TuftsMedicine
Lowell General Hospital

2023 – 2025

Community benefit implementation plan

We're committed to improving the health and wellbeing of the communities we serve. As part of that mission, Tufts Medicine Lowell General Hospital strives to reduce health disparities and health inequities in our community.

We seek to identify current and emerging health needs, collaborate with community partners, provide culturally- and linguistically-appropriate health services and resources, and address community health needs through education, prevention and treatment.

WHAT SETS US APART

This work is guided by the findings of our community health needs assessment (CHNA).

In order to ensure that Lowell General Hospital remains at the forefront of the effort to improve the health of community members, we must understand what issues and systems most affect the health of these communities. To that end, the CHNA is an opportunity to engage community members and to seek their input to inform our efforts over the following three years.

2022 CHNA ranked list of health priorities:

- Mental health
- Chronic health issues: hypertension, heart disease
- Substance use disorder/alcohol use
- COVID and infectious diseases
- Reproductive, sexual and pregnancy health
- Lung and breathing health
- Cancer
- Infant and child health
- Environmental health
- Violence

Community benefit implementation strategy

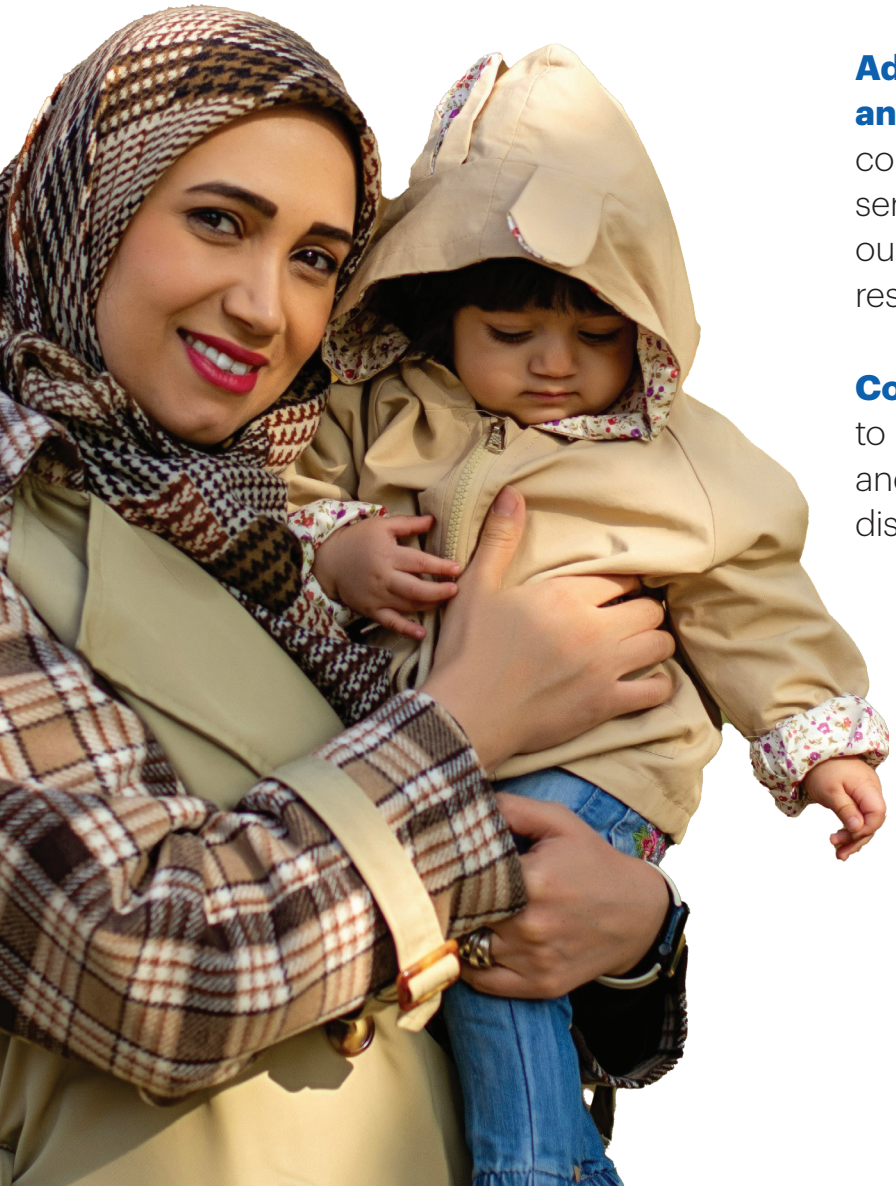
Fund programming directly related to our CHNA priorities:

Access to linguistically and culturally appropriate healthcare and other social services, while addressing the barriers of lack of transportation and technology.

Promote social and emotional wellness by fostering resilient communities and collaborating with accessible, supportive and coordinated systems.

Address the issue of homelessness and housing instability in our community by working closely with social service and municipal groups, assisting our patients with access to housing resources.

Collaborate with food justice partners to provide innovative access to fresh fruits and vegetables for patients with chronic disease to increase healthy eating options.



PRIORITY AREA

Behavioral health

Health + well-being

Goal: Promote social and emotional wellness by supporting community members with behavioral health challenges and ensuring adequate access to behavioral health services and clinicians.

Target population: Elderly, youth, LGBTQIA+ and all community members

Strategy 1: Streamline the path to care for those in our community experiencing a behavioral health crisis and strive to provide support and interventions for our most vulnerable populations.

Projected outcome: Continue to connect with local behavioral health organizations/clinicians to ensure collaboration and promotion of services.

Strategy 2: Support community members in social-emotional wellness activities and programs to foster belonging and reduce isolation, as well as provide access to resources and eliminate barriers to care.

Projected outcome: Provide 5 – 7 opportunities for community members to participate in physical activity and/or support groups to foster belonging and resource sharing.

PRIORITY AREA

Access to care + services

Chronic disease + healthy living

Goal: Ensure equitable access to care with a focus on efforts for youth, recent arrivals and the aging population, while also eliminating barriers to care.

Target population: Marginalized and underserved populations including Hispanic populations

Strategy 1: Eliminate barriers to accessing care by providing transportation and/or interpreter services to community members.

Projected outcome: Collaborate with elder services and immigrant assistance organizations to provide rides and/or interpreters to community members.

Strategy 2: Continue and expand our partnership with Mill City Grows to provide fresh produce, nutritional information and cooking classes to patients experiencing food insecurity to ensure that they have access to fresh produce and healthy meals.

Projected outcome: Provide fresh produce and nutritional education to 50 Lowell General Hospital cardiac and/or diabetic patients.

Strategy 3: Continue to participate in community and city initiatives and partnerships designed to alleviate housing and food insecurity for our patients.

Projected outcome: Participate in at least two community task forces/committees dedicated to housing and food insecurity.

PRIORITY AREA

Health-related social needs

Housing + food security + other social determinants of health

Goal: Reduce the rates of community members experiencing housing and food insecurity in our community.

Target population: Elderly, youth, unhoused, immigrants and refugees

Strategy 1: Continue the partnership with Community Teamwork to provide a housing and resource specialist to support emergency department and social work staff with in-person, real-time assistance for patients who present with housing and food insecurity.

Projected outcome: Connect 100 Lowell General Hospital patients to resources including housing supports, fuel assistance, childcare, etc.

Strategy 2: Continue to participate in community and city initiatives and partnerships designed to alleviate housing and food insecurity for our patients.

Projected outcome: Participate in at least two community task forces/committees dedicated to housing and SDOH issues.

Focusing on vulnerable populations in New England




Addressing critical needs:

More than 300 patients served through CTI Housing Program (referrals to housing programs, WIC, fuel assistance, etc.)

Provided more than 100 patients with fresh produce and 25 cooking classes in partnership with Mill City Grows

Supported the Substance Use Disorder Symposium to bring together stakeholders to discuss programs and services

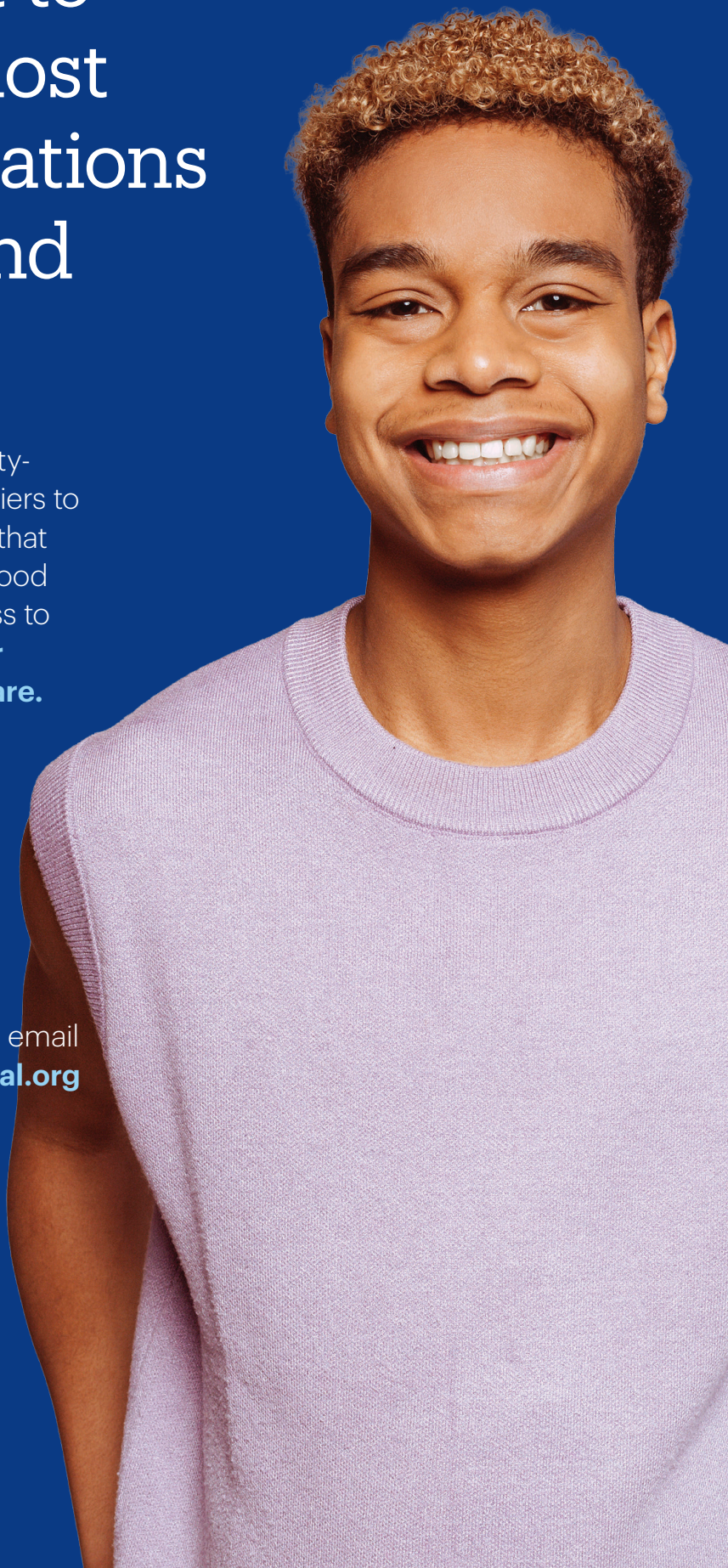
Provided 25 community fitness classes in partnership with the Lowell YWCA

Participation in the Lowell Housing Task Force and the Hunger Homeless Commission

BREAKING BARRIERS

Our commitment to New England's most vulnerable populations extends far beyond clinical care.

Through strategic partnerships and community-centered programs, we're breaking down barriers to health by addressing the social determinants that impact wellness—from housing stability and food security to substance use recovery and access to physical activity. **These initiatives reflect our dedication to meeting people where they are.**



Questions?
For more information on the Lowell General Hospital Community Benefit Program, please email **community.benefit.program@lowellgeneral.org**

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