Lahey Clinic Hospital, Inc.
Implementation Strategy 2020-2022

Lahey Clinic Hospital, Inc. includes both Lahey Hospital & Medical Center (LHMC) and Lahey Medical Center – Peabody (LMCP). Together, they are referred to as LHMC/LMCP throughout this report. Both hospitals are part of the Beth Israel Lahey Health system.

Between November 2018 and August 2019, LHMC/LMCP conducted a comprehensive Community Health Needs Assessment (CHNA) that included an extensive review of existing quantitative data as well as the collection of qualitative information through interviews, focus groups, community listening sessions, and a community health survey. A resource inventory was also completed to identify existing health-related assets and service gaps. This extensive array of assessment and community engagement activities allowed LHMC/LMCP to collaborate with key health system partners across the region. During the CHNA process, LHMC/LMCP also made substantial efforts to engage their own administrative and clinical staff, including senior leadership. A detailed review of the CHNA approach, data collection methods, and community engagement activities is included in LHMC/LMCP's 2019 Community Health Needs Assessment report.

Throughout the CHNA process, LHMC/LMCP's Community Relations staff worked with the hospital's Community Benefits Advisory Committee (CBAC), composed of senior leadership from the hospital and community stakeholders/service providers, to:

- Vet quantitative and qualitative findings
- Prioritize community health issues and vulnerable populations
- Review existing community benefits programming
- Develop LHMC/LMCP's 2020-2022 Implementation Strategy

IMPLEMENTATION STRATEGY PLANNING PRINCIPLES AND STATE PRIORITIES

In developing the Implementation Strategy, care was taken to ensure that LHMC/LMCP's community health priorities were aligned with priority areas determined by the Massachusetts Department of Public Health (MDPH) and the Massachusetts Attorney General's Office (MA AGO). In addition to the four priority areas, MDPH identified six health priorities to guide investments funded through Determination of Need processes. The MDPH and the MA AGO encourage hospitals to consider these priorities during the community benefits planning process.

Table 1: MDPH/MA AGO Priority Areas

Community Benefits Priorities	Determination of Need Priority Areas
Chronic disease with a focus on cancer, heart disease, and diabetes	Built environment
Housing stability/homelessness	Social environment
Mental illness and mental health	Housing
Substance use disorders	Violence
	Education
	Employment

The following is a range of programmatic ideas and principles that are critical to community health improvement; they have been applied in the development of the Implementation Strategy.

- **Social determinants of health:** With respect to community health improvement, especially for low-income and disadvantaged populations, there is growing appreciation for the importance of addressing the underlying social determinants of health. These social determinants have been defined as "the conditions in which people are born, grow, live, work and age that may limit access, lead to poor health outcomes, and are at the heart of health inequities between and within communities."[1] The leading social determinants of health include issues such as poverty, housing, food access, violence, racism/bigotry, and transportation. It is important that hospital implementation strategies include collaborative, cross-sector initiatives that address these issues.

- **Health education and prevention:** Primary prevention aims to prevent disease or injury before it ever occurs by reducing risks, preventing exposures to hazards, and altering unhealthy behaviors that can lead to disease or injury. Secondary and tertiary prevention aim to reduce the impact of chronic disease or health conditions through early detection as well as behavior change and chronic disease management geared toward helping people manage health conditions, lessen a condition's impact, or slow a condition's progress. Targeted efforts across the

[1] O. Solar and A. Irwin, World Health Organization, "A Conceptual Framework for Action on the Social Determinants of Health," Social Determinants of Health Discussion Paper 2 (Policy and Practice), 2010, available at https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf

continuum to raise awareness about a particular condition, educate people about risk factors and protective factors, change unhealthy behaviors, and manage illness are critical to improving health status.

- **Screening and referral:** Early identification of those with chronic and complex conditions, followed by efforts to ensure that those in need of education, further assessment, counseling, and treatment, is critical to preventing and managing illness. A critical component of screening and referral efforts is taking steps to ensure that people are fully engaged in treatment, including links to a primary care provider.

- **Chronic disease management:** Learning how to manage an illness or a condition, change unhealthy behaviors, and make informed decisions about health allows individuals to lead healthier lives. Evidence-based chronic disease management or self-management education programs, implemented in community-based settings by clinical and nonclinical organizations, can help people learn skills to manage their health conditions, improve eating and sleeping habits, reduce stress, and maintain a healthy lifestyle.

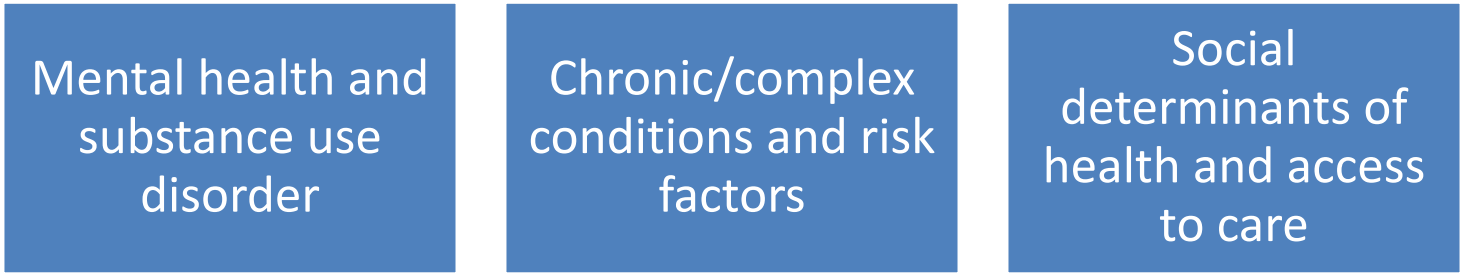
- **Care coordination and services integration:** Efforts to coordinate care and integrate services across the health care continuum are critical to community health improvement. These efforts involve bringing together providers and information systems to coordinate health services, patient needs, and information. This helps better achieve the goals of treatment and care.

- **Patient navigation and access to health insurance:** One of the most significant challenges that people face in caring for themselves or their families is finding the services they need and navigating the health care system. Having health insurance that can help people pay for needed services is a critical first step. The availability of health coverage/insurance enrollment support, patient navigation, and resource inventories are important aspects of community health improvement.

- **Cross-sector collaboration and partnership:** When it comes to complex social challenges, such as community health improvement, there is a clear consensus that success will be achieved only through collective action, partnership, and collaboration across organizations and health-related sectors. No one organization or even type of organization can have a sustained impact on these types of issues on their own. Hospital implementation strategies must be collaborative and include partnerships with service providers across multiple sectors (e.g., health, public health, education, public safety).

COMMUNITY HEALTH PRIORITY AREAS

LHMC/LMCP's CHNA and strategic planning process provided many opportunities to vet the quantitative and qualitative data compiled during the assessment. Based on this process, the LHMC/LMCP's CBAC and Community Relations staff identified three community health priority areas, which together embody the leading health issues and barriers to care for residents of the hospital's service area: mental health and substance use disorder, chronic/complex conditions and risk factors, and the social determinants of health and access to care.



Community Health Needs Not Prioritized by LHMC/LMCP

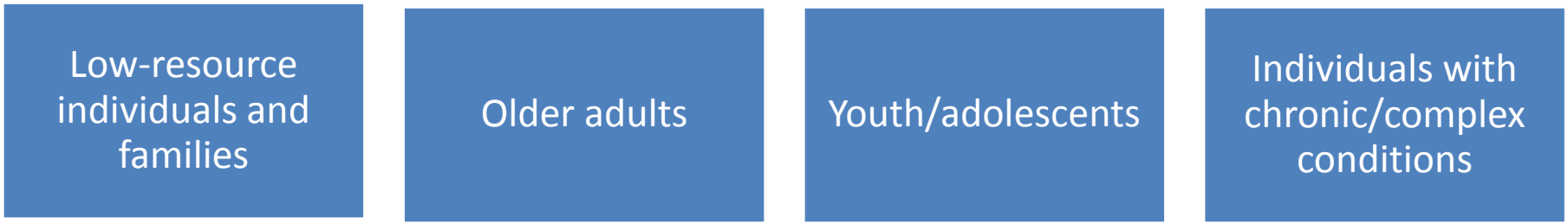
It is important to note that there are community health needs that were identified by LHMC/LMCP's assessment that were not prioritized for inclusion in the Implementation Strategy for a number of reasons:

- Feasibility of LHMC/LMCP having an impact in the short or long term
- Clinical expertise of the organization
- Limited burden on residents of the service area
- The issue is currently being addressed by community partners in a way that does not warrant additional support

For example, lack of affordable housing was identified as a community health issue, but it was deemed by the CBAC to be outside LHMC/LMCP's primary sphere of influence. This is not to say that LHMC will not support efforts in this area; the hospital remains open and willing to work with hospitals across Beth Israel Lahey Health's network and with other public and private partners to address this issue collaboratively.

PRIORITY POPULATIONS

LHMC/LMCP is committed to improving the health status and well-being of all residents living within its service area. However, in recognition of the considerable health disparities that exist in some communities, LHMC/LMCP focuses the bulk of its community benefits resources on improving the health status of underserved populations. The CBAC voted to prioritize low-resource individuals and families, older adults, youth/adolescents, and individuals with chronic/complex conditions.



The following is LHMC/LMCP's Implementation Strategy. The grid below provides details on LHMC/LMCP's goals, priority populations, objectives, activities, sample measures to track progress and outcomes, and potential partners. It is also noted that when applicable, LHMC/LMCP objectives align with state community health priorities. LHMC/LMCP looks forward to working toward these goals in collaboration with community partners in the years to come.

PRIORITY AREA 1: MENTAL HEALTH AND SUBSTANCE USE DISORDER

Description: As it is throughout the Commonwealth and the nation, the burden of mental health issues and substance use disorder on individuals, families, communities, and service providers in LHMC/LMCP's community benefits service area is overwhelming. Nearly every key informant interview, focus group, and listening session included discussions on these topics. From a review of the quantitative and qualitative information, depression, anxiety/stress, and social isolation were the leading issues in this domain. There were particular concerns regarding the impact of depression, anxiety, and e-cigarette/vaping on youth and social isolation among older adults. LHMC/LMCP recognizes the importance of primary prevention, so the hospital will continue to work with community partners to offer educational programs around mental health and substance misuse. The hospital will also enhance partnerships with community-based organizations to identify, screen, and refer youth with mental health and substance use issues to treatment. LHMC/LMCP will continue to partner and collaborate with community-based organizations that work with older adults to enhance access to supportive services and to services to reduce social isolation.

Resources/financial investment: LHMC/LMCP will commit direct community health program investments and in-kind resources of staff time and materials. LHMC/LMCP will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services, as well as on behalf of its community partners.

Goal 1: Address the prevalence and impact, risk/protective factors, and access issues associated with mental health and substance use disorder					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Low-resource individuals and families • Older adults • Youth/adolescents • Individuals with chronic/complex conditions	Promote collaboration, share knowledge, and coordinate activities with internal colleagues and external partners	Support community-based health education events to raise awareness of and provide education about risk/protective factors and services available within the community (e.g., education series on vaping)	• # of events/programs held • # of individuals reached • # of initiatives funded • Financial support provided • # of efforts and individuals reached by grantees • # of meetings attended • # of referrals/links to treatment • Pre-/post-activity tests to measure changes in knowledge, behaviors, intentions, etc.	• Local school districts	• Mental illness and mental health • Substance use disorder

Goal 1: Address the prevalence and impact, risk/protective factors, and access issues associated with mental health and substance use disorder					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Low-resource individuals and families • Older adults • Youth/adolescents • Individuals with chronic/complex conditions	Explore opportunities for partnerships with community-based organizations to identify, screen, assess, and refer those with mental health and substance use disorder to treatment	Provide financial resources to community-based partners to support evidence-based programs that address mental health and substance use disorder (e.g., funds to CHNAs, mini-grants)	• # of events/programs held • # of individuals reached • # of initiatives funded • Financial support provided • # of efforts and individuals reached by grantees • # of meetings attended • # of referrals/links to treatment • Pre-/post-activity tests to measure changes in knowledge, behaviors, intentions, etc.	• CHNA 13/14 • CHNA 15 • Regional/local substance use disorder task forces	• Mental illness and mental health • Substance use disorder
		Participate in collaboratives or task forces that address mental health and/or substance use disorder		• CHNA 13/14 • CHNA 15 Regional/local substance use disorder task forces	
		Enhance partnerships with elder service providers to identify older adults at risk for mental health and substance use issues and promote access to treatment (e.g., licensed independent social workers at senior centers/Councils on Aging (COAs)		• Senior centers/COAs	
	Reduce environmental risk factors associated with mental health or substance use issues	Organize drug takeback opportunities at the hospital and with community-based partners (e.g., a medical disposal program)		• Local law enforcement agencies • Internal clinical staff	

Goal 1: Address the prevalence and impact, risk/protective factors, and access issues associated with mental health and substance use disorder					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Low-resource individuals and families • Older adults • Youth/adolescents • Individuals with chronic/complex conditions	Reduce environmental risk factors associated with mental health or substance use issues (continued)	Support initiatives that help reduce environmental risk factors associated with developing mental health issues (e.g., hoarding, social isolation)	• # of events/programs held • # of individuals reached • # of initiatives funded • Financial support provided • # of efforts and individuals reached by grantees • # of meetings attended • # of referrals/links to treatment • Pre-post-tests to measure changes in knowledge, behaviors, intentions, etc.	• Senior centers/COAs • Aging services access points	• Mental illness and mental health • Substance use disorder
	Increase access to appropriate mental health and substance use disorder treatment and support services	Enhance access to integrated behavioral health services		• Primary care practices	
		Provide support/referrals to individuals with mental health and/or substance use issues		• Emergency department • Internal clinical staff	
	Enhance the ability of local providers and community partners to understand, anticipate, and respond to health needs and social determinants of health	Provide education and support to providers and community partners to allow them to better understand and respond to emerging health needs and social determinants of health	• Financial support provided • # of efforts and individuals reached	• Internal clinical staff • Local coalitions	• Mental illness and mental health • Substance use disorder
		Support efforts to assess the overall health of the community (e.g., a Youth Risk Behavior Survey)		• Local school districts • Youth-serving organizations	

PRIORITY AREA 2: CHRONIC/COMPLEX CONDITIONS AND RISK FACTORS

Description: LHMC/LMCP has a long history of working with community partners to create awareness of and provide education on these risk factors and their link to chronic and complex health conditions. The hospital will continue to support programs that provide opportunities for people to access low-cost, healthy food and opportunities for safe and affordable physical activity. Beyond addressing the risk factors, LHMC/LMCP is also committed to providing screening and educational opportunities, supporting individuals and caregivers throughout the service area to engage in chronic disease management programs and supportive services (e.g., integrative therapies, support groups), and providing links to care.

Resources/financial investment: LHMC/LMCP will commit direct community health program investments and in-kind resources of staff time and materials. LHMC/LMCP will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services, as well as on behalf of its community partners.

Goal 1: Enhance access to health education, screening, and referral services in clinical and nonclinical settings					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Low-resource individuals and families • Older adults • Youth/adolescents • Individuals with chronic/complex conditions	Increase awareness of and education about the risks and protective factors associated with chronic and complex conditions	Organize events and initiatives hosted and informed by clinical staff related to education and management of chronic/complex conditions and their risk factors (e.g., the women's lecture series)	• # of events/programs held • # of individuals reached • # of initiatives funded • Financial support provided • # of partnerships • Pre-/post-activity tests to measure changes in knowledge, confidence in ability to mitigate risk factors, intention for behavioral change	• Internal clinical staff	Chronic disease
	Support programs/activities in clinical and nonclinical settings that screen, educate, and refer patients for chronic/complex conditions and their risk factors	Implement and expand evidence-based programs and screenings (e.g., breast cancer risk assessments, skin cancer awareness and prevention, falls prevention, an osteoporosis program, Matter of Balance)		• Internal clinical staff • YMCAs	

Goal 1: Enhance access to health education, screening, and referral services in clinical and nonclinical settings					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Low-resource individuals and families • Older adults • Youth/adolescents • Individuals with chronic/complex conditions	Enhance access to and promote equitable care for vulnerable individuals with chronic/complex conditions	Explore partnerships with community-based organizations that work with vulnerable populations to overcome barriers to care and engage in appropriate treatment	• # of events/programs held • # of individuals reached • # of initiatives funded • Financial support provided • # of partnerships • Pre-/post-activity tests to measure changes in knowledge, confidence in ability to mitigate risk factors, intention for behavioral change	• Community-based organizations	Chronic disease
Goal 2: Support individuals with or recovering from chronic/complex conditions and their caregivers					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Low-resource individuals and families • Older adults • Youth/adolescents • Individuals with chronic/complex conditions	Increase access to supportive services to reduce stress and anxiety, reduce negative symptoms and side effects, and increase overall well-being	Partner with community-based organizations to increase opportunities for cancer survivors to engage in safe physical activities and reduce social isolation Provide support and care navigation to individuals who are undergoing treatment for chronic/complex conditions and their families	• # of activities/programs • Financial support provided • # of individuals reached • Pre-/post-activity tests to measure changes in knowledge, confidence in abilities, stress/mood, activity level, intention for behavioral change	• YMCAs • Internal clinical staff	Chronic disease

PRIORITY AREA 3: SOCIAL DETERMINANTS OF HEALTH AND ACCESS TO CARE

Description: The social determinants of health are often the drivers of or the underlying factors that create or exacerbate mental health issues, substance misuse, and chronic/complex conditions. These social determinants of health, particularly poverty, also underlie many of the access-to-care issues that were prioritized in the assessment: navigating the health system (including health insurance), chronic disease management, and affording care.

LHMC/LMCP is committed to addressing social determinants and breaking down barriers to care. The hospital will continue to collaborate with community-based organizations to engage individuals in services, reduce financial burdens, increase access to appropriate primary and specialty care services, and support healthy families and communities. LHMC/LMCP is also committed to strengthening the local workforce and addressing unemployment by supporting job-training programs.

Resources/financial investment: LHMC/LMCP will commit direct community health program investments and in-kind resources of staff time and materials. LHMC/LMCP will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services, as well as on behalf of its community partners.

Goal 1: Address the social determinants of health and access to care					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Low-resource individuals and families • Older adults • Youth/adolescents • Individuals with chronic/complex conditions	Increase partnerships and collaboration with community-based organizations to address the social determinants of health	Provide community health grants to support evidence-based programs that address issues associated with the social determinants of health	• # of initiatives funded • Financial support provided • # of individuals/families reached • # of vouchers provided • # of individuals enrolled in health insurance • # of individuals placed at a job • # of individuals trained • Pre-/post-activity tests to measure knowledge, skills, confidence in entering job market • Pre-/post-activity tests to measure physical activity, confidence, behavior change	• CHNA 13/14 • CHNA 15	• Built environment • Social environment • Housing • Education • Employment

Goal 1: Address the social determinants of health and access to care					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Low-resource individuals and families • Older adults • Youth/adolescents • Individuals with chronic/complex conditions	Increase partnerships and collaboration with community-based organizations to address the social determinants of health (continued)	Participate in diverse, multisector collaboratives and task forces to address social determinants of health and risk factors	• # of initiatives funded • Financial support provided • # of individuals/families reached • # of vouchers provided • # of individuals enrolled in health insurance • # of individuals placed at a job • # of individuals trained • Pre-/post-activity tests to measure knowledge, skills, confidence in entering job market • Pre-/post-activity tests to measure physical activity, confidence, behavior change	• CHNA 13/14 • CHNA 15	• Built environment • Social environment • Housing • Education • Employment
	Increase access to affordable and safe transportation options	Support partnerships with regional transportation providers and community partners to enhance access to affordable and safe transportation		• Senior centers/COAs • Aging services access points	Built environment
	Educate providers and community members about hospital and/or public assistance programs that can help identify and enroll individuals in appropriate health insurance plans and/or reduce their financial burden	Provide enrollment counseling/assistance and patient navigation support services to uninsured and/or underinsured residents to enhance access to care (e.g., patient financial counselors, the Serving Health Information Needs of Everyone program)		• Senior centers/COAs • Aging services access points	
		Provide community health grants to community partners to support evidence-based programs that address issues associated with access-to-care issues		• CHNA 13/14 • CHNA 15	

Goal 1: Address the social determinants of health and access to care					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Low-resource individuals and families • Older adults • Youth/adolescents • Individuals with chronic/complex conditions	Work to help strengthen the local workforce	Collaborate with local community partners to support job-training programs that strengthen the local workforce and address underemployment	• # of initiatives funded • Financial support provided • # of individuals/families reached • # of vouchers provided • # of individuals enrolled in health insurance • # of individuals placed at a job • # of individuals trained • Pre-/post-activity tests to measure knowledge, skills, confidence in entering job market • Pre-/post-activity tests to measure physical activity, confidence, behavior change	• Local high schools • Local colleges/universities	Employment
	Increase awareness of domestic violence and promote links to services	Provide crisis intervention and education to staff to identify and respond to the needs of victims		• LHMC Emergency Department • LHMC Social Work • Saheli • Local first responders	Violence
		Promote partnership with local first responders and community organizations that are addressing domestic violence			
	Promote resilience and emergency preparedness	Provide free training to first responders and community partners		• LHMC Trauma Department • Local schools • Local public health departments	
	Increase access to affordable and nutritious foods	Support community-based programs that address food insecurity and promote access to healthy foods		• Mill City Grows	Built environment
		Support community-based organizations that provide counseling and coaching on obesity and exercise		• YMCAs • Senior centers/COAs • Aging services access points	

Goal 1: Address the social determinants of health and access to care					
Target Populations	**Objectives**	**Activities**	**Sample Measures**	**Potential Partners**	**State Priority Area(s)**
• Low-resource individuals and families • Older adults • Youth/adolescents • Individuals with chronic/complex conditions	Increase access to affordable and free opportunities for physical activity	Support community-based initiatives to offer free or low-cost physical activity	• # of initiatives funded • Financial support provided • # of individuals/families reached • # of vouchers provided • # of individuals placed at a job • Pre-/post-activity tests to measure knowledge, skills, confidence in entering job market • Pre-/post-activity tests to measure physical activity, confidence, behavior change	• YMCAs • Senior centers/COAs • Aging services access points	Built environment