Community Benefits Report

Fiscal Year 2021

Beth Israel Lahey Health
Lahey Hospital & Medical Center

Beth Israel Lahey Health

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SECTION I: SUMMARY AND MISSION STATEMENT

Summary and Mission Statement
Lahey Hospital & Medical Center (LHMC/LMCP) is a member of Beth Israel Lahey Health (BILH). BILH brings together an exceptional array of clinical organizations spanning the full continuum of health care delivery – academic and teaching hospitals, community hospitals, ambulatory and urgent care centers, behavioral health programs, and home care – in a shared mission to expand access to great care and advance the science and practice of medicine through groundbreaking research and education.

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. BILH Community Benefits staff are committed to working collaboratively with BILH's communities to address leading health issues and create a healthy future for individuals, families, and communities.

At LHMC/LMCP, our mission guides us toward success. LHMC/LMCP 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.

The following annual report provides specific details on how LHMC/LMCP is honoring its commitment and includes information on LHMC/LMCP's Community Benefits Service Area (CBSA), community health priorities, target populations, community partners, and detailed descriptions of its Community Benefits programs and their impact.

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 assessment process as well as in the development, implementation, and oversight of the hospital's three-year Implementation Strategy;

- **Engaging and learning from residents** throughout LHMC's service area in all aspects of the Community Benefits process, including assessment, planning, implementation, and evaluation. The hospital pays special attention to engaging those community members who are not patients of LHMC and those who are often left out of assessment, planning, and program implementation processes;

- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to identify unmet health-related needs and to characterize those in the community who are most underserved and face disparities in access and outcomes;

- **Implementing community health programs and services** in LHMC's CBSA that are geared toward improving the current and future health status of individuals, families, and communities by removing barriers to care, addressing social determinants of health, strengthening the health care system, and working to decrease the burden of leading health issues;

- **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 responsive care; and

- **Facilitating collaboration and partnership** within and across sectors (e.g., public health, health care, social services, business, academic, and community health) to advocate for, support, and implement effective health policies, community programs, and services.

Target Populations
LHMC/LMCP's CBSA includes eight communities: Arlington, Bedford, Billerica, Burlington, Lexington, Lowell, Lynnfield, and Peabody. Given that LHMC/LMCP operates multiple buildings under a single state license and serves different geographic areas and populations, the communities that are part of the CBSA are an aggregate of these areas and populations. The CBSA does not exclude medically underserved, low-resource, or historically underserved populations. For this assessment, LHMC/LMCP made every effort to identify the health needs of all residents.

To target Community Benefits efforts and to comply with Commonwealth and federal guidelines, there was an effort to prioritize segments of the population that have complex health needs or that face significant barriers to care. With this in mind, four population segments were prioritized within LHMC/LMCP's CBSA: low-resource individuals and families, older adults, youth/adolescents, and individuals and families with chronic/complex conditions, regardless of whether they use or have used services at its facilities.

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

Key Accomplishments for Reporting Year
The accomplishments highlighted in this report are based upon priorities identified and programs contained in LHMC/LMCP's FY19 Community Health Needs Assessment (CHNA) and FY20-22 Implementation Strategy (IS):

- LHMC provided breast cancer risk assessments for over 16,000 people to identify those at high risk for the disease.
- LHMC partnered with Mill City Grows to provide funding for 100 individuals with diabetes to receive a weekly CSA share, totaling over 40,000 pounds of produce.
- LHMC assisted 81,700 patients in FY21 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 improved the built environment by partnering with the Burlington Recreation Department to provide a free outdoor fitness court for the community. In FY21, it is estimated that over 13,205 people used the equipment.
- LHMC provided 24 internships in radiology, nuclear medicine, and sonology for students at surrounding universities to strengthen the local workforce.
- LHMC continued to partner with the New Entry Sustainable Farming Project to provide weekly farmers markets at the Arlington, Burlington, and Billerica Councils on Aging. This program provides free, fresh produce every week to over 200 seniors at those locations and was modified to operate safely during the COVID-19 pandemic.

- LHMC helped support the Peabody Veterans Memorial High School Student Health Center, which provided services for 195 unique individuals.
- LHMC provided funding to the Lowell Community Health Center to support their interpreter services program. Interpretation is required in 44% of the health center's total encounters.
- LHMC provided support to the Greater Boston YMCA and the Metro North YMCA for their evidence-based Enhance Fitness Program. Over 50 older adults participated in the program and 100% reported an improvement in their overall health.
- LHMC provided support to the Middlesex League for their Youth Risk Behavior Survey. The Middlesex League comprises eleven cities and towns in Middlesex County and over 16,000 students were surveyed.
- LHMC partnered with the Merrimack Valley Food Bank to provide a farmers market program at three low-income housing sites in the city of Lowell that served 535 people.
- LHMC partnered with Saheli to provide support for their Supportive Housing Services Program which served over seventy individuals in FY21.

Plans for Next Reporting Year

In FY19, LHMC/LMCP conducted a comprehensive and inclusive CHNA that included qualitative and quantitative data collection, robust community engagement activities, and an inclusive prioritization process. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY19. In response to the FY19 CHNA, LHMC/LMCP will focus its FY20-22 Implementation Strategy on three priority areas; these priority areas collectively address the broad range of health and social issues facing residents living in LHMC/LMCP's CBSA who face the greatest health disparities. These three priority areas are:

- Chronic/complex conditions and risk factors
- Mental health disorders and substance use disorders
- Social determinants of health and access to care

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/LMCP's priorities are also aligned with the priorities identified by 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 (ex. built environment, social environment, housing, violence, education, and employment).

The FY19 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions that are being used to inform and refine LHMC/LMCP's efforts. In completing the FY19 CHNA and FY20-22 Implementation Strategy, LHMC/LMCP, along with its other health, public health, social service, and community partners, is committed to improving the health status and well-being of all residents living throughout its CBSA. As discussed above, based on the CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that LHMC/LMCP's FY20-22 Implementation Strategy should prioritize certain demographic, socioeconomic, and geographic population segments that have complex needs and face barriers to care and service gaps, as well as other adverse social determinants of health. These factors put these segments at greater risk, limit their access to needed services, and can often lead to disparities in health outcomes. More specifically, the FY19 CHNA identified the importance of supporting initiatives that target low-resource populations, youth, older adults, individuals with chronic and complex conditions.

LHMC/LMCP partners with dozens of community-based organizations and service providers to execute its Implementation Strategy, including public agencies, social service providers, community health organizations, academic organizations, and businesses. In FY22, LHMC/LMCP plans to continue to enhance our valuable community benefits programs offered in collaboration with community partners, including:

- Working with the Peabody YMCA, Burbank YMCA, and North Suburban YMCA to continue to increase access for older adults to opportunities for evidence-based physical fitness programs.
- Working with the Housing Corporation of Arlington to continue to expand its social worker program that provides resources, information, and counseling for low-to-moderate-income residents.
- Continuing to provide clinically based education opportunities done in collaboration with colleges to help strengthen the local workforce.
- Supporting the Serving Health Information Needs of Everyone program in collaboration with Minuteman Senior Services to provide no-cost insurance benefits counseling to members of the community to promote access to care.
- Supporting the New Entry Sustainable Farming Project and LHMC/LMCP's extremely successful farmers' market program, which provides free, community-based produce for older adults, increasing access and reducing the barrier of cost to healthy eating.
- Continuing to provide our Medication Disposal Box to provide a safe and convenient way for community residents to dispose of unwanted or unused medications.

Hospital Self-Assessment Form
Working with its Community Benefits leadership team and its Community Benefits Advisory Committee (CBAC), the LHMC/LMCP Community Benefits team completed a hospital self-assessment form (Section VII, page The LHMC/LMCP Community Benefits team also shared the Community Representative Feedback Form with many CBAC members and community stakeholders who participated in LHMC/LMCP's CHNA.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team and Community Benefits Advisory Committee (CBAC)

Lahey Hospital & Medical Center Community Benefits Advisory Committee 2021
Stathis Antoniades, Chief Operating Officer, Lahey Hospital & Medical Center
Jean Bushnell, Director, Billerica Council on Aging
Sharon Cameron, Director of Health and Human Services, City of Peabody
Stephanie Cronin, Executive Director, Middlesex 3 Coalition
Eric Conti, Superintendent, Burlington Public Schools; President, Middlesex League
Randi Epstein, Coordinator, Community Health Network Area 15
Melissa Hastings Cruz, Lahey Hospital & Medical Center Board of Trustees
Christine Healey, Director, Community Relations, Beth Israel Lahey Health
Peter Kilcommons, Corporate Controller, Lahey Hospital & Medical Center
Jennifer Knight, Director of Family and Community Engagement, Burlington Public Schools
Kelly Magee Wright, Executive Director, Minuteman Senior Services

Michelle McCool-Heatley, ACNO Emergency Services, Lahey Hospital & Medical Center
Elvira Omerovic, Director, Site Operations, Beth Israel Lahey Health Primary Care
Rick Parker, Executive Director, Burlington Resident
Michelle Snyder, Regional Manager, Community Relations, Lahey Hospital & Medical Center
Andy Villanueva, MD, Chief Quality Officer, Lahey Hospital & Medical Center, Lahey Hospital & Medical Center Board of Trustees

The membership of LHMC/LMCP's Community Benefits Advisory Committee (CBAC) aspires to be representative of the constituencies and priority populations served by LHMC/LMCP'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. Senior management is actively engaged in the development and implementation of the Community Benefits plan, ensuring that hospital policies and resources are allocated to support planned activities.

It is not only the Board members and senior leadership who are held accountable for fulfilling LHMC/LMCP's Community Benefits mission. Among LHMC/LMCP's core values is 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 LHMC's structure and reflected in how it provides care at the hospital and in affiliated practices.

LHMC/LMCP is a member of BILH. While LHMC/LMCP 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 ensures that Community Benefits efforts, prioritization, planning, and strategy align and are integrated with local and system strategic and regulatory priorities.

The LHMC/LMCP Community Benefits program is spearheaded by the Regional Manager of Community Benefits. The Regional Manager of Community Benefits has direct access and is accountable to the LHMC/LMCP President and the BILH Vice President of Community Benefits and Community Relations, the latter of whom reports directly to the 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 underserved populations are considered every day in discussions on resource allocation, policies, and program development.

This is the structure and methodology 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 Community Benefits.

Community Benefits Committee Meetings
December 15th, 2020
March 16th, 2021
June 15th, 2021
September 21st, 2021 (Annual Meeting) - open to the public

Community Partners
The LHMC/LMCP 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/LMCP's CHNA and the associated Implementation Strategy were completed in close collaboration with LHMC/LMCP staff, its health and social service partners, and the community at large.

LHMC/LMCP's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of LHMC/LMCP's mission.

LHMC/LMCP serves and collaborates with all segments of the population. LHMC/LMCP focuses its Community Benefits efforts on low-resource individuals and families, older adults, youth/adolescents, and individuals and families with chronic/complex conditions living in its CBSA.

LHMC/LMCP currently supports dozens of educational, outreach, community health improvement, and health system strengthening initiatives within the Commonwealth. In this work, the hospital collaborates with many leading health care, public health, and social service organizations. LHMC/LMCP also provides support to community health centers within its CBSA, including the Lowell Community Health Center and North Shore Community Health (NSCH). In FY21, LHMC/LMCP provided funding for the Lowell Community Health Center for their interpreter services program. This partnership will continue in FY22. LHMC/LMCP also continued its support for the NSCH student health center based at Peabody High School in FY21,

These health centers are ideal Community Benefits partners because they are rooted in their communities and, as federally qualified health centers, are mandated to serve low-income, underserved populations.

LHMC/LMCP is also an active participant in CHNA 15 and CHNA 13/14 and supports both organizations with annual Determination of Need (DON) funding. Another important partnership is LHMC/LMCP's involvement with the Greater Boston YMCA Association. LHMC/LMCP partners with several branches of the YMCA to provide opportunities for physical activity and wellness for residents of its CBSA.

LHMC/LMCP's Board of Trustees along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its service area and beyond. World-class clinical expertise, education, and research, along with an underlying commitment to health equity, are the primary tenets of its mission. LHMC/LMCP's Community Benefits Department, under the direct oversight of LHMC/LMCP's Board of Directors, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations.

The following is a comprehensive listing of the community partners with which LHMC joins in assessing community need as well as planning, implementing, and overseeing its Community Benefits Implementation Strategy. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment (Section VII, page 48).

Community Partners

- A Healthy Lynnfield Coalition
- American Cancer Society
- Burbank YMCA
- Burlington Recreation Department
- Burlington School Department
- Community Health Network Area 13/14
- Community Health Network Area 15
- City of Peabody
- Housing Corporation of Arlington
- Lynnfield Public Schools
- Merrimack Valley Food Bank

- Metro North YMCA
- Mill City Grows
- Minuteman Senior Services
- New Entry Sustainable Farming Project
- North Shore Community Health
- North Suburban YMCA
- 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 FY19 CHNA along with the associated FY20-22 Implementation Strategy was developed over a ten-month period from October 2018 to August 2019. 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 LHMC/LMCP'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/LMCP's dedication to its mission, its covenant to the underserved, and its commitment to community health improvement.

As mentioned above, LHMC/LMCP's most recent CHNA was completed during FY19. FY20 Community Benefits programming was informed by the FY19 CHNA and aligns with LHMC/LMCP's FY20-FY22 Implementation Strategy. The following is a summary description of the FY19 CHNA approach, methods, and key findings.

Approach and Methods

The assessment began with the creation of a Steering Committee composed of representatives from the former Lahey Health system, including LHMC/LMCP, Winchester Hospital, and Beverly Hospital-Addison Gilbert Hospital. The hospital hired JSI, a public health research and consulting firm in Boston, to complete the CHNA and Implementation Strategy. The Steering Committee provided vital oversight of the CHNA approach, methods, and reporting process. This committee met monthly, in person and via conference call, to review project activities, vet preliminary findings, address challenges, and ensure alignment in CHNA approach and methods across the BILH system.

LHMC/LMCP engaged its CBAC, made up of hospital leadership and clinical staff, local service providers, and key community stakeholders, extensively throughout this process. This group met three times over the course of the assessment and provided input on the assessment approach, vetted preliminary findings, and helped prioritize community health issues and populations of focus. The CBAC also reviewed and provided feedback on the associated Implementation Strategy.

Finally, the Project Advisory Committee (PAC) was convened to provide input and feedback from a system-wide perspective. The PAC was composed of representatives from clinical and administrative

leadership and local public health officials, along with Community Relations staff. The PAC met three times over the course of the project, provided broad-based feedback on the approach, and vetted preliminary findings relative to priority community health issues and populations of focus.

Quantitative data from a broad range of sources was collected and analyzed to characterize communities in LHMC/LMCP's CBSA, measure health status, and inform a comprehensive understanding of the health-related issues. Sources included:

- U.S. Census Bureau, American Community Survey 5-Year Estimates (2013-2017)
- Massachusetts Department of Elementary and Secondary Education: School and District Profiles (2017 and 2018-2019)
- FBI Uniform Crime Reports (2017)
- MDPH, Registry of Vital Records and Statistics (2015)
- MDPH, Bureau of Substance Abuse Services (2017)
- MDPH, Annual Reports on Births (2016)
- Massachusetts Bureau of Infectious Disease and Laboratory Sciences (2017)
- Massachusetts Center for Health Information Analysis (CHIA) Hospital Profiles (FY 2013-2017)
- Massachusetts CHIA Hospital Discharges (2017)
- Massachusetts Healthy Aging Collaborative, Community Profiles (2018)
- Youth Risk Behavior Surveys (2017 and 2018)

JSI, working in collaboration with staff from BILH and CHIA, obtained federal FY17 hospital discharge data for municipalities within the Commonwealth. JSI analyzed the discharge data for the hospital's CBSA based on patient residence. JSI also developed statewide averages for comparative purposes. CHIA aggregates hospital discharge data from all hospitals in Massachusetts and makes it available to hospitals and researchers to evaluate morbidity, access to care, and health services utilization trends.

The data allowed for hospital-specific analyses based on where the patient was hospitalized within Massachusetts and patient origin analyses based on the patient's address of residence. Related to the CHNA activities, this data was used to:

- Measure hospitalization rates for major health issues as identified by stakeholders in the qualitative research
- Gauge access to high-quality primary and outpatient services for residents within the CBSA using the Agency for Health Research and Quality's Prevention Quality Indicators (PQIs) software

PQI rates were developed for eight chronic PQI measures, four of which are related to diabetes. PQIs use data from hospital discharges to identify admissions that might have been avoided through access to high-quality primary or outpatient care. The PQIs are population-based and, therefore, can help public health agencies, health care systems, and others interested in improving health care quality in their communities.

JSI compared municipal-level PQI rates with Massachusetts' statewide average.

Relative to most states, Massachusetts does an exemplary job at making comprehensive data available at the Commonwealth, county, and municipal levels through the MDPH. Historically, this data has been made available through the Massachusetts Community Health Information Profile (MassCHIP) data system, an automated and interactive resource provided by MDPH; MassCHIP is no longer being updated. To replace this system, MDPH is creating the Population Health Information Tool (PHIT), which will include municipal-level data stratified by demographic and socioeconomic variables (e.g., gender/sex, age, race/ethnicity, poverty level). At the time this report was produced, community profiles were not available via the PHIT. The most significant limitation this caused was the availability of timely data related to morbidity, mortality, and service utilization. The data sets used in this report are the most up to date provided by MDPH. This data was still valuable and allowed for identification of health needs

relative to the Commonwealth and specific communities; however, these data sets may not reflect recent trends in health statistics.

Additionally, quantitative data was not stratified by age, race/ethnicity, income, or other characteristics, which limited the ability to identify health disparities in an objective way. Qualitative activities allowed for exploration of these issues, but the lack of objective quantitative data constrained this effort.

LHMC/LMCP recognizes that authentic community engagement is critical to assessing community needs, identifying health priorities and populations of focus, and creating a robust implementation strategy. The hospital was committed to engaging the community throughout this process. Using the community engagement continuum included in MDPH's Community Engagement Standards for Community Health Planning as a guide, LHMC/LMCP employed a variety of approaches to ensure that community members were informed, consulted, and involved throughout the assessment process, and that they were collaborators in ensuring that the Implementation Strategy addressed priority issues and populations of focus.

LHMC/LMCP's Community Benefits program is predicated on the notion of partnership and dialogue with its many communities. LHMC/LMCP's understanding of these communities' needs is derived from discussions with and observations by health care and health-related workers in the neighborhoods as well as more formal assessments through available public health data, focus groups, surveys, etc. This data was then augmented by demographic and health status information gleaned from a variety of sources, including the Massachusetts Department of Public Health, the Boston Public Health Commission, federal resources such as the Institute of Medicine and the Centers for Disease Control and Prevention, and review of literature relevant to a particular community's needs.

The articulation of each specific community's needs (done in partnership between LHMC/LMCP and community partners) is used to inform LHMC/LMCP'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 undertaken each year.

Summary of FY19 CHNA Key Health-Related Findings
Below is a high-level summary of health-related findings that were identified after a comprehensive review of all the quantitative and qualitative information that was collected as part of the CHNA. A detailed and in-depth discussion of key findings is included in the full CHNA report.

- **The social determinants of health (e.g., transportation, economic stability, access to care, housing, food insecurity) affect many segments of the population.** A key theme from the assessment's key informant interviews, focus groups, listening sessions, and Community Health Survey was the continued impact that the social determinants of health have on residents of LHMC/LMCP's service area, especially those who are low-to-moderate income, homebound, have mental health or substance use issues, or lack a close support system.

- **Certain populations are at an increased risk for healthcare disparities and barriers to care.** Despite the fact that Massachusetts has one of the highest rates of health insurance enrollment and the communities that make up LHMC/LMCP's service area have strong, robust safety net systems, there are still substantial numbers of low-income, Medicaid-covered, uninsured, and otherwise underserved indviduals who face health disparities and are not engaged in essential medical and behavioral services. Efforts need to be made to expand access, reduce barriers to care, and improve the quality of primary care medical, medical specialty, and behavioral health services.

- **Mental health issues (e.g., depression, anxiety/stress, access to treatment, stigma) underlie many health and social concerns.** Nearly every key informant interview, focus group, and listening session included discussions on the impact of mental health issues. From a review of the quantitative and qualitative information, depression, anxiety/stress, and social isolation were the leading concerns. There were particular concerns about the impact of depression, anxiety, and e-cigarette/vaping on youth as well as social isolation among older adults.

- **Substance dependency continues to affect individuals, families, and communities.** The opioid epidemic continues to be an area of focus. Beyond opioids, key informants were also concerned with alcohol misuse, changing community norms in light of the legalization of recreational marijuana use, and e-cigarette/vaping among adolescents.

- **Chronic diseases (e.g., cardiovascular disease, cancer, diabetes, asthma) require more education, screening/early intervention, and management – and a focus on risk factors.** Although there was a major emphasis on behavioral health issues, many key informants, focus group participants, and listening session participants identified a need to address the many risk factors associated with chronic and complex health conditions. Physical inactivity and poor nutrition/lifestyle were discussed by many, with some of these issues being associated with age (mobility issues among older adults), education/health literacy (lack of understanding about healthy eating), and socioeconomic status (fresh foods being expensive, and gyms and health centers unaffordable). Addressing the leading risk factors is at the root of many chronic disease prevention and management strategies.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Patient Financial Counseling** **Health Issue: Additional Health Need as Defined by Community**		
Brief Description or Objective	LHMC employs four MassHealth-certified application counselors who can screen patients and assist them in applying for state aid. They also estimate for patients their financial responsibility (copay, deductible, coinsurance, self-pay). The financial counselors spend their time with patients discussing financial assistance and estimates and helping patients understand their insurance benefits.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Assist patients who are uninsured to assess their eligibility for and align them with state and hospital-based financial assistance programs.	
Goal Status	LHMC assisted 81,700 patients in FY21 who had Medicaid coverage, presented as self-paying, and completed an application with a Financial Navigator, and who qualified for upgraded MassHealth coverage or otherwise required support navigating the financial components of their health care visit. This was an increase of 20% from the number of patients from FY20. The ages of patients served were: 0-19 years (9%) ; 20-39 years (36%) ; 40-59 years (34%) ; 60-69 years (17%) ; 70-107 years (5%) Their employment status at time of service: 17,350 employed full time or part time; 15,270 unemployed; 3,000 self-employed; 4,070 retired; 4,325 disabled; 2,440 full- or part-time students	
Program Year: Year 2	**Of x Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Interpreter Services** **Health Issue: Additional Health Need as Defined by Community**		
Brief Description or Objective	LHMC/LMCP offers an extensive Interpreter Services program that provides interpretation (translation) and assistance in over 60 different languages, including American Sign Language, and hearing augmentation devices for those who are hard of hearing. The Interpreter Services Department routinely also helps with facilitating access to care, helping patients understand their course of treatment, and adhering to discharge instructions and other medical regimens. LHMC/LMCP also routinely translates materials such as legal consents for treatment, patient education forms, and discharges to continue to reduce barriers to care.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Provide culturally responsive care through the Interpreter Services Department
Goal Status	LHMC interpreters reported 7,572 total encounters. The top three languages were Spanish, the Chinese languages (Mandarin and Cantonese), and Portuguese languages (Portuguese and European).

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Merrimack Valley Food Bank Community Market Program** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	LHMC partners with the Merrimack Valley Food Bank (MVFB) to provide funding to support its Community Market Program, which serves residents of four Lowell Housing Authority (LHA) properties, offering them the opportunity to supplement their food by enjoying fresh produce at no cost. Bringing the market to the LHA properties helps residents who have difficulty traveling to a grocery store or pantry. The convenience of having fresh produce available outside one's front door may encourage individuals to eat more fresh fruits and vegetables.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal	Increase access to fresh produce for residents of Lowell.
Goal Status	In this year's Community Market program, a total of 535 clients received over 12,200 pounds of food.
Program Goal	Serve a diverse population of residents of Lowell.
Goal Status	The population breakdown for FY21 is as follows: 2 % African/Black; 32% Asian; 42% White; 19% Hispanic; 5% other. Of the FY21 ethnicities, the following age groups were served: 11% Children 0-17; 33% Adults 18-64; 59% Seniors 65+

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Mill City Grows Community Gardens Program** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	LHMC partners with Mill City Grows (MCG) to provide funding for improvements to its community-based garden program. MCG, a longtime partner of LHMC, has designed and built and now oversees 21 community and school gardens in Lowell that are used by over 6,500 Lowell residents. In this urban environment environmental challenges exist that contribute to health inequities among low-income families, elders, immigrants and refugee residents. Low-income neighborhoods are blighted by vacant, contaminated and underutilized lots containing soils with legacy heavy metals and other toxins that are remnants of Lowell's industrial past. This renders much of the open space in these neighborhoods unsuitable for recreational use with little incentive for developers to remediate the land.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	50% of participants increase physical activity as a result of community gardening
Goal Status	45% reported getting more physical activity; 84% reported more time outdoors.
Program Goal(s)	50% of participants increase produce consumption as a result of community gardening
Goal Status	60% reported eating more produce; 69% report eating 3-5+ servings of produce per day.
Program Goal(s)	50% of participants increase skills or knowledge as a result of community gardening
Goal Status	62% reported increasing skills or knowledge as a result of program.
Program Goal(s)	Grow 12,000 pounds of produce for participant consumption
Goal Status	13,020 pounds of produce raised in community gardens.
Program Goal(s)	Increase gardeners from 450 to 500 individuals
Goal Status	482 total individuals are currently enrolled as gardeners or household members. This is a 7% increase from last year.

Program Goal(s)	Install seating and share structures at 2-4 gardens
Goal Status	New picnic table seating areas installed at 3 gardens.
Program Goal(s)	Provide additional community building activities such as a newsletter, in person and virtual gardener skill shares, and technical assistance via garden hours
Goal Status	Monthly newsletter sent to all gardeners, 1 virtual skill share held, monthly volunteer gatherings at each garden, 4 hours of technical assistance offered in each garden each month
Program Goal(s)	Repair 40 garden beds throughout the community garden network
Goal Status	48 beds repaired/rebuilt during the course of the season.

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Mill City Grows Food is Medicine Program** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	LHMC partners with Mill City Grows (MCG) and their partner, the Lowell Community Health Center on REACH LoWell, a multi-year program partly funded by the Centers for Disease Control, to provide a holistic care plan for Southeast Asian and Latinx residents who need assistance in preventing and managing diabetes. REACH LoWell will include culturally competent medical care, access to fresh food, family-centered food education, and resources to engage in gardening as physical activity. MCG will provide farm shares, cooking classes, and food education through recipes and taste tests.
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)	Conduct a Community Food Assessment
Goal Status	Public Data collection is complete as of 9/30/21, responses coded, and first draft of report completed by 10/25/21, with final report due 3/1/22
Program Goal(s)	Conduct monthly taste tests for Community Shared Agriculture shares from May - Nov 2021

Goal Status	8 taste tests conducted throughout the year, featuring seasonal produce including roasted squash, apple, kale salad AND barley/appaloosa bean bowl. Lots of great conversations with participants about high fiber foods to manage diabetes.
Program Goal(s)	Host 2 virtual Farm to Table series, serving up to 20 total families
Goal Status	5 Farm to Table series held, 2 in person, 2 virtual. Serving 15 families total. (less than anticipated, several cancellations due to COVID-19
Program Goal(s)	Increase community knowledge of food assistance programs by hosting 2 virtual training sessions for up to 50 trainers, and disseminate training materials to 12+ organizations.
Goal Status	2 trainings held (3/25/21 and 5/20/21). 40 trainers attended, from 15 different organizations.
Program Goal(s)	Serve up to 100 households through a Community Share Agriculture (CSA) distributing 40,000 pounds of food.
Goal Status	150 households served through CSA program. 39,999 pounds of food distributed.

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Strengthening the Local Workforce: Internship Programs** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	LHMC is committed to collaborating with partners to strengthen the local workforce by supporting job training and internship programs. Every year, through the Radiology Job Training Program, students from surrounding colleges and universities are given the opportunity to receive hands-on clinical experience in radiation, breast imaging, CT scan, nuclear medicine, and ultrasound technologies. Internships range from 6 months to 2 years and interns are supervised and educated by LHMC staff members. LHMC partners with Bunker Hill Community College, Middlesex Community College, Massachusetts College of Pharmacy and Health Science, and Regis College on this program.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide clinical-based education opportunities to help strengthen the local workforce.

Goal Status	In FY21, LHMC provided: 2 internships for students in ultrasonology; 1 graduating intern was hired by LHMC; 4 three-month internships in nuclear medicine, 1 graduating intern was hired by LHMC; 18 two-year radiology internships; 7 of 9 of those 18 who were graduating were hired by LHMC post-internship.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Community-Based Exercise Programs** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	LHMC partners with the Burlington Council on Aging to offer free exercise classes and opportunities for fitness for community members.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide opportunities for community members to participate in group exercise classes at no cost to them.
Goal Status	In FY21, LHMC provided funding to the Burlington Council on Aging for a Senior Stretch program that operated both virtually and in-person and a Tai Chi Class. Overall, the classes served almost 150 older adults in Burlington with Senior Stretch (in-person) reporting 49 unduplicated, 452 duplicated; Virtual Senior Stretch 78 unduplicated 4552 duplicated and Tai Chi 20 unduplicated 101 duplicated. The classes run once a week for 52 weeks per year and operated both virtually and in-person in FY21.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: YMCA Enhance Fitness Program** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	LHMC partners with the Greater Boston YMCA and 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)	Increase general health, physical ability, and physical activity of participants from the participant pre & post assessments.
Goal Status	Greater Boston YMCA Program Data 33 total Participants were evaluated on fitness checks and were asked to complete three exercises to the best of their ability on the first and last days of the sessions. Burbank YMCA: 78% attendance, N. Suburban YMCA: 74% attendance Up-and-go: The number of seconds it took to stand, walk eight feet, and return to sitting was recorded. • Burbank YMCA: 44% improved or maintained at average or above. North Suburban does not yet have 16-week post data available Arm curls: The number of reps completed by each arm in 30 seconds was recorded. • Burbank YMCA:100% improved or maintained at average or above North Suburban does not yet have 16-week post data available. Chair stands: The number of stands from a seated position in 30 seconds was recorded • Burbank YMCA: 67% improved or maintained at average or above. North Suburban does not yet have 16-week post data available Metro North YMCA Program Data 28 participants and had the following results: • 100% of participants reported an improvement in general health. • 100% of participants reported an improvement in physical ability. • 100% of participants reported that they have either maintained or improved their workout routine, with the same intensity of Enhance Fitness. • There was a 50% reduction in the amount of participant falls in the last 4 months of post assessment • Participants were also evaluated on fitness checks and were asked to complete three exercises to the best of their ability on the first and last days of the sessions. • The number of seconds it took to stand, walk eight feet, and return to sitting was recorded. This metric showed a 64% improvement in the post-assessment. • Arm curls: The number of reps completed by each arm in 30 seconds was recorded. This metric showed a 57% improvement in the post-assessment. • Chair stands: The number of stands from a seated position in 30 seconds was recorded. This metric showed a 50% improved or maintained in the post-assessment. Overall, there was a significant improvement in participants' performance in all three fitness tests as compared with the initial assessment.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Serving Health Information Needs of Everyone (SHINE) Program** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	LHMC maintains extremely successful partnership with Winchester Hospital and Minuteman Senior Services to continue to provide SHINE counselors at the Arlington and Burlington Councils on Aging and at a designated site on the LHMC campus at 41 Mall Road. From April-September of FY20, counseling was provided virtually. The consumers served in the LHMC region received no-cost, one-on-one insurance benefits counseling provided by state-certified SHINE volunteers or staff members. LHMC is the only acute care health system serving as a SHINE counseling site in Massachusetts. The collaboration includes private, in-kind space so SHINE counselors can be accessible to the hospital community, volunteer support provided by the LHMC Volunteer Services Department, and related services.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To provide Medicare beneficiaries and their families with confidential and unbiased health insurance information to address inpatient, outpatient, and prescription drug benefit gaps in coverage. The counseling sessions help Medicare beneficiaries and their caregivers: - Navigate the complex health insurance options - Understand the language of the plans and how the components work - Review their current coverage and compare the costs and benefits of available options - Enroll in assistance programs if needed
Goal Status	In FY21, SHINE counselors conducted a total of 309 free confidential, unbiased counseling sessions for community members at two locations: Arlington: 142; Burlington: 167. This was a 9% decrease, due to COVID-19. As of March, due to COVID restrictions, all counseling sessions were conducted over the phone. Of the 309 participants: 75% were over the age of 65. 70% were female; 32% were male; 12% were below 150% of the federal poverty level; with 73% above and 15% below the low-income subsidy asset limit. The following outcomes were reported by 176 of participants who completed a post-program evaluation: 118 had a Medigap supplemental plan. 26 were new to Medicare and benefited from the information/assistance received on the various plans; 35 post-program evaluation participants did not report on insurance status.
Program Goal(s)	Develop a screening tool to assess social determinants of health and the need for additional services for clients.
Goal Status	169 community members in Arlington and Burlington were screened using the tool. Referrals were made for participants to 11 including MassHealth; Mass College of Pharmacy; Council on Aging, Minuteman Senior Services, Medicare Advocacy Project,

	Mass Health Connector, SNAP, Fuel Assistance, Legal Services, pharmacies and Prescription Advantage.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Domestic Violence Initiative** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	LHMC's Domestic Violence Initiative (DVI) is a group that includes physicians and nonclinical staff from departments such as behavioral health, clergy, general internal medicine, and social work, as well as the Emergency Department. This group helps collaborate with local police and community organizations to provide crisis intervention and links to services for victims of domestic violence, and relationship violence in all forms, including spousal violence and elder abuse.
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)	Heighten awareness of domestic violence, provide crisis intervention and links to services, strengthen community partnerships, and train clinical staff to recognize and respond to the needs of victims.
Goal Status	In FY21, LHMC hosted 4 meetings of community organizations that serve victims of domestic violence to share information and resources. In FY21, LHMC identified 353 cases of domestic violence among patients who self-reported.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Lowell Community Health Center Keys to Health Equity Project: Language Supports** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	LHMC partners with the Lowell Community Health Center on their interpreter services program. Nearly 40% of Lowell CHC patients are best served in languages other than English, this grant will strengthen the health center's capacity to deliver on-demand language services for more than half of their 35,000 patients.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Provide funding to support interpretation services to the Lowell Community Health Center.
Goal Status	In FY21, 44.27% of a total of 253,769 patient visits (all cause) to the Lowell Community Health Center required language access to interpretation in more than 50 languages and dialects, translation of COVID-19 and other health guidance and information.
Program Goal(s)	Serve a diverse population of residents of Lowell.
Goal Status	73.08% identify as a Racial/Ethnic Minority, with 32.78% Hispanic/Latino. 30.45% of patients identify as Non-Hispanic/White; 26.68% as Asian; 17.01% Black/African-American, and 5.29% More than one race. In calendar year 2020, 45% of 31,808 patients requested interpretation in over 60 languages to 14,313 patients. 91.74% of patients live at or below 200% Federal Poverty Guidelines, and 72.74% live below 100% FPG.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Improving Access to Transportation--Arlington Council on Aging** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	LHMC partners with the Arlington Council on Aging to help to provide a curb to curb transportation to in-person medical appointments for underserved populations. There is no charge to older adults utilizing these rides and would include rides to all medical appointments within Arlington and surrounding towns. All COA transportation options follow strict COVID-19 safety protocols. With LHMC's support, the Arlington COA recruited additional volunteers to help to specifically outreach into populations of focus for the community, including people of color.
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 free rides to medical appointments for a diverse population of Arlington older adults.
Goal Status	In FY21, the ride program provided 40 unique individuals with a total of 164 taxi rides to medical appointments. Participants identified as the following: 27 Asian; 5 African-American; 18 White Hispanic; 18 Hispanic Latino; 18 non-Hispanic.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Council on Aging Farmers Market Program** **Health Issue: Additional Health Needs as Defined by Community**	
Brief Description or Objective	LHMC partners with the New Entry Sustainable Farming Project to run 20-week farmers' markets at Burlington, Arlington, and Billerica Councils on Aging. Depending on location, the program served 50-80 seniors per week from June through October, and on average, participants took home 6 varieties of fresh, local produce each week. In total, the program distributed more than 40,000 pounds of produce to the community. LHMC also supports a monthly grab and go program at the Burlington Council on Aging during the months that the market is not running to help to provide a socialization opportunity for older adults and as a way for staff to check on the well-being of their clients.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase knowledge of healthy eating for program participants.
Goal Status	59% of program participants reported that they gained more knowledge of food/recipes.
Program Goal(s)	Provide seniors in Arlington, Billerica, and Burlington with fresh fruits and vegetables.
Goal Status	The program served between 50-80 seniors per week, depending on location. Approximately 18,000 pounds of produce was distributed in total over the course of 20 weeks between all three locations.
Program Year: Year 1	**Of X Years: Year 3** | **Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Burlington Affordable Housing Coordinator** **Health Issue: Housing/Homelessness**	
Brief Description or Objective	LHMC collaborates with the Burlington Affordable Housing Coordinator. This position administers the affordable housing program for the Town of Burlington which provides support, referrals and assistance for those who are undergoing a period of housing instability. This program primarily serves residents of Burlington who are seniors or are experiencing homelessness.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

	☒ Total Population or Community Wide Intervention
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	Number of encounters: 18 Number of referrals: 12 Demographics of people served: All encounters were with residents that qualify as low income.

Program Year: Year 1	**Of X Years: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Homelessness Prevention Program--Citizens Inn** **Health Issue: Housing/Homelessness**	
Brief Description or Objective	LHMC supports the Citizens Inn's Homelessness Prevention Program which provides longer-term supportive case management services to our clients who have moved on to permanent housing or are experiencing a housing crisis. The case management team works with each family to create a personalized stabilization plan. This plan not only addresses issues of economic stability, such as establishing a budget and setting up a bank account, it also creates support structures in the community, such as: monitoring school attendance and educational progress for children; assisting with landlord relations; and facilitating access to health care services. Case managers ensure that clients are referred to all the right places and support services, so none of these things become a barrier to stability.
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 2021, the Homelessness Prevention Program will provide supportive services, such as food and employment assistance, for clients that allow them to remain housed.
Goal Status	3,490 clients were served in FY 21.
Program Goal(s)	By September 2021, the Homelessness Prevention Program will assist clients in finding or maintaining housing.
Goal Status	94 clients/households were served in FY 21.

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Housing Corporation of Arlington Homelessness Prevention Program** **Health Issue: Housing/Homelessness**	
Brief Description or Objective	LHMC supports the Housing Corporation of Arlington's Homelessness Prevention Program (HPP). The program operates by identifying Arlington's residents who are most in need and stabilizing them with services coordinated by the Arlington Human Services Network (AHSN). The HPP interview process includes an assessment/case management service to see whether the family requires more than rental assistance. They help with applying for social security, medical insurance, food stamps, or referring to other partners for 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 the end of 2021, HCA will assist 107 families in the HCA housing development with case management, homeless prevention funds, and ten head of household assist in finding jobs.
Goal Status	As of September 2021, HCA's social workers had provided 101 clients with the following types of assistance: • 84 clients were able to maintain or find housing through the Homelessness Assistance Program • 17 clients were provided with case management services such as applying for social security, medical insurance, food stamps, etc. • Four residents are currently working with staff to find jobs and are currently working on preparing a resume, interview skills, and how to interview by using zoom.
Program Year: Year 1	**Of X Years: Year 2** | **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Saheli Housing Stabilization Program** **Health Issue: Housing/Homelessness**	
Brief Description or Objective	LHMC partners with Saheli on its Housing Stabilization Program (SHSP) which provides housing support services for domestic violence survivors, many of whom are immigrants. This program helps to make housing accessible and affordable for those who are often disproportionately affected by homelessness. Through this program, Saheli provides rental assistance for up to 6 months; offers financial assistance in the form of flex funds to help with a short term crisis that could jeopardize a survivor's housing; provides housing advocacy services to develop a personalized Housing Stabilization Plan for each survivor and link them to community resources; enrolls survivors into Saheli's Economic Empowerment Program to help survivors build credit, manage personal finances, learn basic English and access job and career-related 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)	Provide support and advocacy to survivors receiving rental assistance, and survivors requiring short-term flex funds.
Goal Status	A housing specialist was hired by Saheli to provide Saheli clients help with subsidized/affordable housing and helping them remain stably housed after exit from rental assistance support. In 2021, 63 clients were provided with comprehensive housing advocacy and provided financial assistance to stabilize housing and prevent homelessness to 49 survivors. Of that total 74% (36/49) received rental assistance. The remainder received utility and food assistance.
Program Year: Year 1	**Of X Years: Year 1** | **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Increasing Access to Supportive Housing Services: 12 Russell Terrace Resident Support Program** **Health Issue: Housing/Homelessness**	
Brief Description or Objective	LHMC provided support to help to offset the cost of the resident services coordinator at an affordable housing site in Arlington. This role is essential to allowing residents of the facility and regularly meets with residents to help them become educated about their housing and advise them if there are any lease violations, connects residents with services such as medical, mental health programs, food stamps such as SNAP benefits, and any rental assistance programs. The coordinator also regularly makes referrals to the Caritas Homelessness Prevention Program, an early intervention for residents who miss a rent payment and provides coaching, repayment plans, and referral to assistance programs, while fostering accountability, so residents can continue to maintain their affordable housing.
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 2021, 100% of residents at 12 Russell Terrace will have accessed supportive services that will enable them to be stabilized enough to maintain their affordable housing
Goal Status	In FY 21, residents attended the following programs: Employment Opportunities - Counseling and Connection (18/ 18); Employment Assistance (Project Place) (3/18); Financial Budgeting Workshop (6/18)
Program Goal(s)	By September 2021, 100% of residents at 12 Russell Terrace will have stabilized housing.
Goal Status	100% (18/18) residents have maintained their stabilized housing status.
Program Year: Year 1	**Of X Years: Year 2** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health and Access to Care **Program Name: Infrastructure to support Community Benefits collaborations across BILH hospitals** **Health Issue: Various**	
Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital have worked together to plan, implement, and evaluate Community Benefits programs. Staff have worked together to plan the FY22 Community Health Needs Assessment, understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH, in partnership with MGB, has developed a Community Benefits (CB) database. This database is part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2021, increase the capacity of BILH Community Benefits staff to understand program evaluation through workshops and case studies.
Goal Status	All 20 BILH Community Benefits staff participated in 6 evaluation workshops on SMART Goals, Logic Models, process and outcome evaluations, and program improvement.
Program Goal(s)	By September 30, 2021, in partnership with MGB, create and implement a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits Committee data to more accurately capture and quantify CB/CR activities and expenditure
Goal Status	All 20 BILH Community Benefits staff were trained on the Community Benefits Database and began data entry for FY20 regulatory reporting.
Program Year: Year 1	**Of X Years: Year 1** / **Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Bone Health and Osteoporosis Prevention Program** **Health Issue: Chronic Disease**	
Brief Description or Objective	LHMC conducts a Bone Health and Osteoporosis Prevention program to help patients understand a diagnosis of osteopenia and/or osteoporosis, discusses treatment measures to improve bone health after a fracture, provides education on the types of exercises necessary to promote bone health and prevent falls, provides information on a healthful diet with important nutrients that contribute to bone health, and aims to reduce the burden of fragility fractures for the individual and community.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide free Bindex bone scans to patients referred to the program. Increase the number of scans in FY 2022.
Goal Status	42 scans completed during FY21. Education was provided during the screening process, and each scan took between 5-10 minutes.
Program Goal(s)	Provide information and motivation for lifestyle changes to positively impact bone health. Improve access to patients through an improved referral process utilizing the "Ambulatory referral to Orthopaedic Specialty Classes"
Goal Status	LHMC provided 6 of classes with a total of 48 participants in FY21. The program transitioned to a virtual platform this year. The following are some of the comments provided by the participants: (a formal evaluation process will be developed using the O365 forms) Participants verbally reported new ideas and information to apply to their lifestyles for better health, such as diet and exercise routine. Participants verbally reported plans to make changes to their exercise routine and take vitamin D and calcium as recommended by their health care professional. Participants verbally reported that background and explanation of medications provided better understanding for decision-making and adherence to treatment.
Program Year: Year 2	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Burlington Diabetes Care Program** **Health Issue: Chronic Disease**	
Brief Description or Objective	LHMC partners with the Town of Burlington to support the Burlington Diabetes Care Program. This program provides assistance for Town of Burlington Employees who have a diagnosis of pre-diabetes or are diabetic. The program provides those who are identified with an annual foot exam, eye exam, and an A1C analysis, among other support services, every six months with no copays for participants. This program is intended to help offset the cost of these services to help to avoid serious chronic conditions often associated with diabetes and pre-diabetes.

Program Type	☐ Direct Clinical Services ☒ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population or Community Wide Intervention
Program Goal(s)	Improve A1c3 of 25% of participants.
Goal Status	Percent improvement A1C: 31% of program participants had a reduction in A1C and 28% of program participants maintained a healthy A1C of 7 or below
Program Goal(s)	Provide education, support, and intervention for persons with diabetes.
Goal Status	Number of people served: 82 Members with diabetes; 23 Enrolled in the program; 15 Adherent; 17 Adherent in last 12 months Demographics of people served: Eligible 40% female 60% male; Enrolled 26% female 74% male Adherent 27% female 73% male

Program Year: Year 1	**Of X Years: Year 2**	**Goal Type: Outcomes Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Cooking Up Good Health** **Health Issue: Chronic Disease**	
Brief Description or Objective	LHMC provides free nutrition and cooking classes to community members through its Cooking Up Good Health series. Participants learn different culinary tips and nutrition information about meals, snacks, sides, and desserts.
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒ Total Population or Community Wide Intervention
Program Goal(s)	Launch a virtual cooking class program.
Goal Status	In FY 21, LHMC hosted their Cooking Up Good Health Series in a virtual format and hosted a total of six classes with an average participation of 6 people per class.
Program Goal(s)	80% of attendees will report more confidence in using healthier ingredients when cooking a meal.
Goal Status	In FY 21, over six classes, an average of 99% of program participants reported being more confident in using healthier ingredients when cooking a meal.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Memory Café** **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)	Provide support through the Memory Café to 15 participants per class.
Goal Status	32 unduplicated individuals attended the Memory Cafe in FY 21 and 117 duplicated individuals. The age range for participants is 66-91.
Program Year: Year 2	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Women's Health Lecture Series** **Health Issue: Chronic Disease**	
Brief Description or Objective	LHMC hosts a quarterly education program called the Women's Health Lecture Series. This program supports education and health care advocacy for women of all ages that helps empower women to be their own health care advocates.
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 annual Women's Health Lecture Series strives to educate the community on important and timely health issues.
Goal Status	Approximately 366 attendees were served through this program in FY 21.
Program Year: Year 2	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Livestrong** **Health Issue: Chronic Disease**	
Brief Description or Objective	LHMC partners with the North Suburban YMCA on their exercise-based Livestrong Program for cancer survivors. Classes are tailored for all cancer survivors, regardless of stage of diagnosis or treatment, and adapted for all fitness levels. Two trained and certified instructors run each session for 12 weeks, with participants meeting twice a week. Staff members are trained on the unique physical and emotional needs of cancer survivors, curriculum, and best practices. They work with each participant to create an individualized exercise program from pre-program assessment results, and then teach and demonstrate exercise technique and safety considerations. This individualized attention helps participants meet their goals and overcome their specific barriers.
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 communities among cancer survivors and guide them through safe physical activity, helping them build supportive relationships leading to an improved quality of life.
Goal Status	Livestrong at the YMCA has an established, research-based evaluation plan that uses pre- and post-assessment tests. The detailed assessments evaluate arm function and range of motion; lymph node prognosis; shoulder flexion, extension, and abduction; and posture. Program participants are asked to rate overall quality of life, ability to perform daily tasks, mobility, eating habits, fitness level, perceived body image, current energy levels, and overall happiness. The program collects pre- and post-assessment data to show participants progress over the 12 weeks in the areas of cardiovascular endurance, strength, flexibility, mobility, and behavioral health. Among the 24 participants who graduated in two sessions, the results were as follows: • 83% Attendance • 78.5% improved leg strength; • 90% improved upper body strength • 50% improved their balance
Program Year: Year 2	**Of X Years: Year 3** | **Goal Type: Outcomes Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: PINK Breast Cancer Support** **Health Issue: Chronic Disease**		
Brief Description or Objective	LHMC partners with the Burbank YMCA to provide a PINK support program for breast cancer survivors. The PINK Program is a locally developed program specifically designed to help breast cancer survivors boost energy, increase strength, and restore ease of movement while performing daily tasks. Classes are tailored for the different types of breast cancer surgeries and adapted for all fitness levels. The instructors are trained in cancer survivorship, post-rehabilitation exercise, and supportive cancer care. Through PINK, survivors and their families receive a membership at the YMCA for the duration of the program, whether they are new to the program or participate in the maintenance 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)	Provide supportive services to breast cancer survivors.	
Goal Status	The PINK Program has restructured, and is now offered as a continuously operating, drop-in group exercise class/program with unique social support for breast cancer survivors. The YMCA ran a virtual class and 18 total people participated to date.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Oncology Nurse Navigator and Supportive Services for Cancer Patients** **Health Issue: Chronic Disease**		
Brief Description or Objective	LHMC provides oncology navigation services for patients with a cancer diagnosis. RNs with oncology-specific clinical knowledge work with newly diagnosed cancer patients by offering individualized support and assistance with coordinated care through a holistic and collaborative approach that includes communication and coordination with the patient's family and/or caregivers along with a multidisciplinary team consisting of physicians, nurse practitioners, oncology nurses, and social workers.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	To 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 FY21, the navigators served on average between 10-15 individuals per day.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions and Risk Factors **Program Name: Cancer Programs: Screening & Prevention** **Health Issue: Chronic Disease**	
Brief Description or Objective	LHMC has implemented an assessment screening tool at the Burlington, Peabody, and Lexington locations to help community residents determine whether they might be at risk for breast cancer. Using an electronic tablet, people confidentially answer questions that help determine whether they may be at a higher risk for breast cancer. The assessment, evaluation, and follow-up are all provided at no cost to participants. Results are given to their physicians, who can help them determine whether they might benefit from a higher level of screening beyond regular checkups and mammograms. LHMC is also a long-standing partner and provides support to the American Cancer Society on many community-based prevention activities.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Identify persons who may be at a higher risk for breast cancer and provide screening follow-ups to their physicians.
Goal Status	In FY21, LHMC completed 16,892 risk assessments for 17,303 unique individuals. 13% of patients screened across the system were identified as having a high lifetime risk of breast cancer and 25% were identified as having a high-risk mutation.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington Council on Aging Outreach Workers** **Health Issue:**		
Brief Description or Objective	LHMC partners with the Burlington Council on Aging on outreach workers who provide essential services to seniors in 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)	Provide referrals for program clients to supportive services.	
Goal Status	The social workers made 840 referrals to various agencies such as Legal Services, adult day health, housing and Minuteman Senior Services for home care services, health insurance benefits (SHINE), protective services just to name a few. Most of those referrals also stayed with the COA for ongoing case management.	
Program Goal(s)	Provide supportive services to Burlington residents	
Goal Status	The Burlington Council on Aging social workers had 3,389 encounters serving 926 people (including family members or caregivers).	
Program Year: Year 1	**Of X Years: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington Police Department Substance Use Coordinator** **Health Issue: Substance Use Disorders**		
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)	Provide referrals and supportive services to persons with substance use disorder.
Goal Status	Number of encounters for substance use coordinator: 27 Number of referral: 17 Demographics of people served: By gender male 10 & female 17 By age: • 15 to 19 = 1 • 20 to 39 = 16 • 40 to 59 = 8 • 60 and over =2

Program Year: Year 1	**Of X Years: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington Public Schools: Social Emotional Learning** **Health Issue: Mental Illness and Mental Health**	
Brief Description or Objective	LHMC partners with Burlington High School on their implementation of a project to develop the necessary social and emotional skills and mental health in students for them to be successful in school, employment, and citizenry. The project focuses on Tier 1, Tier 2, and Tier 3 supports. The implementation of Tier 1 supports will provide universal, social-emotional programming at Burlington High School in an effort to promote equitable care and access to social-emotional and mental health services regardless of age, income, education, race, gender, or sexual orientation. The implementation of Tier 2/3 targeted services will support youth identified as at-risk due to cultural, linguistic, and/or financial reasons to ensure equitable care and access to services. In addition, funding went to support a district-wide social-emotional and mental health needs assessment. This needs assessment will guide the district in identifying areas of need, determine goals/action steps, plan necessary supports, and monitor progress towards meeting the identified goals/actions steps thus promoting equitable care and increasing access and literacy in using technology to communicate with the school community.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By the end of the 2020/2021 academic year Burlington High School will have explicit taught skill-based lessons on six social-emotional domains/strategies; including but not limited to Social-Awareness, Goal-Directed Behavior, Self-Awareness, Self-Management, Optimistic Thinking, and Personal Responsibility.
Goal Status	Completed: Burlington High School staff have had access to and have incorporated lessons based on the following social-emotional domains: January: Responsible Decision Making February: Goal Directed Behavior/Career Readiness March: Social

	Awareness/Social Justice April: Personal Responsibility May: Relationship Skills/Healthy Relationships June: Optimistic Thinking
Program Goal(s)	Professional development opportunities on each domain/strategy will also be coordinated and offered to the Burlington High School staff on a monthly basis and led by the program coordinator through the remainder of the 2021 academic school year
Goal Status	Completed: Burlington High School staff have been given the opportunity to participate in ongoing professional development; hosted by the program coordinator, on the following social-emotional domains: January: Responsible Decision Making (01/15) February: Goal Directed Behavior/Career Readiness (02/26) March: Social Awareness/Social Justice (03/19) April: Personal Responsibility (04/13) May: Relationship Skills/Healthy Relationships (05/14) June: Optimistic Thinking (06/11)
Program Goal(s)	Progress monitoring of student skills, strengths and needs will be conducted in February and May utilizing the DESSA program. DESSA is a social emotional learning assessment tool that is a standardized, strength-based behavior rating scale used by educators to measure the competence for children in grades K-12.It is grounded in Resiliency Theory and aligned with the CASEL framework. A baseline assessment of all high school students has already been completed in October of this year utilizing this program.
Goal Status	Completed: Burlington High School has completed the third round of progress monitoring utilizing the DESSA program. A third and final round of progress monitoring was completed between May 17th and May 31st.
Program Goal(s)	By the end of the 2020/2021 academic year Burlington Public Schools will have developed, disseminated and reported upon a district-wide social emotional and mental health needs assessment. This needs assessment will be developed by the coordinator in conjunction with stakeholders including fellow Burlington Public Schools staff, parents/guardians, and students. The needs assessment will aim to garner information related to district level social-emotional and mental health programming, communication strengths and areas for improvement, and access to and coordination of social-emotional and mental health services
Goal Status	Completed: Burlington Public Schools has developed and disseminated a district-wide mental health needs assessment to parents/guardians & staff. The district received a total of 677 responses.
Program Goal(s)	By the end of the 2021 academic school year, tier 2/3 students will have been identified and met with coordinator/staff members to provide ongoing SEL support.
Goal Status	Completed: 41 Burlington High School students were identified as tier 2/3 students and also as students who received free/reduced lunch or identified as ELL. These students were assigned to a BHS coordinator/staff members and are meeting to provide ongoing SEL support with explicit goals.

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Middlesex League Youth Risk Behavior Survey** **Health Issue: Mental Illness and Mental Health**	
Brief Description or Objective	LHMC partners with the Middlesex League Collaborative to provide a Youth Risk Behavior Survey (YRBS) for the towns of Arlington, Wakefield, Belmont, Watertown, Burlington, Wilmington, Melrose, Winchester, Reading, Woburn, and Stoneham. The YRBS can determine the prevalence of health behaviors; assess whether health behaviors increase, decrease, or stay the same over time; examine the co-occurrence of health behaviors; provide comparison data for geographies and subpopulations; and monitor progress toward achieving Healthy People objectives and program indicators. The YRBS allows the schools to better understand the extent to which middle school and high school students in the district engage in risky behaviors. LHMC's support has allowed the Middlesex League to create an online, standardized test that allows for the data to be processed in a timely manner and synthesized into a regional report.
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)	Identify mental health risk factors for youth in the Middlesex League.
Goal Status	29% of HS and 21% of middle school students reported that their mental health was not good most of the time or always. Genderqueer students were more likely to report experiencing overwhelming stress, depression, and suicidal ideations than male or female students. School demands and expectations continued to cause students the most negative stress, with keeping up with schoolwork reported as the primary contributing factor. Suicidal ideation and attempts were reported at similar rates compared to prior YRBS data. Students in 8th grade are at particularly high risk for planning and attempting suicide. Students most often identified a parent as their support network.
Program Goal(s)	Identify potential health and social impacts to youth from COVID-19.
Goal Status	Over one-third of high school students and about one-fourth of middle school students reported that their mental health was not good most of the time or always. Genderqueer students were significantly more likely to report experiencing poor mental health. While the majority of students did not experience any adverse financial or health-related effects of COVID-19, 11% of HS students and 6% of MS students experienced a family financial problem and 23% of HS students and 22% of MS students had a family member or close friend who died. More than half of high school and middle school students reported experiencing feelings of anger, sadness, worry, numbness, or frustration in reaction to the coronavirus. Just over half of high school and middle school students reported feeling close to people in their school (52% and 53%, respectively).
Program Goal(s)	Identify risk factors and rates of substance use in Middlesex League youth.

Goal Status	Overall, substance use increased as students increased in grade. Alcohol was most commonly used by high school and middle school students. About one-fifth of high school students report having drank alcohol in the past 30 days. White and female high school students were more likely to report drinking alcohol. Hispanic high school students were more likely to report marijuana and electronic vapor product use. High school students generally accessed substances through friends or family members. Smoking cigarettes was perceived as the most risky and marijuana use the least among high school students. Trend data between 2019 and 2021 shows a decline in overall alcohol consumption amongst high school students by 12% and a 3% decline amongst middle school students. Similar trend data across marijuana use was reported, with a 10% decline in usage amongst high school students and a 1% decline amongst middle school students.
Program Goal(s)	Identify the risk factors and rates of unintentional injury and violence for youth in the Middlesex League.
Goal Status	Overall, high school students are more likely to report driving under the influence of marijuana than alcohol. Hispanic and Multi-Racial students are most likely to report driving under the influence of alcohol or marijuana. About one-fifth of high school students report that they check their cell phone while driving. White and female students are most likely to report that they check their cell phone while driving. Forced sexual behavior was consistent across reporting years. Genderqueer students were significantly more likely to experience electronic bullying than male or female students. Trend data shows a 10% decline in experiencing electronic bullying amongst Middlesex middle school students from 30% in 2019 to 20% in 2021. Trend data indicates the number of high school students who reported having been forced to do sexual things they did not want to do as similar to previous years (7-8% across 2017, 2019 and 2021).
Program Goal(s)	Identify the risk factors for physical health and chronic disease in Middlesex League youth.
Goal Status	About 7% of HS students were obese (>= 95th percentile for body mass index, based on sex-and age-specific reference data from the 2000 CDC growth charts) and 14% were overweight (>= 85th percentile but <95th percentile for body mass index). The percent of HS students who were obese decreased from 8% to 7% while overweight rates increased from 13% to 14% compared from 2019 to 2021. The majority of MS and HS students report that they are about the right weight. HS students reporting eating fruit in the past 7 days slightly more often in 2021 compared to 2019 (95% vs 92%) and similar rates of vegetable consumption (94% vs 95%). The majority of HS students did not drink soda (53%) or an energy/sports drink (69%) in the past 7 days. White students were most likely to have drunk soda or an energy/sports drink in the past 7 days, while Asian students were least likely. Physical activity per week decreased while average screen time per day increased as students increased in age. Amongst MS Middlesex Students there was a 5% increase in students who reported not trying to do anything about their weight from 31% in 2019 to 36% in 2021.

Program Goal(s)	Identify the risk factors for sexual activity in Middlesex League youth.
Goal Status	Overall, 19% of high school students and 2% of MS students reported that they had ever had sexual intercourse. Hispanic, Multi-Racial, and genderqueer students were more likely to report drinking alcohol or using drugs before sexual intercourse. Trend data indicates an overall decrease in the number of Middlesex high school students who report having had sexual intercourse. This decreased from 28% in 2017 to 26% in 2019 to now 19% in 2021. High school students reported that condoms were the most common method used to prevent pregnancy.
Program Goal(s)	Provide funding to support the administration of a regional, comprehensive Youth Risk Behavior Survey.
Goal Status	At the district-level, survey administration occurred over 1 to 3 day period, during the regular class time. Given the COVID-19 public health emergency, the 2021 survey process was typically administered while students were participating in remote learning, although some districts had students take it in the school-setting. The survey was administered to 7,337 middle school students and 8,852 high school students across the Middlesex League towns.

Program Year: Year 1	**Of X Years: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Burlington Youth & Family Services** **Health Issue: Mental Illness and Mental Health**	
Brief Description or Objective	LHMC partners with Burlington Youth & Family Services support on support groups, trainings for staff to enhance services, and clinical consultation services from behavioral health providers.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide supportive mental health services to youth in Burlington.
Goal Status	In FY 21, the following numbers of people were served: • Number of annual visits: 3,083 • Number of referrals: 346 • Number of trainings: 12 • Number of support groups and individuals served through support groups: 8 groups, and during COVID-19 a 4 part series was offered and 87 attended.

Program Year: Year 1	**Of X Years: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Collaborative Care Model** **Health Issue: Mental Illness and Mental Health**	
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)	To increase access to behavioral health services.
Goal Status	2,827 patients were served in FY 21.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Hospital-Based Screening and Addiction Support** **Health Issue: Substance Use Disorders**	
Brief Description or Objective	LHMC provides Hospital-Based Screening and Addiction Support. This includes providing screening, brief intervention, and referral to treatment (SBIRT) for persons presenting in the ED with an elevated blood alcohol level (BAL) or a positive CAGE screening; and instituting the Medication Assisted Treatment program (MAT) through the Emergency Department (ED) which can dispense, administer, and prescribe opioid agonist treatment (i.e., buprenorphine and/or methadone), including partial agonist treatment (buprenorphine), and offer treatment to patients after an opioid-related overdose.

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 MAT for patients who choose treatment in the ED and dispense take-home kits.	
Goal Status	4 patients were provided with MAT in FY21.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: LHMC Medication Disposal Program** **Health Issue: Substance Use Disorders**		
Brief Description or Objective	LHMC provides a medication disposal box 24 hours, 7 days a week medication disposal to safely dispose of expired or unwanted medication.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To increase the amount of medications collected.	
Goal Status	LHMC increased the amount of medications collected by approximately 50%.	
Program Goal(s)	To provide a safe and convenient way for community members to dispose of unwanted or unused medications.	
Goal Status	In FY 21, LHMC collected and disposed of over 525 pounds of medications	
Program Goal(s)	To provide community-based medication counseling.	
Goal Status	In FY 21, LHMC pharmacists counseled approximately 10 people in the community.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: LHMC Psychiatry Services** **Health Issue: Mental Illness and Mental Health**		
Brief Description or Objective	LHMC provides a hospital-based, outpatient program for adults with complex medical and psychiatric needs in a single care setting. Services include 24-hour emergency care, individualized/family therapy, stress management, and many other programs designed to enhance access to behavioral health resources in the community. LHMC/LMCP provides nine support groups between the two hospital sites that help to provide counseling and support for individuals undergoing cancer treatment as well as other chronic diseases, such as ALS, COPD, and kidney disease.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide behavioral health resources and supportive services.	
Goal Status	In FY21, LHMC provided 9 virtual support groups at the Burlington and Peabody locations.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Peabody High School Health Center** **Health Issue: Mental Illness and Mental Health**		
Brief Description or Objective	This program provides high-quality, comprehensive health care to students on site at Peabody High School. Services include management of chronic illnesses such as asthma and diabetes, urgent care visits, immunizations, routine and sports physicals, health education, and confidential services, including reproductive health care and behavioral health services.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide support and funding for services at the PVMHS SHC that meet a critical, identified community need.	
Goal Status	In FY21, the SHC had the following impacts: 195 unique individuals were served in 332 medical visits (319 onsite and 13 telehealth) and 958 behavioral health visits (182 onsite	

	and 776 telehealth) between October 2020-June 2021. The top 3 diagnoses were Anxiety Disorder, Major Depressive Disorder, and Adjustment disorder (new for FY21).
Program Goal(s)	The student-based health center will help to provide access to critical behavioral health services for students who are uninsured/health safety net or on Masshealth.
Goal Status	70% of total clients had either MassHealth or were uninsured/health safety net.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	**$5,419,233.38**	**$ -**
Community-Clinical Linkages	**$843,075.86**	**$ -**
Total Population or Community Wide Interventions	**$1,647,481.65**	**$1,012,429.00**

Access/Coverage Supports	**$1,698,923.53**	**$127,673.58**
Infrastructure to Support CB Collaborations	**$213,848.00**	**$ -**
Total Expenditures by Program Type	**$9,822,562.42**	**$1,142,002.58**
CB Expenditures by Health Need		
Chronic Disease	**$4,729,150.45**	**$421,106.00**
Mental Health/Mental Illness	**$1,514,115.78**	**$331,602.00**
Substance Use Disorders	**$103,166.55**	**$72,800.00**
Housing Stability/Homelessness	**$108,597.26**	**$72,800.00**
Additional Health Needs Identified by the Community	**$3,367,532.38**	**$30,000.00**
Total by Health Need	**$9,822,562.42**	**$1,142,002.58**
Leveraged Resources	**$276,350.87**	
Total CB Programming	**$10,098,913.29**	
Net Charity Care Expenditures		
HSN Assessment	**$17,467,463.00**	
Free/Discounted Care	**$-**	
HSN Denied Claims	**$1,470,392.64**	
Total Net Charity Care	**$18,937,855.64**	
Total CB Expenditures	**$29,036,768.93**	

Additional Information	
Net Patient Services Revenue	**$1,033,758,000.00**
CB Expenditure as % of Net Patient Services Revenue	**2.81%**
Approved CB Budget for FY22 (*Excluding expenditures that cannot be projected at the time of the report)	**$29,030,768.93**
Bad Debt	**$6,073,251**
Bad Debt Certification	**Yes**
Optional Supplement	

Comments	

SECTION VI: CONTACT INFORMATION

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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

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

I. Community Benefits Process:

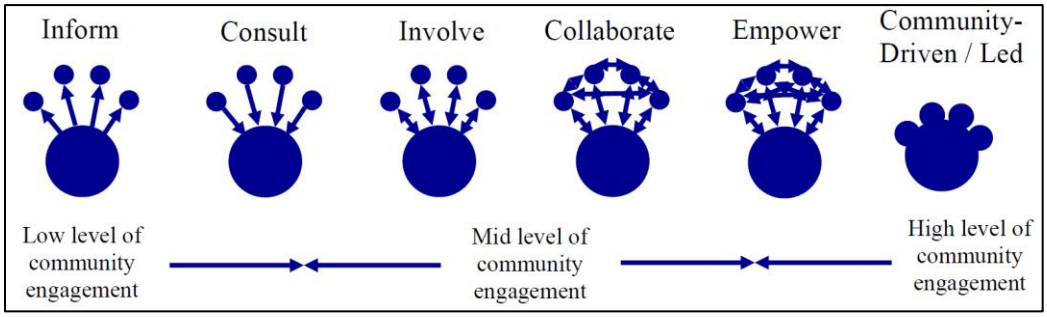
- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? ☒ Yes ☐ No
    - If so, please list updates:
      LHMC has worked to align its Community Benefits Advisory Committee membership to reflect the demographics included in the LHMC Community Benefits Service Area (CBSA). LHMC has worked to have the Community Benefits Advisory Committee membership include representatives from sectors such as public health, local employers, education and community-based organizations, as well as residents. LHMC has most recently added the following members to better reflect our CBSA, including:
        - Allison Kilcoyne, Northshore Community Health Center
        - Stephanie Cronin, Middlesex 3 Coalition
        - Jennifer Knight, Burlington Public Schools
        - Melissa Hastings-Cruz, LHMC Board of Trustees
        - Elvira Omerovic, Lahey Health Primary Care

II. Community Engagement:

- 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
Peabody Public Health Department	Sharon Cameron, Director of Public Health	Local Health Department	CBAC Member Program partner
Northshore Community Health Center	Allison Kilcoyne, Director of School-Based Health Programs	Community Health Centers	CBAC Member Program partner
Lowell Community Health Center	Karen Myers, Director of Development	Community Health Centers	Program partner
Mill City Grows	Jessica Mills, Executive Director	Social service organizations	Program partner
Citizens Inn	Gianna Langis, Director of Development	Housing organizations	Program partner

- 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.



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	Involve	LHMC plans to further engage it's CBAC in the development of the Implementation Strategy in FY 22	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Collaborate	LHMC's CBAC participates in a grant review process for funding proposals.	Collaborate
Implementing Community Benefits programs	Collaborate	LHMC collaborated with many partners on community benefits programs in FY21. Community Benefits staff reached out to partners on a regular basis to discuss priorities, existing program feasibility, and changes to programs based on needs that were derived from the community.	Collaborate

[1] "Community Engagement Standards for Community Health Planning Guideline," Massachusetts Department of Public Health, *available at*: http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf. For a full description of the community engagement spectrum, see page 11 of the Attorney General's Community Benefits Guidelines for Non-profit Hospitals.

Evaluating progress in executing Implementation Strategy	Collaborate	LHMC continues to collaborate with the CBAC members to evaluate programs for this past fiscal year. LHMC looks forward to continuing to collaborate and respond to changing health needs.	Collaborate
Updating Implementation Strategy annually	Consult	LHMC provided regular updates to the CBAC on the IS and plans to collaborate with the CBAC in developing the IS in FY22.	Collaborate

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

  LHMC remains committed to community engagement. During FY22, LHMC will undertake its triennial community health needs assessment and prioritization process. Guided by LHMC's Community Benefits Advisory Committee and conducted in collaboration with community partners, this initiative's guiding principles include community engagement, equity, collaboration and capacity building. In FY22, LHMC will continue to work with its CBAC and community partners to engage the community including holding an annual public meeting. Additionally, LHMC will engage with our community by interviewing key community partners from a number of sectors during our community interview process, widely distributing a survey in ten different languages throughout our Community Benefits Service Area, and engaging with populations of focus, such as the LGTBQIA+ community in our community-based focus groups to ensure that we are hearing diverse perspectives in our assessment process.

- COVID Question: Please describe how the COVID-19 pandemic impacted the hospital's process for engaging its community and developing responsive Community Benefits programming.

  LHMC dedicated a great deal of time and resources at the local level in response to the COVID-19 global pandemic. LHMC worked to expand community testing access and worked with BILH as a system to develop and distribute written materials (in nine languages) to the communities most impacted by COVID-19, to help slow the spread. LHMC redeployed staff and procured tangible necessities for both the community at large and hospital staff, such as personal protective equipment (PPE), food, hand sanitizer, and other critical items. Additionally, working with BILH, LHMC opened a vaccination site in our community to vaccinate thousands of individuals including those disproportionately impacted by the pandemic.

  While in-person meetings were hindered in the community, LHMC sought creative ways of engaging with our community including:

  i. Modifying in-person farmers markets to be drive-up

ii. Hosting classes virtually
iii. Supporting community-based virtual programs

Many of the programs highlighted in this report had to be modified significantly due to COVID-19 and related safety guidelines. In some cases, programs were expanded. In others, programs were cut or significantly reduced because of the pandemic.

- 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 held a public meeting in conjunction with its CBAC. This meeting was held on September 21st, 2021. LHMC will also be hosting listening sessions for its CHNA on February 9th, 2022 and February 16th, 2022.

III. Updates on Regional Collaboration:

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

LHMC is part of the Beth Israel Lahey Health (BILH) system community health planning process. In 2019, BILH formed a system-wide Community Benefits Committee (CBC). This Committee provides strategic direction for all 10 BILH hospitals and their affiliates and seeks to ensure that strategies are in place to meet the health care needs of at-risk, underserved, uninsured, and government-payer patient populations in the communities. Guided by the CBC, the hospitals Community Benefits staff meet regularly to review regulatory requirements and share community health programming best practices. Together, hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact.

All ten hospitals are also now undergoing a Community Health Needs Assessment process collectively.

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.**

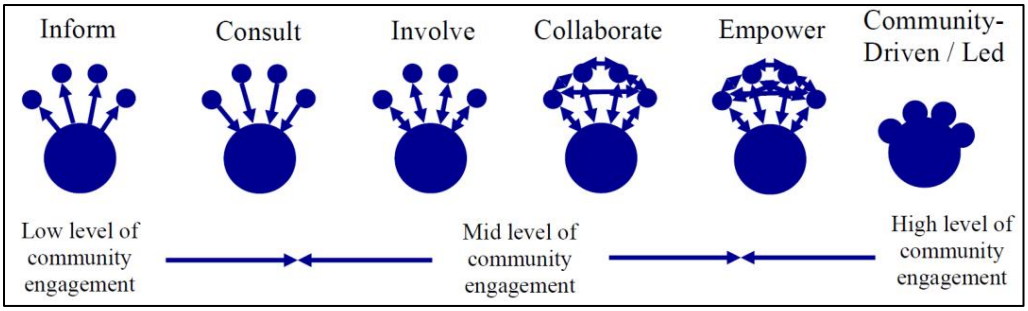
SECTION VIII: COMMUNITY REPRESENTATIVE FEEDBACK FORM

Hospital Community Benefits - Community Representative Feedback Form

Instructions: You have been asked to complete this form based on your role as a community representative with whom a hospital has engaged in developing its Community Health Needs Assessment and/or Implementation Strategy. Please submit a copy of the completed form to the hospital (please see the hospital's most recent Community Benefits report for contact information) and to the Attorney General's Office (at CBAdmin@state.ma.us).

1. Background Information
   - Your Name
     Click or tap here to enter text.
   - If You Represent an Organization, Name of Organization and Your Position
     Click or tap here to enter text.
   - Name of Hospital
     Click or tap here to enter text.
   - Are you a member of the hospital's Community Benefits Advisory Committee (CBAC)? ☐ Yes ☐ No
     - If no, please briefly describe your involvement in the hospital's Community Benefits process.
       Click or tap here to enter text.

2. Level of Engagement Across CHNA and/or Implementation Strategy
   Please use the spectrum below from the Massachusetts Department of Public Health[2] to assess the hospital's level of engagement with the community.



A. Community Health Needs Assessment:
Based on your knowledge and experience, please assess the hospital's level of engagement with the community in developing its Community Health Needs Assessment ("CHNA"). If your

[2] "Community Engagement Standards for Community Health Planning Guideline," Massachusetts Department of Public Health, *available at*: http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf. For a full description of the community engagement spectrum, see page 11 of the Attorney General's Community Benefits Guidelines for Non-Profit Hospitals.

knowledge and/or experience do not encompass a particular category, please select "N/A" from the drop-down menu.

Category	**Level of Engagement**
Overall engagement in assessing community health needs	Choose an item.
Defining the community to be served	Choose an item.
Establishing priorities	Choose an item.

B. Implementation Strategy:

Based on your knowledge and experience, please assess the hospital's level of engagement with the community in developing and implementing its plan to address the significant needs documented in its CHNA. If your knowledge and/or experience do not encompass a particular category, please select "N/A" from the drop-down menu.

Category	**Level of Engagement**
Overall engagement in developing and implementing hospital's plan to address significant needs documented in CHNA	Choose an item.
Selecting Community Benefits programs	Choose an item.
Implementing Community Benefits programs	Choose an item.
Evaluating progress in executing Implementation Strategy	Choose an item.

3. Engagement Experience
   Please indicate the degree to which you agree or disagree with the following statements:

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	N/A
When the CBAC comes together, I feel comfortable sharing my opinion	☐	☐	☐	☐	☐	☐
I am satisfied with my/my organization's participation in this process	☐	☐	☐	☐	☐	☐

- What is an example of a community engagement strategy by the hospital that has worked well over the past year?
  Click or tap here to enter text.

- What change, if any, would you most like to see in your engagement going forward?
  Click or tap here to enter text.