well as their caregivers in a safe, supportive, and welcoming space.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2024, the Council on Aging will provide support through the Memory Café to 15 participants per class	
Goal Status	60 clients were served by this program in FY 24, generally 30 participants per class.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Burlington Council on Aging Exercise Classes** **Health Issue: Chronic Disease**		
Brief Description or Objective	LHMC partners with the Burlington Council on Aging to 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 30, 2024, the Council on Aging will provide opportunities for community members to participate in group exercise classes at no cost to them.	
Goal Status	In FY24, LHMC provided funding to the Burlington Council on Aging for a Senior Stretch 52-week exercise program. Overall, the classes served 327 older adults in Burlington with 80% of participants identifying as female and 20% as male. 7% of the total participants were Asian, 79% white and 14% did not report their race/ethnicity. No one identified as Hispanic and 1 person identified as African American.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **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 ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	To increase participation in the Enhance Fitness program to 20 unique (non-recurrent) participants by September 30, 2024.	
Goal Status	Complete. 21 participants reached in the most recent session.	
Program Goal	To onboard an additional referral partner by February 1, 2024, to ensure a steady referral stream for new participants.	
Goal Status	Complete. Metro North YMCA began a new partnership with Chelsea Jewish, an affiliate of Legacy Life Care. This adds to its existing partnerships with Sports Medicine North, Spaulding Rehab, Peabody Council on Aging, and the Lynnfield Council on Aging.	
Program Goal	To positively affect the lives of older adults by delivering the Enhance Fitness Program resulting in an average 75% improvement in fitness assessments.	
Goal Status	Complete. In the last session, 85% of participants showed improvement in mobility as measured through chair stand and arm curl counts and 65% showed increased mobility as measured through “8 Foot Up & Go” counts (how many seconds it takes to stand up from a seated position and walk 8 feet). The second session of the year is currently underway, beginning in September 2024, so only initial assessments have been completed. The final assessments will be completed in December.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **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)	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 has trained another instructor within the center, there are now two certified instructors. They were one participant shy of hitting the goal of 25.	
Program Goal	Establish and maintain enrollment in the Enhance Fitness program (capacity =1 5 in year one, 25-30 in years 2 and 3) running classes year-round.	
Goal Status	The YMCA was one participant shy of meeting its goal. There were 24 participants in this reporting year.	
Program Goal	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.	
Goal Status	This goal was met with all 24 participants.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Tai Ji Quan: Moving for Better Balance** **Health Issue: Chronic Disease**		
Brief Description or Objective	Tai Ji Quan: Moving for Better Balance is an evidenced-based fall prevention program designed to help and improve balance as well as core strength. The program combines elements of Tai Ji with sensory and motor balance training to increase strength, improve balance & function. The program is for individuals who are able to ambulate within the community (with or without an assistive device), stand without hand support, and possess the cognitive ability to safely understand directions. The class meets 2X/week for 1 hour for 24 weeks for a total of 48 sessions.	
Program Type	☐ Direct Clinical Services ☐Community Clinical Linkages ☒Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2024, LHMC will conduct 48 classes of Tai Ji for the community.	
Goal Status	9 participants started the program in October 2023; 8 completed the program (attended at least 75% of the sessions) and 1 did not complete the program; ages ranged from 67 to 81 years of age with 7 females and 2 males.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Bone Health & Falls Prevention Programs** **Health Issue: Chronic Disease**		
Brief Description or Objective	LHMC conducts a Bone Health and Osteoporosis Prevention program to help patients understand a diagnosis of osteopenia and/or osteoporosis, discusses treatment measures to improve bone health after a fracture, provides education on the types of exercises necessary to promote bone health and prevent falls, provides information on a healthful diet with important nutrients that contribute to bone health, and aims to reduce the burden of fragility fractures for the individual and community. LHMC also offers A Matter of Balance (MOB). MOB is specifically designed to reduce fear of falling and increase activity levels among older adults. The program includes eight two-hour classes presented to 8-12 participants and led by trained coaches. This program sets goals for increasing activity levels, encourages small changes to reduce fall risks at home, and teaches exercises to increase strength and balance. LHMC's trauma department also offers many other programs for older adults, including Carfit Screenings and other community-based educational programs designed to prevent fractures and trauma injuries in older adults.	
Program Type	☐ Direct Clinical Services ☒Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	By September 30th, 2024, LHMC will provide information and motivation for lifestyle changes to positively impact bone health. Improve access to patients through an improved referral process utilizing the "Ambulatory referral to Orthopedic Specialty Classes." QR codes were added to the flyers for easy and efficient self-registration.	
Goal Status	LHMC provided 6 classes with a total of 35 participants in FY24. 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.	
Program Goal(s)	By September 20th, 2024, LHMC will offer two sessions of A Matter of Balance Falls Prevention Program.	
Goal Status	LHMC offered three sessions of A Matter of Balance in FY 24. 100% of program participants reported a decreased risk of falls.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Oncology Nurse Navigator and Supportive Services for Cancer Patients** **Health Issue: Chronic Disease**		
Brief Description or Objective	LHMC provides oncology navigation services for patients with cancer diagnosis. RNs with oncology-specific clinical knowledge work with newly diagnosed cancer patients by offering individualized support and assistance with coordinated care through a holistic and collaborative approach that includes communication and coordination with the patient's family and/or caregivers along with a multidisciplinary team consisting of physicians, nurse practitioners, oncology nurses, and social workers.	
Program Type	☐ Direct Clinical Services ☒Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2024, 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 24 Oncology Navigators assisted 10-15 patients per day and provided referral and supportive services.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Complex and Chronic Conditions **Program Name: Cancer Programs Screening and Prevention** **Health Issue: Chronic Disease**		
Brief Description or Objective	LHMC has implemented an assessment screening tool at the Burlington, Peabody, and Lexington locations to help community residents determine whether they might be at risk for breast cancer. Using an electronic tablet, people confidentially answer questions that help determine whether they may be at a higher risk for breast cancer. The assessment, evaluation, and follow-up are all provided at no cost to participants. Results are given to their physicians, who can help them determine whether they might benefit from a higher level of screening beyond regular checkups and mammograms.	
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2024, 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 24, LHMC completed 14,684 risk assessments for 14,436 unique individuals. 13% of patients screened were identified as having a high lifetime risk of breast cancer and 29% were identified as having a high-risk mutation.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

SECTION V: EXPENDITURES

Item/Description	Amount
CB Expenditures by Program Type	
Direct Clinical Services	$8,098,914
Community-Clinical Linkages	$1,552,009
Total Population or Community Wide Interventions	$1,499,373
Access/Coverage Supports	$3,259,640
Infrastructure to Support CB Collaborations	$81,493
Total Expenditures by Program Type	**$14,491,429**
CB Expenditures by Health Need	
Chronic Disease	$6,513,545
Mental Health/Mental Illness	$1,301,189
Substance Use Disorders	$939,737
Housing Stability/Homelessness	$242,890
Additional Health Needs Identified by the Community	$5,494,068
Total by Health Need	**$14,491,429**
Leveraged Resources	$161,368
Total CB Programming	**$14,652,797**
Net Charity Care Expenditures	
HSN Assessment	$5,697,695
Free/Discounted Care	N/A
HSN Denied Claims	$2,877,934
Total Net Charity Care	$8,575,629
Total CB Expenditures	$23,228,426

Additional Information	
Net Patient Services Revenue	$1,161,877,442
CB Expenditure as % of Net Patient Services Revenue	2%
Approved CB Budget for FY24 (*Excluding expenditures that cannot be projected at the time of the report)	$23,228,426
Bad Debt	$6,085,393
Bad Debt Certification	Yes

Optional Supplement	Statewide CHI fund for LHMC Tier 2 DoN Radiation Oncology Linear Accelerator = $365,964.84
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, Manager Community Benefits and Community Relations
Lahey Hospital & Medical Center
41 Mall Rd
Burlington, MA 01803
michelle.snyder@bilh.org

SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

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

I. **Community Benefits Process:**

- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? Yes
    - If so, please list updates:

    - Gloria Wojtaszek replaced Rosemary DeSousa from Burlington Public Schools
    - Paulina Do, resident of Lowell and Renata Ivnitskaya of Northeast Arc joined in FY24
    - Brian Quigley, LICSW, LHMC Social Work joined in FY24
    - Randi Epstein of CHNA 15 left in FY24

II. **Community Engagement**

a. Organizations Engaged in CHNA and/or Implementation Strategy

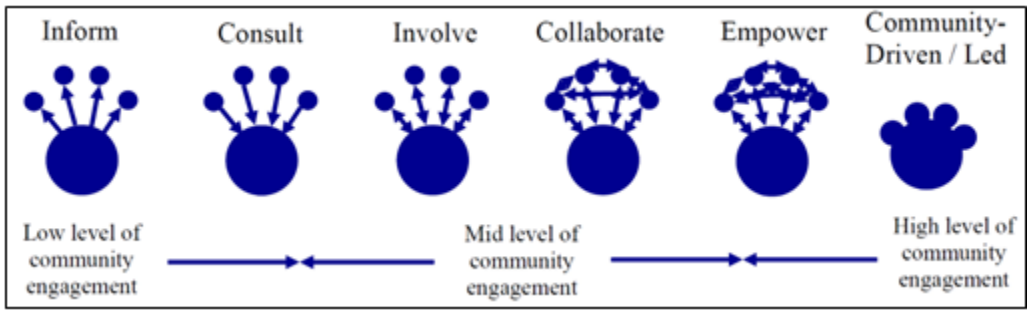
If there have been any updates to the key partners with whom the hospital collaborates, please indicate in the table below. Please feel free to add rows as needed.

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
Community Teamwork, Inc.	Connie Martin, Director of Community Partnerships	Housing Organizations	LHMC partners with Community Teamwork, Inc. through our Determination of Need Funding to provide a three-year grant to support Secure Jobs for families who are newly arrived in Lowell
Torigian YMCA	Erica Cashman, Senior Grants Director	Social service organizations	LHMC partners with the Metro North YMCA to provide funding for a three-year grant for a behavioral analyst position.
Place of Promise	Jeff Kiel, Executive Director	Behavioral Health and Mental Health Organizations	LHMC provides funding for a three-year grant to provide supportive services for persons in substance use recovery in Lowell.

Greater Lowell Health Alliance	Hannah Tello, Director of Evaluation	Social Service Organizations	LHMC provides funding for a three-year grant to support mental health services in the older adult Cambodian community in Lowell.

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 filer's plan to address significant needs documented in CHNA	Collaborate	Goal was met	Collaborate

Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Collaborate	Goal was met – IN FY 24 LHMC engaged with its CBAC in an RFP process to allocate three-year grants through the Determination of Need process to organizations addressing health needs identified in the LHMC Implementation Strategy	Collaborate
Implementing Community Benefits programs	Collaborate	Goal was met – LHMC engaged an allocation committee in the review process for RFPs for three-year Determination of Need 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	Collaborate	Goal was met – BILH and LHMC have worked to update and engage the CBAC in tracking data for community benefits programs on a regular basis	Collaborate

- 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 its annual public meeting in person at LHMC on September 25th, 2024.

III. Maternal Health Focus

a. How does your organization assess maternal health status in the Community Health Needs Assessment Process? (150-word limit)
LHMC's Community Health Needs Assessment includes comprehensive collection and review of primary and secondary data sources. Secondary data sources include March of Dimes, MDPH, National Center for Health Statistics. Data specific to maternal health are included in the hospital's data table under Reproductive Health" and include low birth weight (%), Mothers with late or no prenatal care (%), Births to adolescent mothers (%, and mothers receiving publicly funded pre-natal care (%) as well as data on screening for post-partum depression. In addition to secondary data capture and review, throughout the CHNA, LHMC engages with the community to collect primary data on priorities identified by community residents. This is through a community survey as well as focus groups.

b. How have you measured the impact of your Community Benefits programs and what challenges have you faced in this measurement? (150-word limit)
LHMC is a member of Beth Israel Lahey Health, which, as a system is working to address maternal health equity. Beth Israel Lahey Health established its Maternal Health Quality and Equity Council (MHQEC) in September of 2023. The Council's objective is to improve maternal health outcomes and eliminate inequities in care, with an overarching aim to reduce the occurrence of maternal morbidity and mortality. The Council is comprised of representatives from all of the BILH hospitals providing maternity services, as well as BILH leadership, including BILH Health Equity system leadership. BILH's Chief Clinical Officer serves as the Executive Sponsor. FY 24 was the Council's inaugural year and MHQEC established initial goals related to Equitable Access to Doulas & Midwifery, Perinatal Mental Health, and Severe Maternal Morbidity. Additionally, BILH established a health equity goal beginning in FY 25 – a year over year improvement in maternal transfusion rate (the goal is to reduce disparities in maternal transfusion rates measured at the system level).

c. Do you need assistance identifying community-based organizations doing maternal health work in your area?
LHMC's maternal health work will be guided by the MHQEC and the hospital looks forward to spreading this work and collaborating with its myriad of long-standing community partners in pursuit of maternal health equity.

IV. 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