Community Benefits Report Fiscal Year 2020

Mount Auburn Hospital

Beth Israel Lahey Health

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SECTION I: SUMMARY AND MISSION STATEMENT

Summary and Mission Statement
Mount Auburn Hospital (MAH) 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.

The mission of Mount Auburn Hospital *is to improve the health of the residents of Cambridge and the surrounding communities through the delivery of excellent, compassionate care. MAH is equally committed to teaching students of medicine and the health professions to benefit the next generation of patients and their families.*

MAH's mission is supported by MAH's commitment to personalized, excellent care for patients; a workforce committed to individual accountability, mutual respect, and collaboration; and a commitment to maintaining financial health.

MAH is equally committed to providing a robust Community Benefit program within our service area. The mission of MAH's Community Benefits reads:

"Mount Auburn Hospital is steadfast in its commitment to improving the health and wellbeing of community members, through collaboration with community partners to reduce barriers to health care and to continually strive to reduce health disparities and health inequities for those who are most vulnerable in our community. We seek to identify current and emerging health needs and address these needs through education, prevention, treatment and the promotion of healthy behaviors.

The following annual report provides specific details on how MAH is honoring its commitment and includes information on MAH'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, MAH's Community Benefits mission is fulfilled by:

- **Involving MAH'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 MAH'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 MAH 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 vulnerable and face disparities in access and outcomes;

- **Implementing community health programs and services** in MAH CBSA that is 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 healthcare 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 responsiveness 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
MAH's CBSA includes Arlington, Belmont, Cambridge, Somerville, Waltham and Watertown. MAH's FY18 Community Health Needs Assessment's (CHNA) findings, on which this report is based, clearly show that low-income and racially/ethnically diverse populations living in MAH's CBSA face the greatest health disparities and are most at-risk. The FY18 CHNA also identified two smaller but high need segments of the population that are also underserved, at- risk, and face disparities, namely older adults and the Lesbian Gay Bisexual Transgender and Queer (LGBTQ) community. Collectively, these geographic, demographic, and socio-economic population segments are MAH's priority populations. While MAH is committed to improving the health status and well-being of those living throughout its entire service area, the MAH Implementation Strategy focuses on the following most at-risk priority populations in the hospitals service area – Low Income, Racial/Ethnic minorities, immigrants, LGBTQ, Older Adults, and Limited English Speakers.

Basis for Selection
Community health needs assessments; public health data available from government and private resources (foundations, advocacy groups).

Key Accomplishments for Reporting Year

The accomplishments highlighted in this report are based upon priorities identified and programs contained in MAH's FY18 Community Health Needs Assessment (CHNA) and FY19-21 Implementation Strategy (IS).

In July of 2018 Mount Auburn Hospital (MAH) revised its Community Health IS. The revised IS was based on the July 2018 Community Health Needs Assessment. This is the third year of executing the Community Health Implementation Strategy

The top health priorities identified were:
1. Mental health
2. Substance use
3. Chronic/complex conditions and their risk factors
4. Healthy aging

It should be noted that Access to Health Care and the Social Determinants of health were also identified and are top health priorities of the hospital as they are interwoven in multiple ways in each of the mentioned health priorities identified above. Many if not all of the Community Benefits programming can be linked to the social determinants of health. 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). MAH's priorities are also aligned with the priorities identified by the Massachusetts Department of Public Health (DPH) to guide the Community-based Health Initiative (CHI) investments funded by the Determination of Need (DON) process, which underscore the importance of investing in the Social Determinants of Health (i.e., built environment, social environment, housing, violence, education, and employment).

The main goals of the MAH Community Benefit programs of this reporting year were to implement programs and activities aimed at addressing health concerns identified in the FY18 CHNA. These goals included:

- Increasing the capacity of CHNA 17 to fulfill its mission to promote healthier people and communities by fostering community engagement, elevating innovative and best practices, advancing racial equity, and supporting reciprocal learning opportunities to address the needs of the most marginalized members of our communities.
- Increasing the capacity if local health departments to address the top health concerns identified in MAH's most recent Community Health Needs Assessment by providing funding in order for them to identify how to best impact their community.
- Hosting the Metro Region Opioid Task Force
- Promoting transportation equity.
- Developing partnerships with local housing authority programs and providing funding in order for them to identify how to best make a positive impact in their communities.
- Promoting Cross-Sector Collaboration and Partnerships.

MAH increased the health and wellbeing of community members this year with the following activities:

- Worked to address cancer disparities.
- Supported Community Health Network Area (CHNA) 17 and its work to improve racial equity and mental health.
- Grant funded programs, which included funding to local health departments, local housing authorities and local organizations working to improve health equity and food access.

- Participated in community coalitions and community group meetings to improve community connections, share best practices and help improve care.
- Addressed the growing number of overdose patients in the emergency department and listened to community needs. MAH has created a program which gives patients an opportunity to connect with a substance use provider upon discharge or to be seen by this specialist with in a 5 day period.
- Facilitated access to health care and public health insurance enrollment.
- Supported the Prenatal/Postpartum/Doula Support for women at Charles River Community Health Center.
- Coordinated the programs of the Herzstein Wellness Center and provided space and appointments for healing, revitalization, and hope through education and integrative care.
- Provided Interpreter Services for Non-English speakers and those with limited English proficiency to improve access to care.

A sampling of activities, which addressed each of the four health priorities are listed below:

Mental Health included but was not limited to supporting CHNA 17 in their efforts to address mental illness and racial equity, bereavement support group sessions, providing a Doula program and cancer disparity work. The Herzstein Wellness Center supported the mental health of cancer patients, caregivers and community members. A breast cancer support group was also developed and launched this year.

Substance Use included space for AA, SMART Recovery and NA community groups, a smoking cessation program, and working with local coalitions addressing substance use disorders. MAH continued to host and coordinate the Metro Region Opioid Task Force meetings until the pandemic halted the in person meetings. The Task Force now meets virtually. An internal sub group working on patient transitions to the community worked to support and identify patients who would benefit from the use of substance use counseling or support within the ED and as they are discharged.

Chronic and Complex Conditions included community health education, programming for the Hertzstein Wellness Center, health equity and food access grants to local organization and providing a stroke nurse coordinator who educates patients, families and community members.

Healthy Aging included the elder service provider stakeholders network group and providing the Healthy Eating for Successful Living program. MAH provided elder cardiovascular screenings at local community locations which included blood pressure screening and a connection to health care. Lifeline personal emergency response services are provided at a reduced cost for those elders who qualify. A fall prevention program was developed in order to provide fall prevention strategies to older adults.

Health Access and Social Determinants of Health were identified as priorities which intersect the four health priorities listed above. MAH improved access to care by providing Certified Application Counselors at Mount Auburn Hospital and at Charles River Community Health Center and transportation subsidies for our most vulnerable community members. Community Education for emergency care provided education to local EMS, local police and Fire departments. An

emergency medicine provider serves as Medical Director for local fire departments, police departments and EMS services, which includes providing in-service education and updates in the field. This also includes case reviews for education. MAH provides a EMS medical director who works with our affiliated EMS services to provide credentialing, continuous review/quality assurance, and education for our affiliated community EMTs and Paramedics. This involves protocol reviews, medical control, monthly education sessions, and other educational opportunities. This also involves serving as EMS Medical Director for Massachusetts Institute of Technology EMS, Harvard University, EMS and Pro Ambulance EMS. As Medical Directors they give medical direction, planning and support to Fire Departments and EMS staff.

MAH has long supported the work of Charles River Community Health Center both clinically and financially. Through financial support MAH contributes to its lab service and fees, information systems, staffing financial counselors and providing space for the financial services to patients (rent). As a response to the pandemic, MAH was intentional about increasing support and funding for local food pantries and those working to provide food for food insecure families.

Services for patients in both the inpatient and outpatient psychiatry departments are subsidized. These patients who were either uninsured or underinsured were supported by our subsidized health service program. Many patients who were unable to pay their deductible payment also benefitted from this program.

For the FY20 reporting year, MAH dedicated significant time and resources at the local level in response to the COVID-19 global pandemic. MAH was intentional when assessing risk factors within our CBSA and worked closely with our local health departments. MAH worked with Charles River Community Health 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 of the virus. MAH 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.
Because of COVID, several programs highlighted in this report were modified. In some cases, programs were expanded and in others, programs were reduced in response to the pandemic and its impact on our community.

Plans for Next Reporting Year

In FY21 Mount Auburn Hospital will implement the Community Health Implementation Strategy based on the CHNA of 2018 and a review of the hospital's activities during FY20.

Based upon the identified health priorities, activities for the next reporting year will include:

- Support to CHNA 17 in their efforts to address mental illness in African American/Black populations and other vulnerable segments facing discrimination.

- Collaborate with CHNA17 in its efforts to provide grant opportunities/funding for community based organizations to increase awareness and break down barriers for priority populations.

- Continue to collaborate with community partners to provide Healthy Aging programs for older adults.
- Collaborate and provide funding for local Health Departments
- Support Charles River Community Health Center.
- Collaborate with Metro Housing Boston to continue to look for ways to support community members and patients to access affordable housing, including eviction prevention and provide access to resources to help people stay in current housing.
- Work with local food pantries and markets and other organizations who support food insecure families and residents to improve health equity and access to healthy foods for our most vulnerable populations.
- Continue to provide health coverage and public assistance support for enrollment.
- Partner with local English as a second language adult learner's programs to improve health education and health care access education for students
- Continue to respond to COVID 19 pandemic and look for ways to support those most affected by the pandemic

MAH will continue to partner with dozens of community base organizations and service providers to execute its Implementation Strategy, including public health agencies, local cities and town agencies, social service providers, community health organizations, community based organizations, academic organization businesses as well as community members. New activities to address identified health needs will be considered based on the changing environment and any newly identified programs or activities by our partners or hospital staff. These new activities will be properly reviewed for feasibility to carry out and implement.

In FY21 MAH will embark on its triennial community health needs assessment and based on its findings will develop a new Implementation Strategy for Community Benefits activities.

Hospital Self-Assessment Form

Working with its Community Benefits leadership team and its Community Benefits Advisory Committee (CBAC), the MAH Community Benefits team completed a hospital self-assessment form (Section VII, page 86). MAH Community Benefits team also shared the Community Representative Feedback Form with many CBAC members and community stakeholders who participated in MAH's CHNA.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team and Community Benefits Advisory Committee

The membership of MAH's Community Benefits Advisory Committee (CBAC) aspires to be representative of the constituencies and priority populations served by MAH's programmatic endeavors, including those from diverse racial and ethnic backgrounds, age, gender, sexual orientation and gender identity, as well as those from local city and town agencies and community 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 MAH's Community Benefits mission. Among MAH'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 MAH's structure and reflected in how it provides care at the hospital and in affiliated practices.

MAH is a member of Beth Israel Lahey Health (BILH). While MAH oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Strategy 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 MAH Community Benefits program is spearheaded by Mary DeCourcey, Director of Community Benefits at MAH. The Director of Community Benefits has direct access and is accountable to the MAH President and the BILH Vice President of Community Benefits and Community Relations, the latter of whom reports directly to the BILH Chief Strategy 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
October 18, 2019
February 28, 2020
September 18, 2020

Community Partners

MAH 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. MAH's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy were completed in close collaboration with MAH's staff, its health and social service partners, and the community at-large. MAH's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of MAH's mission.

MAH's Board of Directors 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. MAH's Community Health Department, under the direct oversight of MAH'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 MAH 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 74).

List of Community Partners:

AIDS Action Committee
Alcohol Anonymous
American Cancer Society
American Lung Association
Arlington Council on Aging
Arlington Eats
Arlington Fire Department
Arlington Health and Human Services
Arlington Housing Authority
Arlington Police Department
Arlington Youth Counseling Center
Arl. Youth Health and Safety Coalition
Belmont Council on Aging
Belmont Department of Public Health
Belmont Fire Department
Belmont First Armenian Church
Belmont Housing Authority
Belmont Police Department
Belmont Veteran's Memorial
Cambridge Community Foundation
Cambridge Council on Aging
Cambridge Department of Public Health
Live Well Watertown
Marino Foundation
Mass. Department of Public Health -
Mass. Institute of Technology EMS
Massachusetts Bay Transit Authority
Meadowgreen Rehabilitation and Nursing
Metro Cab of Boston
Middlesex District Attorney Office
Neville Place
Professional Ambulance EMS
Schenderian Pharmacy
SCM Community Transportation
Somerville Cambridge Elder Services
Somerville Center for Adult Learning Experiences (SCALE)
Somerville Council on Aging
Somerville Department of Health and Human Services
Somerville Homeless Coalition
Somerville Housing Authority
Somerville Police Department
Somerville Stakeholders Coalition
Springwell Elder Services
Tufts University

Cambridge Fire Department
Cambridge Health Alliance
Cambridge Housing Authority
Cambridge Police Department
Cambridge SNAP Match Coalition
CASPAR INC.
Charles River Community Health Center
City of Cambridge
Community Health Network Area 17 (CHNA 17)
Crivello Foundation
Elder Services of Merrimack Valley
Greater Boston Food Bank
Harvard University EMS
Healthy Living Center of Excellence
Healthy Waltham
Housing Corp. of Arlington
Lexington Fire Department
Lifeline In Home Services at Mount Auburn
Waltham Challenger Program
Waltham Connections
Waltham Council on Aging
Waltham Family School
Waltham Fields Community Farm
Waltham Health Department
Waltham Housing Authority
Waltham Partnership for Youth
Waltham Police Department
Watertown Baseball and Softball Challenger Program
Watertown Cares
Watertown Council on Aging
Watertown Fire Dept.
Watertown Health Department
Watertown High School
Watertown Housing Authority
Watertown Police Department
Wayside Youth and Family Services

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

Date Last Assessment Completed and Current Status

The FY18 Community Health Needs Assessment (CHNA) along with the associated FY19–21 Implementation Strategy was developed over an eleven month period from September 2017 to July 2018. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and Federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill the MAH'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 MAH's dedication to its mission, its covenant to the underserved, and its commitment to community health improvement.

As mentioned above, MAH's most recent CHNA was completed during FY18 and its FY19 Community Benefits programming was informed by the FY19 Implementation Strategy which was informed by the FY18 CHNA. The following is a summary description of the FY18 CHNA approach, methods, and key findings.

Approach and Methods

In FY18 MAH hired John Snow, Inc. (JSI) an outside firm to manage the CHNA. This decision was made after thoughtful internal review. The MAH Community Health Department staff worked closely throughout the entire process with staff members from John Snow Inc. in order to complete the project. A Community Benefits Advisory Committee was created at the beginning of the process which consisted of over 20 community members and/or community organization representatives including city or town public health officials.

The CHNA was conducted through a three-phased process. Phase I involved a rigorous and comprehensive review of existing quantitative data along with a series of interviews with community stakeholders. Phase II involved a more targeted assessment of need and broader community engagement activities that included focus groups with health, social service, and Public health service providers and clients, community forums that included the community at large, as well as community health survey that captured information from residents, service providers, and other stakeholders regarding leading health-related priorities.
Phase III involved a series of strategic planning and reporting activities that involved a broad range of internal and external stakeholders. MAH communicated the results of the CHNA and outlined the core elements of its Current and revised Implementation Strategy during the strategic planning retreat.

The goal of Phase I and Phase II was to gain an understanding of health-related characteristics of the region's population, including demographic, socio-economic, geographic, health status, care seeking, and access to care characteristics. This involved quantitative and qualitative data analysis, including, to the extent possible, an analysis of changes over time.

Key Informant Interviews with Internal and External Stakeholders. JSI conducted key stakeholder interviews with 25 community leaders and staff members at MAH. These individuals were chosen to amass a representative group of people who had the experience necessary to provide insight on the health of communities in MAH's service area. Interviews were conducted on the phone or in person using a standard interview guide. Interviews focused on identifying major health issues, including possible strategies to address those concerns, and target populations.

Focus Groups and Community Forums. JSI conducted a series of eight community and provider focus groups in MAH's service area to gather critical community input from service providers, community leaders and residents; staff from MAH's Community Health Department conducted an additional two focus groups on their own. These focus groups were organized in collaboration with MAH's existing community health partners to leverage their community connections and to help ensure community participation. In addition, MAH coordinated four community forums while JSI lead the discussions which were open and marketed to the public at-large. These forums took place in Arlington, Cambridge, Waltham, and Somerville. MAH made every effort to promote these events to the community at-large in order to recruit participants. During the community forums, JSI discussed findings from quantitative data and posed a range of questions to solicit input on community ideas, perceptions and attitudes, including: 1) What are the leading social determinants of health (e.g., housing, poverty, food access, transportation, etc.), 2) What are the leading health conditions (e.g., diabetes, hypertension, asthma, respiratory disease, etc.), 3) Which segments of the population are most vulnerable (e.g., immigrants, LGBTQ, older adults, etc.), and 4) What strategies would be most effective to improving health status and outcomes in these areas?

The MAH Community Benefits Advisory Committee (CBAC) was also integrally involved in providing input on community need and prioritizing the leading health issues. The CBAC met three times during the course of the assessment to refine the approach, provide input regarding the assessment, and to guide the prioritization and planning phase. Please refer to the FY18 CHNA for a full listing of all community engagement activities.

The main objectives of Phase III of the assessment were to: 1) review the assessment's major findings, 2) identify MAH's Community Benefits priority populations and community health priorities, 3) review MAH's existing community benefits activities, and 4) determine if the current range of Community Benefits activities needed to be augmented or changed to respond to the year's assessment. The CBAC meetings and the Strategic Planning Retreat, along with the interviews, focus groups, community health survey and service providers, and other key stakeholders regarding community need and the prioritization of those needs.

Summary of Key Health-Related Findings from FY18 CHNA

The key priority populations identified through the FY18 CHNA process were:

- Racial and Ethnic Minorities
- Immigrants
- Low Income Populations
- Older Adults
- Non-English Speakers
- LGBTQ Community

The key Community Health Priorities identified through the FY18 CHNA process were:

- Mental Health
- Substance Use
- Chronic/Complex Conditions and their Risk Factors
- Healthy Aging

Two cross-cutting priorities include:

- Social Determinants of Health
- Health System Issues (Health Care Access)

The CHNA which was completed in FY18 will inform the work of FY19, FY20 and FY21.

Community Benefits Programs FY2020

Addressing the Opioid Epidemic - Substance Use

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	This year our partnership with the Middlesex DA to host the Metro Regional Opioid Task Force continued. This Task Force provides a quarterly meeting for staff and community members. These meetings hosted at MAH provide a venue for education, information sharing and partnership. When the pandemic hit this meeting quickly pivoted to a virtual venue and continued on a monthly basis. To address the growing number of overdose patients in the emergency department, MAH continues to provide support for patients in the ED with a social work navigator. Patients who present in the ED with an overdose are given a 3 day supply of suboxone (as appropriate) until they can be seen in the outpatient clinic (Bridge Clinic) for follow-up. In conjunction with the START Program (Substance Treatment and Referral Team), the department of Psychiatry also is involved with these transitions of care. These programs not only improve patient care but also help with reducing the stigma of substance use. MAH continues to support a Substance Use Navigator who is part of the START Program (Substance Treatment and Referral Team).
Program Hashtags	Community Education, Health Professional/Staff Training, Prevention,
Program Contact Information	Mary DeCourcey, Mount Auburn Hospital 330 Mount Auburn St. Cambridge, MA 02138 617-499-5625

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame

Build relationships with providers, city agencies, and community organizations to gain knowledge and access to services to improve care of our community members.	Ongoing	Process Goal	Year 3 of 5
Improve communication, share best practices and dissemination of information between hospital staff, city agencies and community organizations as it pertains to the opioid crisis.	Ongoing	Process Goal	Year 3 of 5
Continue to partner with the Middlesex DA in order to host the Metro Region Opioid Task Force to share knowledge and information with community stakeholders.	Ongoing	Process Goal	Year 1 of 5
To improve the outcome and care of our community members who overdose or present with drug use symptoms in the Emergency Department.	Ongoing	Outcome Goal	Year 2 of 5

EOHHS Focus Issues	Substance Use Disorders,

DoN Health Priorities	Not Specified
Health Issues	Substance Addiction-Opioid Use, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Arlington Police Department	https://www.arlingtonma.gov/departments/police
Arlington, Health and Human Services Department	https://www.arlingtonma.gov/departments/health-human-services
Belmont Health Department	http://www.belmont-ma.gov/health-department
Belmont Police Department	http://www.belmontpd.org/Pages/BelmontPD_Webdocs/chief
Cambridge Department of Public Health	http://www.cambridgepublichealth.org/

Cambridge Police Department	http://www.cambridgema.gov/CPD/
Somerville Board of Health Department	https://www.somervillema.gov/departments/board-of-health
Somerville Police Department	http://somervillepd.com/
Waltham Police Department	https://www.city.waltham.ma.us/police-department
Walthm Health Department	https://www.city.waltham.ma.us/health-department
Watertown Health Department	http://www.ci.watertown.ma.us/index.aspx?nid=186
Watertown Police Department	http://www.watertownpd.org/
Open to any community organization and community members	Not Specified
Middlesex District Attorney's Office	https://www.middlesexda.com/

Cancer Disparity Work - Access to Healthcare

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No

Program Description	To address cancer disparities in vulnerable populations in particular women and immigrants, MAH offered free mammography screening to women from CRCH who have limited access or coverage, for mammography. MAH also provided a series of Tobacco education and cessation sessions which included Lung Screening Education, at CASPAR, a homeless shelter for men in Somerville who receive treatment and resources for substance use disorders. This program also includes the hospitals work with ESOL programs to provided cancer prevention and health education programs. Unfortunately, due to the pandemic our work with these programs was canceled with the hopes of resuming virtually when the time allowed.
Program Hashtags	Community Health Center Partnership, Health Screening, Prevention,
Program Contact Information	Mary DeCourcey 330 Mount Auburn St. Cambridge, MA 02138 617-499-5625

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide at least 10 men tobacco education and lung screening information while they are receiving services at CASPAR.	10 men participated in program when they were receiving services at CASPAR	Process Goal	Year 1 of 1
At least 50 % of men report that they felt more confident to be able to develop a quit plan related to tobacco dependence after the program sessions at CASPAR.	75% of men who participated reported after the program sessions that they feel more confident to be able to develop a quit plan related to tobacco dependence.	Outcome Goal	Year 1 of 1
Collaborate with Charles River Community Health center to provide free mammography	Free mammography offered to women from CRCH and offered to community members who are uninsured or underinsured.	Outcome Goal	Year 1 of 1

screening for women in need.			
Provide women in need free mammography screening and follow up.	15 women screened with a mammogram and one woman was referred for a follow up visit.	Outcome Goal	Year 1 of 1

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Substance Use Disorders,
DoN Health Priorities	Not Specified
Health Issues	Access to Health Care, Cancer-Lung, Other: Cancer - Breast, Other: Uninsured/Underinsured,
Target Populations	• **Regions Served:** Cambridge, Waltham, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** Adults, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Charles River Community Health Center	www.charlesriverhealth.org
CASPAR	www.casparinc.org

American Lung Association	https://www.lung.org/

Caregiver Support Group – Mental Health

Program Type	Community-Clinical Linkages
Program is part of a grant or funding provided to an outside organization	No
Program Description	Caring for Caregivers: This support group allows those who care for a loved one suffering from Alzheimer's' Disease or Dementia to connect with others who understand their challenges. Facilitated by licensed social workers this group allows participants to share their stories with people who understand the challenges they face. This is a safe supportive and engaging environment to help support the mental health of the participants. This program was created out of requests from family members and caregivers of patients who are seen in the Quimby Center where the MAH geriatricians provide care for older adults. The program is open to community members and quickly became a virtual meeting when the pandemic did not allow people to meet in person.
Program Hashtags	Support Group,
Program Contact Information	Kathy Howard, Mount Auburn Hospital 330 Mount Auburn Street Cambridge, MA 02138 617-499-5050

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide a caregivers support group.	Complete	Outcome Goal	Year 1 of 1

Caregiver support group will meet twice a month.	Complete, the group met two times per month for 1.5 hours per session.	Process Goal	Year 1 of 1
Provide support for at least 50 caregivers.	58 people attended at least one caregiver support group session.	Outcome Goal	Year 1 of 1

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Not Specified
Health Issues	Chronic Disease-Alzheimer's Disease, Health Behaviors/Mental Health-Mental Health,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** Adults, Elderly, • **Race/Ethnicity:** All, • **Language:** All, English, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

Coalition Building - Access to Healthcare

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	To address the social determinants of health, healthy aging, prevention and self-management of chronic illness, mental health and substance use disorders, Mount Auburn Hospital continues to support a wide range of community groups by supporting them through technical assistance and participation at regular meetings. At these meetings stakeholders share experiences, ideas and best practices. This gives MAH an opportunity to listen to concerns of the community in order to help strategize community benefit work. These coalitions include but are not limited to City of Cambridge CHIP, Watertown Cares, Waltham Connections, Cambridge Health Alliance Community Health Advisory Committee, Cambridge Community Stakeholders, and Somerville Community Stakeholders. These meetings reach many community members and organizations. Mount Auburn also hosted two Elder Services Provider Stakeholder meetings to help hospital staff improve services, listen to needs and also to engage agencies to share best practices. Partners listed are a sampling of organizations. Due to the pandemic many of these meetings were shifted to virtual meetings.
Program Hashtags	Prevention,
Program Contact Information	Mary DeCourcey

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
MAH staff to attend community meetings	MAH staff attended over 20 community coalition and or task force meetings in its service area.	Process Goal	Year 1 of 1

Bridge the gap between community members and hospital staff	Ongoing	Process Goal	Year 1 of 1
Provide technical assistance and information sharing	Ongoing	Process Goal	Year 1 of 1
Provide community engagement opportunities	Ongoing	Process Goal	Year 1 of 1
Host the Elder Services Stakeholder meeting two times in FY2020	MAH hosted the Elder Services Stakeholder meetings for those organizations and agencies serving elders to come together to share best practices and learn from each other.	Process Goal	Year 1 of 1

EOHHS Focus Issues	Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities	Built Environment, Housing, Social Environment, Violence,
Health Issues	Health Behaviors/Mental Health-Mental Health, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Homelessness, Social Determinants of Health-Public Safety, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** All,

- **Race/Ethnicity:** All,
- **Language:** All,
- **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Arlington Housing Corporation	https://housingcorparlington.org/
Watertown Police Department	www.ci.watertown.ma.us/
City of Cambridge, Cambridge Police Department	https://www.cambridgema.gov/
Healthy Waltham	http://www.healthy-waltham.org/
City of Waltham, Waltham Police Department	https://www.city.waltham.ma.us/
City of Somerville, Somerville Police Department	www.somervillema.gov/
Arlington Youth Counseling Center	https://www.arlingtonma.gov/departments/health-human-services/arlington-youth-counseling-center-aycc
Arlington Council on Aging	https://www.arlingtonma.gov/
Live Well Watertown	www.livewellwatertown.org

Waltham Council on Aging	https://www.city.waltham.ma.us/council-on-aging
Watertown Council on Aging	https://www.ci.watertown.ma.us/128/Council-on-AgingSenior-Center
Belmont Council on Aging	https://www.beechstreetcenter.org/
Somerville Council on Aging	https://www.somervillema.gov/departments/health-and-human-services/council-aging
Cambridge Council on Aging	http://www.cambridgecoa.org/
Somerville Cambridge Elder Services	https://eldercare.org/
Watertown Cares	www.ci.watertown.ma.us/
Somerville Stakeholders Coalition	www.somervillema.gov/

Collaborations with Local Departments of Public Health - Aligns with all Health Priorities

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	Realizing that local health departments have unique perspectives on the needs of the community members they serve, Mount Auburn Hospital has an annual noncompetitive grant program for the cities and towns in its service area. These funds are designated for capacity building and projects or programs which coincide with the health priorities which were identified through

	Mount Auburn's most recent Community Health Needs Assessment. Each City or Town reflects on their own needs and considers programs which will have a positive impact on the health of their community members. These funds were designated to support our public health colleagues in addressing one or more of the top health concerns identified in the 2018 Community Health Needs Assessment. The programs listed below were funding in FY2019 but the work was completed in FY2020. The timeline for these projects was increased due to the pandemic.
Program Hashtags	Community Education, Health Professional/Staff Training, Prevention,
Program Contact Information	Mary DeCourcey 330 Mount Auburn Street Cambridge, MA 02138 617-499-5625

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
To build the capacity of local DPHs (or their designee) to address health concerns identified in the 2018 community need assessment.	Timeline for projects was extended due to the pandemic.	Outcome Goal	Year 2 of 2
In Arlington: Create relationships and support to homeless residents in a wooded area.	Complete	Outcome Goal	Year 2 of 2
In Arlington: move residents out of the wooded area into supportive housing	7 residents were able to be supported and moved into their own housing.	Outcome Goal	Year 2 of 2
In Belmont: educate the community in particular youth on	Provided a speaker series for youth and parents. Education and Resources provided to participants.	Process Goal	Year 2 of 2

issues around youth mental health and resilience.			
In Belmont: : Increase access to food for food insecure residents.	Purchased food to increase the capacity of the food pantry to serve the growing need. Food was distributed to food insecure residents.	Process Goal	Year 2 of 2
In Cambridge: Build capacity to conduct and provide department and community wide QI projects.	Staff training for the quality improvement specialist. This allowed Cambridge to meet the requirements of the Public Health Accreditation Board .	Outcome Goal	Year 2 of 2
In Cambridge: Build Capacity to be better prepared to respond to this pandemic and future emergencies.	Developed a COVID â€“ 19 After Action review process to evaluate how 1. The incident Command System was used within the department to respond to the pandemic and 2. Case investigation and contact tracing was conducted in response to pandemic. 3.Setup of mobile testing in response to pandemic	Outcome Goal	Year 2 of 2
In Somerville: Increase education and awareness around racial equity and mental health for the youth population.	Provided a virtual program for youth highlighting and discussing Racial Equity and Youth Mental Health. 24 people participated and received resources.	Outcome Goal	Year 2 of 2
In Somerville: Increase Capacity to provide Youth Mental Health First Aid Training.	Purchased 72 training units to provide access for 72 Somerville Community youth workers to be trained in the Youth Mental Health First Aid curriculum. Training is currently ongoing.	Outcome Goal	Year 2 of 2
In Waltham: Increase access to the food pantry to those who do not have transportation.	Provided rolling carts for community members receiving food at the weekly food distribution. 200 rolling carts purchased and distributed allowing recipeints to carry more food as they are walking to and from the pantry.	Outcome Goal	Year 2 of 2

Watertown : Increase substance use prevention education.	Coordinated a Erase the Stigma of Substance Use Event and Panel Discussion This was a virtual event which reached residents community wide through Cable Access Network, youtube and website posting.	Outcome Goal	Year 2 of 2
In Watertown: Increase resources for people challenged with substance use disorder and family and friends of substance users.	Created a resource brochure. Completed and distributed. These are on hand for the Watertown Cares Coalition.	Outcome Goal	Year 2 of 2

EOHHS Focus Issues	Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities	Not Specified
Health Issues	Health Behaviors/Mental Health-Mental Health, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Homelessness, Social Determinants of Health-Racism and Discrimination, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** Adults, Teenagers, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Cambridge Department of Public Health	http://www.cambridgepublichealth.org/
Waltham Public Health Department	https://www.city.waltham.ma.us/health-department
Somerville Department of Public Health	http://www.somervillema.gov/departments/board-of-health
Watertown Department of Public Health	http://www.ci.watertown.ma.us/index.aspx?nid=186
Arlington Department of Public Health	http://arlingtonma.gov/departments/health-human-services/health-department
Belmont Department of Public Health	http://www.belmont-ma.gov/health-department

Collaborations with Local Housing Authorities - Social Determinants of Health

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	Recognizing that affordable and safe housing has an impact on our community member's health, this year Mount Auburn Hosptial was able to provide a non competitive mini grant to each local Housing Authority. This grant funding was designated for improvement of housing access, living conditions within buildings, to help improve upon safe and affordable housing space or to work on policy changes that would increase access to affordable housing. These funds were made available as a result of the

	priorities which were outlined in the most recent implementation strategy developed in conjunction with the 2018 Community Health Needs Assessment.
Program Hashtags	Not Specified
Program Contact Information	Mary DeCourcey Mount Auburn Hospital 330 Mount Auburn Street, Cambridge, MA 02138, 617499-5625

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide funding to local Housing Authorities to be designated for improvement of housing access, living conditions within buildings, to improve upon safe and affordable housing space or to work on policy changes that would increase access to affordable housing.	Complete	Outcome Goal	Year 1 of 1
In Arlington, improve upon language access and reduce barriers for those with limited English proficiency.	Complete. Created and implemented a tracking system for the Language Access Plan. This allowed the Housing Authority to better serve those with limited English proficiency.	Outcome Goal	Year 1 of 1
In Arlington, reduce access barriers by translating vital documents regarding resident's individual tenancy.	Ongoing as documents are being translated for individuals as needed.	Process Goal	Year 1 of 1
In Belmont, provide basic toiletry items and self cleaning supplies during the pandemic.	Complete. This funding allowed the housing authority to create and provide a toiletry bag for 154 households in the elderly/disabled sites. It also was a way for the housing authority to check in on those	Outcome Goal	Year 1 of 1

	who were isolated in their apartments and follow up with them with any urgent needs.		
In Cambridge, improve the health and wellbeing of residents in the LBJ Apartments.	Complete. Purchased 2 NU-Step exercise machines for residents to utilize. This provided a safe environment to exercise on a regular basis. Residents can now sign up and use the machines safely with in the building.	Outcome Goal	Year 1 of 1
In Somerville, increase access for residents to digital literacy	Complete. We were able to purchase a computer for the community room to increase access for residents to connect online.	Outcome Goal	Year 1 of 1
In Somerville, provide training for those interested in using the new computer.	Ongoing. Training is available and a system has been put into place so residents can sign up to use the computer on a regular basis.	Process Goal	Year 1 of 1
In Waltham, increase access to fresh fruits and vegetables for residents.	Purchased a refrigerator and freezer to complement the food distribution program for food insecure residents. We have had a sharp increase in food insecure residents during the pandemic.	Outcome Goal	Year 1 of 1
In Waltham, increase distribution of fresh foods to food insecure residents and community members.	With the purchase of the refrigerator we are now able to distribute and increase access to additional fresh produce to our most vulnerable residents as well as community members who come to the housing building on food distribution days.	Outcome Goal	Year 1 of 1
In Watertown, improve the common areas of the residential communities.	Complete. Natural plants and wall hangings to add natural life and a peaceful environment creating a more relaxing area for residents. Needed furniture was purchased.	Outcome Goal	Year 1 of 1

EOHHS Focus Issues	Housing Stability/Homelessness,

DoN Health Priorities	Housing,
Health Issues	Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Language/Literacy,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** Adults, Elderly, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Arlington Housing Authority	https://www.arlingtonhousing.org/
Belmont Housing Authority	https://www.belmont-ma.gov/housing-authority
Cambridge Housing Authority	http://www.cambridge-housing.org/
Somerville Housing Authority	http://www.sha-web.org/
Waltham Housing Authority	http://www.walhouse.org/

Watertown Housing Authority	http://watertownha.org/

Community and Professional Education for Emergency Care - Access to Healthcare

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	MAH Emergency Room physicians work with Arlington, Belmont, Cambridge, Watertown Lexington Fire and Police departments and privately owned Professional EMS to increase their capacity to serve community members in need of emergent care. Often times, our most vulnerable community members are in need of emergency care. This work prepares our local EMS providers to bridge the gap from the community setting to health care and improve access for all. MAH provides a EMS medical director who works with our affiliated EMS services to provide credentialing, continuous review/quality assurance, and education for our affiliated community EMTs and Paramedics. This involves protocol reviews, medical control, monthly education sessions, and other educational opportunities. This also involves serving as EMS Medical Director for Massachusetts Institute of Technology EMS, Harvard University, EMS and Pro Ambulance EMS. As Medical Directors they give medical direction, planning and support to these Fire Departments, police departments and EMS staff.
Program Hashtags	Community Education, Health Professional/Staff Training,
Program Contact Information	Dr. William Porcaro Mount Auburn Hosptial 330 Mount Auburn Street Cambridge, MA 02138

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame

MAH ED Physicians meet with Belmont, Watertown, Cambridge, and Lexington Fire Department pre-hospital providers as well as Pro EMS providers to review cases and discuss best practices and processes for treatment improvement on a monthly basis.	Monthly peer review sessions provided by MAH ED Physicians.	Process Goal	Year 1 of 1
MAH Physicians serve as EMS Medical Directors to local cities and towns.	MAH physicians serve as EMS Medical Directors to the City of Cambridge and the towns of Watertown, Belmont, Arlington and Lexington.	Process Goal	Year 1 of 1
MAH Physicians serve as EMS Medical Directors to local organizations	MAH Physicians serve as EMS Medical Directors to MIT EMS, Harvard University EMS and Pro Ambulance EMS.	Process Goal	Year 1 of 1
Provide medical direction, planning and support as well as ongoing education for Arlington, Belmont, Watertown, and Cambridge Fire Departments, Pro Ambulance EMS, MIT EMS, and Harvard University EMS. Reach at least 20 staff with education medical direction and support monthly.	As medical directors the Emergency Department provides monthly education sessions to Cambridge, Arlington, Belmont Watertown Fire departments. A total of 20 - 30 staff in attendance each month (all towns).	Process Goal	Year 1 of 1
To serve on state regional EMS advisory boards to lend medical oversight to the region.	Ongoing: Emergency Department physicians serve on state and regional EMS advisory boards to lend medical oversight to the region. Emergency Department physicians also serve on a committee with Metropolitan Boston Emergency Medical Services Council to help guide pre-hospital care in the region.	Process Goal	Year 1 of 1

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Not Specified
Health Issues	Social Determinants of Health-Public Safety,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Professional Ambulance	http://proems.com/
Belmont Fire Department	www.belmont-ma.gov/fire
Arlington Fire Department	https://www.arlingtonma.gov/departments/fire
Cambridge Fire Department	https://www.cambridgema.gov/cfd/

MIT EMS	https://ems.mit.edu/
Watertown Fire Department	https://www.fire.watertown-ma.gov/
Harvard University EMS	https://huhs.harvard.edu/services/crimsonems
Lexington Fire Department	http://lexfire.org

Elder Cardiovascular Health - Healthy Aging/Chronic/Complex Conditions

Program Type	Direct Clinical Services
Program is part of a grant or funding provided to an outside organization	No
Program Description	To address prevention and early detection of illness, MAH nurses go to community settings and provide free blood pressure screenings. Seniors are seen in Councils On Aging sites or elder housing complexes. In addition to providing community members with a record of their blood pressure reading to share with their providers; the nurses take this opportunity to review warning signs of heart attack and stroke. Unfortunately, due to the pandemic this program had to be cancelled in March 2020.
Program Hashtags	Community Education, Health Screening, Prevention,
Program Contact Information	Mary DeCourcey 330 Mount Auburn Street Cambridge, MA 02138 617-499-5625

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide at least 50 blood pressure clinics to underserved elders to increase understanding of prevention and early detection of stroke, and cardiovascular disease.	24 blood pressure clinics were provided between October 2019 - February 2020. We were unable to meet this goal due to the pandemic.	Process Goal	Year 1 of 1
Provide elders with education to increase positive health behaviors to reduce stroke and access emergent care for any signs and symptoms of stroke.	593 elders attended and received education on signs and symptoms of high blood pressure and stroke to increase positive health behaviors and reduce stroke.	Outcome Goal	Year 1 of 1
Provide blood pressure screening for elders at risk for cardiovascular disease with documentation for follow up with primary care physicians.	All community members who attended received their blood pressure screening on a form which they could bring to their primary care physician for follow up care.	Process Goal	Year 1 of 1

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities	Not Specified
Health Issues	Chronic Disease-Cardiac Disease, Chronic Disease-Hypertension, Social Determinants of Health-Access to Health Care,
Target Populations	• **Regions Served:** Belmont, Cambridge, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All,

	• **Age Group:** Adults, Elderly, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Belmont Council on Aging	www.town.belmont.ma.us/
Cambridge Council on Aging	https://www.cambridgema.gov/
Waltham Council on Aging	www.city.waltham.ma.us/council-on-aging
Watertown Council on Aging	www.ci.watertown.ma.us
BILH at Home	https://www.bilh.org/system/beth-israel-lahey-health-at-home

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Health Coverage and Public Assistance Enrollment - Access to Healthcare

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	No
Program Description	Mount Auburn Hospital recognizes that navigating the applications for health insurance can be overwhelming and cumbersome. To address access to health care, Mount Auburn Hospital provides

	Certified Application Counselors (CACS) to assist patients and community members in applying for public assistance programs. Mount Auburn Hospital provides staffing of CACSs to work directly at Charles River Community Health Center which is a Federally Qualified Health Center to augment their enrollment staff to help with health coverage and public assistance enrollment.
Program Hashtags	Not Specified
Program Contact Information	Angelo Diorio, 330 Mount Auburn Street, Cambridge, MA 02138 617-499-5566

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Support community members through the process of enrollment for health insurance and public assistance programs.	3.74 full time equivalets (FTE's) provide support and enrollment services, at both MAH and Charles River Community Health Center. These staff are Certified Application Counselors.	Process Goal	Year 1 of 1
Facilitate connection to health care by providing Certified Application Counselors to work on site at Charles River Community Health Center, Waltham.	1.65 MAH FTE (Certified Application Counselors) are provided to Charles River Community Health Center to provide these services.	Process Goal	Year 1 of 1

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Not Specified
Health Issues	Social Determinants of Health-Access to Health Care,
Target Populations	• **Regions Served:** Arlington, Boston-Allston, Cambridge, Somerville, Waltham, Watertown,

	• **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Charles River Community Health Center	www.charlesriverhealth.org

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Health Equity and Food Access - Social Determinants of Health

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	This year MAH was able to provide grant funding to support health equity and food access. Local food markets, food collaboratives as well as the Watertown School Department received funding to help underserved residents increase their access to fresh produce. Each organization tailored a plan to fit the needs of their constituents. MAH worked with Healthy Waltham to help them start up a food distribution program during the pandemic as they saw a sharp increase in food insecure families and residents. Mount Auburn also provided funding for Cambridge SNAP Coalition in order to increase residents purchasing power at local farmers markets. MAH also partnered

	with Waltham Senior Center to provide Healthy Eating for Successful Living in Older Adults which is an evidenced based program for seniors who want to learn more about nutrition and how lifestyle changes can promote better health. Another evidenced based program, Chronic Disease Self-Management was conducted at Belmont Senior Center. In response to the pandemic MAH used its purchasing power to purchase food and then have it sent out to Arlington Eats Market which saw a 70% increase in residents needed help with food for their tables. Through these programs the hospital was able to improve health equity and healthy food access to many community members dispite the challenging times of the pandemic.
Program Hashtags	Community Health Center Partnership,
Program Contact Information	Mary DeCourcey Mount Auburn Hospital 330 Mount Auburn Street Cambridge MA 02138

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Collaborate with the city of Waltham to provide a Healthy Eating for Successful Living for Older Adults course.	Complete. Hosted the evidenced based Healthy Eating for Successful Living for Older Adults at the Waltham Council on Aging. 12 participants completed the class	Outcome Goal	Year 1 of 1
At least 80 % of participants in the Healthy Eating for Successful Living for Older adults report that their diet is more healthy after completing course.	88% of the participants reported that their diet is more healthy after completing the course.	Outcome Goal	Year 1 of 1
Provide funding to 7 organizations to improve health equity and healthy food access.	Completed	Process Goal	Year 1 of 1
Collaborate with Arlington Eats to provide funding to support	Complete. This funding allowed Arlington Eats to purchase additional food and coordinate volunteers to pack and deliver	Process Goal	Year 1 of 1

purchase of fresh produce, eggs, dairy shelf-stable foods and prepared meal, and to help support a staffing model for coordinating volunteers and deliveries.	requested food to community members in need.		
Provide food to Arlington Eats for the purpose of distributing to their growing need of food insecure residents.	Complete. Over a 2 month period MAH purchased and delivered 600 dozen eggs, 400 loaves of bread, 200 jars of peanut butter and 200 jars of shelf stable orange juice.	Outcome Goal	Year 1 of 1
Collaborate with Belmont Council on Aging to provide the evidenced based program Chronic Disease Self Management.	Complete. Hosted this program at the Belmont Senior Center and 10 participants completed this course.	Outcome Goal	Year 1 of 1
At least 80 % of participants in the Chronic Disease Self Management class held in Belmont report that they agree or strongly agree that "I have made changes in my diet to improve my medical condition,â€□ after taking this class.	100% of participants reported they agree or strongly agree that "I have made changes in my diet to improve my medical condition."	Outcome Goal	Year 1 of 1
Collaborate with Waltham Fields Community Farm to provide funding to help support their food access programs including the subsidized CSA Shares program in Waltham.	Complete. In order to safely provide their subsidized CSA program (during the pandemic) to identified families this funding supported the purchase boxes that were then filled with fresh produce for families to pick up rather than handle the produce themselves. These changes were necessary during the pandemic and costly to the program.	Outcome Goal	Year 1 of 1
In Belmont double two matching programs to increase the purchasing power for low income	Not Specified	Outcome Goal	Year 1 of 1

shoppers at the farmers market.			
In Cambridge improve access to healthy foods for low-income shoppers who use SNAP benefits at three farmers markets.	Complete. These funds were used to increase purchasing power of those qualifying. The SNAP match program allows shoppers to purchase $30 of fresh food while using only $15 of their SNAP funds thus doubling their share of fresh produce.	Outcome Goal	Year 1 of 1
In Belmont: Increase food access to low-income food insecure residents.	This funding allowed the Belmont Food Pantry to increase options of healthy food for residents. With the increase in residents seeking help the Belmont Food Pantry food was able to purchase the needed food to support the increase numbers.	Process Goal	Year 1 of 1
Collaborate with the Watertown public schools to increase access to food for school families who are in need.	This funding supported the school nutrition department to increase their purchasing power to provide every student or family who participated in the free meals program through the school with fresh fruits and vegetables with every meal.	Outcome Goal	Year 1 of 1
Provide Healthy Waltham funding to expand vital food access programs within Waltham, for those who are low income and underserved.	Complete. Waltham had to strategically look at systems and infrastructure as the pandemic resulted in a doubling of food insecure residents. This funding helped to support a community effort to add an additional distribution center for food insecure community members.	Outcome Goal	Year 1 of 1
Collaborate with Somerville Homeless Shelter to increase access to healthy foods for their food delivery service to housing and food insecure community members	Complete. The monthly average of food deliveries increased 62% during the months of March through mid-June when the pandemic hit hardest. This funding supported the food budget in these times of increased volume and allowed SHC to be able to fulfill these needs.	Outcome Goal	Year 1 of 1
Provide Charles River Community Health with grocery store gift cards	Complete. This program allowed CRCH to support 60 food insecure families with a $25 grocery store gift card to supplement their food needs.	Outcome Goal	Year 1 of 1

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Built Environment,
Health Issues	Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Income and Poverty,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Belmont Council on Aging	https://www.belmont-ma.gov/council-on-aging
Belmont Food Pantry	https://sites.google.com/site/thebelmontfoodpantry/
Watertown School Department, Nutrition Services	https://www.watertown.k12.ma.us/
Healthy Waltham	https://www.healthy-waltham.org/
Arlington EATS	https://www.arlingtoneats.org/

Waltham Fields Community Farm	https://communityfarms.org/
Waltham Council on Aging	https://www.city.waltham.ma.us/council-on-aging
Somerville Homeless Coalition	https://somervillehomelesscoalition.org/
Cambridge SNAP Match Coalition	http://cambridgecf.org/portfolio-items/snap-match-cambridge/
Charles River Community Health	https://www.charlesriverhealth.org/

Hertzstein Wellness Center - Chronic/Complex Conditions and Mental Health

Program Type	Community-Clinical Linkages
Program is part of a grant or funding provided to an outside organization	No
Program Description	The mission of the Herzstein Wellness Center is to provide a space for healing, revitalization, and hope through education and integrative care for cancer patients and their caregivers. We offer programs that address the whole person, including physical body, mind-body connection, spiritual vitality, and social support to improve quality of life, cancer survival, and cancer prevention. Acupuncture, Massage and Reikki therapy was available on an individual basis. This program is funded through grants generously donated by the Marino Foundation to the hospital. The pandemic forced the Hertzstein Wellness Center to close but through dedication to the program, staff worked on creating a virtual panel of programs that will be available in the next fiscal year.
Program Hashtags	Not Specified

Program Contact Information	Mary DeCourcey Mount Auburn Hospital 330 Mount Auburn Street, Cambridge MA

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide free alternative and integrative therapies to patients, their caregivers, staff and community members.	Complete. Individual appointments or programs included chair yoga, Reiki, therapeutic massage, therapeutic music, and paint break classes. There were over 500 appointments /encounters for these programs throughout the year, until March of 2020 when we closed the space due to the pandemic.	Outcome Goal	Year 1 of 1

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities	Not Specified
Health Issues	Cancer-Colorectal, Cancer-Lung, Cancer-Multiple Myeloma, Cancer-Other, Cancer-Ovarian, Cancer-Prostate, Cancer-Skin, Health Behaviors/Mental Health-Mental Health,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** Adults, • **Race/Ethnicity:** All,

	• **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Marino Foundation	Not Specified
Crivello Foundation	Not Specified
Waltham Fields Community Farm	https://communityfarms.org/

In Kind Wheelchair Accessible Space for Local Support Groups - Substance Use

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	To address substance use disorder, MAH provides handicapped accessible space for NA, AA and SMART recovery groups to meet weekly. Unfortunately, in March of 2020 we no longer could host outside groups due to the pandemic.
Program Hashtags	Support Group,
Program Contact Information	Kathy Howard 330 Mount Auburn Street Cambridge, MA 02138 617-499-5699

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide handicapped accessible space for substance use support groups.	Complete. In-kind space provided for NA, AA and SMART Recovery groups to meet on a regular basis until March 2020.	Process Goal	Year 1 of 1

EOHHS Focus Issues	Substance Use Disorders,
DoN Health Priorities	Not Specified
Health Issues	Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website

AA	http://www.aabosmeetings.org/results-town.aspx
Narcotics Anonymous	https://www.na.org/
Smart Recovery	http://www.smartrecovery.org/meetings_db/view/showalpha_state.php?search=M

In-home Services/Lifeline - Healthy Aging

Program Type	Community-Clinical Linkages
Program is part of a grant or funding provided to an outside organization	No
Program Description	To address access to healthcare this program provides personal emergency response services (Lifeline) to underserved Elders and disabled adults. Mount Auburn Hospital works closely with local Aging Services Access Point Agencies and provides the emergency response systems below cost to over 1,000 community members who are in need.
Program Hashtags	Not Specified
Program Contact Information	Kathy Howard Director, Social Work 330 Mount Auburn Street Cambridge, MA 02138 617-499-5050

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Work with local Aging Services Access Points to provide personal	Over 1,000 eligible elders and or disabled adults received a personal emergency response system installed at below cost.	Process Goal	Year 1 of 1

emergency response systems at low cost to at least 1000 lower socioeconomic elders and disabled adults			

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Not Specified
Health Issues	Other-Emergency Preparedness, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Uninsured/Underinsured,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** Adults, Elderly, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Disability Status,

Partners:

Partner Name and Description	Partner Website
Somerville Cambridge Elder Services	www.eldercare.org
Springwell	www.springwell.com

LifeLine Inhome Services at Mount Auburn Hospital	https://www.mountauburnhospital.org/care-treatment/home-health/medical-alert-services/

Medical Interpreter Services - Access to Healthcare

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	No
Program Description	In order to bridge the gap and improve access to care Mount Auburn Hospital provides professional medical interpreter services to non-English speaking, limited-English speaking, Deaf, and Hard of Hearing patients. These free interpreter services are provided in a variety of ways: In-person (for both Spoken and Sign Language), Over-the-phone, using a portable speaker phone to connect patients to their care team with an interpreter, and with a video remote interpreter service, using a computer to connect patients with an interpreter. Services are coordinated in a variety of ways to meet the needs of patients including full time staff, per-diem staff, and agency interpreters for all languages including American Sign Language (ASL). Professional interpretation from an over-the-phone service, offers access to hundreds of languages 24/7. The interpreter service department had to be nimble and flexible during this year. When the pandemic hit the interpreter team transitioned to all encounters being remote video or telephonic except in certain circumstances.
Program Hashtags	Not Specified
Program Contact Information	Lilia Karapetyan Interpreter Services Coordinator 330 Mount Auburn St. Cambridge, MA 02138 617-499-5750

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame

Provide free, timely, medical professional interpreter services for patients of all cultural and linguistic backgrounds with limited English proficiency, non-English speaking, and deaf or hard of hearing patients.	Provided 14,977 individual encounters either face to face, video, or telephonic encounters.	Outcome Goal	Year 1 of 1

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Not Specified
Health Issues	Social Determinants of Health-Language/Literacy,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

Patient Clothing Closet - Social Determinants of Health

Program Type	Direct Clinical Services
Program is part of a grant or funding provided to an outside organization	No
Program Description	Mount Auburn Hospital supports a patient clothing closet. When patients are in need of additional, clean clothing upon discharge staff have access to a clothing closet. Mount Auburn Hospital Staff donate new and used clean clothes and manage it in a way that it is available all year long 24 hours a day to staff to be able to provide clean clothing to our most vulnerable patients.
Program Hashtags	Not Specified
Program Contact Information	Kathy Howard Mount Auburn Hospital 330 Mount Auburn Street, Cambridge, MA 02138

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide emergency clothing 24 hours a day for patients in need upon discharge from an inpatient location or the emergency department.	Ongoing	Process Goal	Year 1 of 1

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Not Specified

Health Issues	Social Determinants of Health-Income and Poverty, Social Determinants of Health-Public Safety, Social Determinants of Health-Uninsured/Underinsured,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

Pharmacy Benefit - Access to Healthcare

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	No
Program Description	Realizing our most vulnerable population may not have the means for emergency pharmacological medicine, this program helps patients who are in need of emergency one time medicine but don not have a system or the health insurance to pay for it. MAH

	partners with a local pharmacy to provide free of cost one time medicine prescriptions to help those who would otherwise not be able to afford or have access to medicine. The social work department then works with these patients to help them transition to a health insurance plan or connect them to resources.
Program Hashtags	Not Specified
Program Contact Information	Kathy Howard, Director of Social Work - Mount Auburn Hospital 330 Mount Auburn St. Cambridge, MA 02138

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide free medications for our most vulnerable population who otherwise would not be able to pay for medication when being discharged from the hospital.	ongoing	Process Goal	Year 1 of 1

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Not Specified
Health Issues	Social Determinants of Health-Access to Health Care, Social Determinants of Health-Income and Poverty,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** All,

	• **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Schenderian Pharmacy	http://www.skenderianapothecary.com/

Prenatal/Post partum Support for women at Charles River Community Health Center - Access to Healthcare

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	No
Program Description	The Mount Auburn Hospital Latina Doula Program has been operating for over 10 years serving hundreds of our most vulnerable patients and their families in the important moment of giving birth. Doulas are trained professionals who provide continuous physical, emotional and informational support to a mother before, during and shortly after childbirth. For those women from underserved communities with limited supports, Doulas are cultural brokers-helping the laboring person to understand the medical culture and helping the medical team understand the family's cultural beliefs. There is excellent clinical data showing the benefits of doulas in decreasing C-section rates and increasing patient satisfaction. Mount Auburn strives to provide doulas for women who have limited resources and support. Often they are non-English speaking, undocumented and/or have no partner or family with them in labor. Most of our patients who get doula support through the Latina Doula Program receive prenatal care at the Charles River Community Health Center. This program also provides a prenatal community outreach worker who helps patients navigate the health care

	system and provide support and for families navigating and enrolling in governments benefit programs. This outreach worker is an important bridge between our hospital social workers and to behavioral health. This year the hospital was able to provide portable blood pressure cuffs to prenatal patients. This was a huge relief to patients as they were now able to take their own blood pressure at home during the pandemic when their regular appointments were offered virtually. This program also offers infant car seats to those women who would otherwise not have a car seat to transport their newborn safely home after delivery. Due to the pandemic, this program was forced to be reduced but the team worked to the best of their ability to support these women by changing protocols and continueing to support those who are most vulnerable.
Program Hashtags	Health Screening,
Program Contact Information	Mary DeCourcey

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide a Doula for women who request this support during birth.	A doula support coach is on call to support women at the time of delivery in person.	Outcome Goal	Year 1 of 5
Provide Doula support for at least 20 deliveries.	Provided Doula support for 7 deliveries. We were not able to meet this goal due to the limited visitors and support people allowed at the hospital during COVID restrictions.	Outcome Goal	Year 1 of 1
Provide an outreach worker to support Latina women through pregnancy, birth and post partum issues to help them navigate the system and support them for their own health and wellbeing.	Community outreach worker available to provide support.	Process Goal	Year 1 of 1

Provide a Doula for women who request this support during birth.	A Doula is on call to support women at the time of delivery in person.	Outcome Goal	Year 1 of 5
Provide blood pressure kits for prenatal women for the purpose of home checks during their virtual prenatal appointments, as the need arises.	70 blood pressure cuffs purchased.	Outcome Goal	Year 1 of 1
Institute a borrowing program for the newly purchased blood pressure cuffs. This allows women to return the blood pressure cuffs for other patients to use when they no longer need to monitor their own blood pressure.	Complete.	Process Goal	Year 1 of 1
Provide infant car seats to women who are in need of transporting their newborn home after delivery.	Provided 18 car seats to women in need of transporting their newborn safely home.	Outcome Goal	Year 1 of 1

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Not Specified
Health Issues	Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Stress Management, Maternal/Child Health-Reproductive and Maternal Health, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Language/Literacy,

Target Populations	• **Regions Served:** Waltham, • **Environments Served:** Suburban, Urban, • **Gender:** Female, • **Age Group:** Adults, • **Race/Ethnicity:** All, Hispanic/Latino, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Charles River Community Health Center	https://www.charlesriverhealth.org/

Racial Justice and Mental Health, Collaboration with Community Health Network Area (CHNA) 17 - Mental Health

Program Type	Infrastructure to Support CB Collaborations Across Institutions
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	To increase the capacity of Community Health Network Area (CHNA) 17 MAH collaborates with CHNA 17 to help support and fulfill its mission. CHNA 17's mission is to promote healthier people and communities by fostering community engagement, elevating innovative and best practices, advancing racial equity, and supporting reciprocal learning opportunities to address the needs of the most marginalized members of our communities. MAH provides funding, technical assistance and active steering

	committee membership. This reporting period, MAH provided CHNA 17 support for Mental Health and Racial Equity Grants which were awarded in FY 2019. These grants are now on their implementation phase (year 2). The goal of the grants is to increase access and reduce racial inequities in mental health services for African Americans. CHNA 17 is also working on increasing the capacity of Community Health Network Area (CHNA) 17. This year, CHNA 17 continued to track its partnerships through social network analysis. The key to CHNA 17's success to fulfull its mission is to increase its integrated partnerships.
Program Hashtags	Not Specified
Program Contact Information	Mary DeCourcey, Community Health 330 Mount Auburn Street Cambridge, MA 02139 617-499-5625

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Participation on the Steering Committee	MAH Community Benefits Director is an active participant in the CHNA 17 Steering Committee	Outcome Goal	Year 1 of 1
Help support 4 Mental Health and Racial Equity Grants to increase access and reduce racial inequities in mental health services for more marginalized populations especially African Americans.	4 Grants offered to increase access and reduce racial inequities in mental health service for more marginalized populations especially African Americans. FY 2019 represented the planning year for the work of these grants. The 4 organizations are ACCESS, Arlington Public Schools, Brandeis University/Heller School (Divine Dialogurs), and Kingdom Empowerment. They all are continuing to work on their grant projects.	Process Goal	Year 2 of 2
Provide funding for stipends for African American students in graduate level programs. This supported the wealth gap for these students.	Complete. Provided funding to support this effort. 12 graduate level students were funded through this program to support them while earning their degree. These students also shared their lived experiences with youth/high school students.	Process Goal	Year 1 of 1

Increase CHNA 17 capacity by increasing the network of partnerships of CHNA 17 members.	CHNA 17 grew from 71 to 97 active partners and connections across the network. The network grew 75% from the previous year.	Outcome Goal	Year 1 of 1
Develop a tool or system to track how organizations will build upon existing resources through sustained partnerships.	Complete. This is measured through the social network analysis tool utilized for CHNA 17.	Process Goal	Year 1 of 1
Integrate or coordinate partnerships among active CHNA 17 members. Goal is to have 65% of coordinated or integrated partnerships by FY 2022.	Through social network analysis 61 % of partnerships reported they were either integrated or coordinated partnerships.	Outcome Goal	Year 1 of 2

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Not Specified
Health Issues	Health Behaviors/Mental Health-Mental Health, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Education/Learning, Social Determinants of Health-Racism and Discrimination,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** African, All, Black,

	• **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Community Health Area Network 17	http://chna17.org/

Reducing Health Disparities - Social Determinants of Health

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	No
Program Description	The Mount Auburn Hospital Disparities Committee is focused on reducing identified health disparities. This year the committee identified people of color as a priority population in reducing health disparities for our patients. This committee reviews national, local and hospital data to identify where disparities in healthcare may exist and works creatively to make an impact on reducing health disparities at Mount Auburn Hospital. The committee recognizes that breaking down barriers for any priority population will reduce disparities for all. This year was challenging due to the pandemic for this committee to meet and deliberate best practices and what steps to take to make progress on reducing disparities. The first priority was to collect baseline hospital data. This project is multiyear and the goal is to fortify the hospital's ability to improve the health and wellbeing of this priority population while reducing health disparities.
Program Hashtags	Not Specified

Program Contact Information	Healther Gibbons Mount Auburn Hospital 330 Mount Auburn Street Cambridge, MA 02138

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Convene a disparities committee to decrease health disparities with a focus on people of color.	Complete.	Process Goal	Year 1 of 1
Collect hospital data as it pertains to health outcomes for people of color.	Ongoing	Process Goal	Year 1 of 3

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Not Specified
Health Issues	Social Determinants of Health-Access to Health Care, Social Determinants of Health-Racism and Discrimination,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** African, All, Black, Hispanic/Latino, • **Language:** All,

	• **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

Safe Beds - Mental Health

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	No
Program Description	To address mental health, Mount Auburn provides temporary Safe Beds for victims of domestic violence. This program is done in partnership with the local Police Departments and the associated expenses with this program are in-kind.
Program Hashtags	Not Specified
Program Contact Information	Kathy Howard 330 Mount Auburn Street Cambridge,MA 02138 617-499-5050

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Facilitate connection to safe care for men, women and people of all	Ongoing	Process Goal	Year 1 of 1

genders and their dependents who are victims of domestic violence.			

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Not Specified
Health Issues	Health Behaviors/Mental Health-Mental Health, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Violence and Trauma,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Domestic Violence History,

Partners:

Partner Name and Description	Partner Website
Cambridge Police Department	www.cambridgema.gov/cpd
Arlington Police Department	www.arlingtonma.gov

Belmont Police Department	www.belmontpd.org
Watertown Police Department	www.watertownpd.org
Waltham Police Department	www.city.waltham.ma.us
Somerville Police Department	www.somervillepd.com

Social Work Community Support - Mental Health

Program Type	Community-Clinical Linkages
Program is part of a grant or funding provided to an outside organization	No
Program Description	Mount Auburn Hospital social workers attend community meetings to share best practices, identify opportunities to improve collaborations and address challenges to optimizing health for our most vulnerable community members including the homeless and elders. Local community meetings include but are not limited to Watertown task force on Hoarding, Cambridge Police Stakeholders meetings, Cambridge Homeless Meeting, Elder Abuse prevention task force and the Arlington Human Services Network. Many of these meetings met virtually during the pandemic.
Program Hashtags	Prevention,
Program Contact Information	Kathy Howard, Director of Social Work Mount Auburn Hospital 330 Mount Auburn Street Cambridge, MA 02138 617-499-5050

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Build relationships with providers, community organizations, city agencies to share knowledge, access to services and to improve care for community members.	Social Workers attend monthly meetings in Arlington, Belmont, Cambridge, Somerville, Waltham and Watertown	Process Goal	Year 1 of 1
Social workers to attend community meetings and facilitate bidirectional communication between community based organizations and hospital staff.	Designated social workers attend a variety of community meetings as a representative of MAH to facilitate bidirectional communication and support for transitional care.	Process Goal	Year 1 of 1

EOHHS Focus Issues	Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities	Built Environment, Housing, Social Environment,
Health Issues	Health Behaviors/Mental Health-Mental Health, Infectious Diseaseâ€"COVID-19, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Homelessness, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Nutrition, Social Determinants of Health-Public Safety, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of Health-Violence and Trauma, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown,

	• **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** Not Specified • **Race/Ethnicity:** Not Specified • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Town of Watertown	https://www.ci.watertown.ma.us/
City of Waltham	https://www.city.waltham.ma.us/
City of Cambridge	https://www.cambridgema.gov/
Town of Arlington	https://www.arlingtonma.gov/
Town of Belmont	https://www.belmont-ma.gov/
City of Somerville	https://www.somervillema.gov/

Stroke Navigation and Prevention - Chronic/Complex Conditions

Program Type	Community-Clinical Linkages
Program is part of a grant or funding	No

provided to an outside organization	
Program Description	Mount Auburn Hospital supports a stroke certified nurse who is a member of the American Association of Neurological Nurses (AANN), both nationally and locally with the Boston chapter. She provides Stroke Education and Awareness within the hospital to patients, families and staff. She collaborates with the AHA/ASA which is vitally important to providing evidence based care to all stroke patients. Stroke and heart health education is also provided in a variety of community settings to our community members. At local skilled nursing facilities she provides annual competency training for their staff. This position also collaborates with the local private EMS, and local cities and town fire departments to provide staff with updated information and education about recognizing the signs of stroke, performing national stroke assessments and alerting the hospital prior to arrival in order to provide patients with efficient time sensitive care. This year the stroke education program in the community was greatly reduced due to the pandemic.
Program Hashtags	Health Professional/Staff Training,
Program Contact Information	Marie McCune Mount Auburn Hospital 330 Mount Auburn Street Cambridge, MA 02138 617-499-6090

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide annual competency education and training at Neville Place, Cambridge and Meadow Green in Waltham	Completed. Staff training.	Outcome Goal	Year 1 of 1
Provide annual competency education and training at Pro Ambulance, Cambridge, Watertown EMS/Fire Department, Belmont EMS/Fire Department	Complete. Staff trained	Outcome Goal	Year 1 of 1

and Lexington Fire/EMS Fire Department.			
Provide stroke education and awareness within the hospital to patients, families and staff.	Ongoing education and support to patients and their families.	Process Goal	Year 1 of 1

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Not Specified
Health Issues	Chronic Disease-Stroke,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** Adults, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Belmont Council on Aging	https://www.beechstreetcenter.org/
Watertown Council on Aging	https://www.watertown-ma.gov/

Cambridge Pro Ambulance	http://proems.com/
Meadow Green, Waltham, MA	https://www.meadowgreenrehabandnursing.com/
Watertown Fire Department	https://www.fire.watertown-ma.gov/
Belmont Fire Department	https://www.massmetrofire.org/belmont.html
Lexington Fire Department	https://www.lexingtonma.gov/fire-department
Neville Place, Cambridge, MA	https://www.nevillecenter.org/
Waltham Council on Aging	https://www.city.waltham.ma.us/council-on-aging

Support for Community Members with Cancer - Chronic/Complex Conditions

Program Type	Community-Clinical Linkages
Program is part of a grant or funding provided to an outside organization	No
Program Description	This program works with cancer patients to create a sense of support, confidence, courage, and community among cancer patients. In addition to our collaboration with the American Cancer Society, MAH has garnered its own internal resources to provide support services for community members touched by cancer. Most of these programs were cancelled due to the pandemic. A support group for women who finish treatment of breast cancer continued to run virtually when participants were not longer able to meet. These programs are aimed at increasing hope and empowerment

	for those affected by cancer, and to improve mental health and wellbeing.
Program Hashtags	Support Group,
Program Contact Information	Beth Roy, LICSW Breast Center Coordinator 330 Mount Auburn Street Cambridge, MA 02138 617-499-5755

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide a breast cancer support group to women who have completed treatment.	Ongoing. Created and ran a support group which meets twice a month.	Process Goal	Year 1 of 1
Improve hope, empowerment and/or confidence in community members experiencing breast cancer.	Over 50 women attended at least one session of the breast cancer support group.	Outcome Goal	Year 1 of 1

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities	Not Specified
Health Issues	Cancer-Breast,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, Female,

	• **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
American Cancer Society	www.cancer.org

Support Groups/Bereavement - Mental Health

Program Type	Community-Clinical Linkages
Program is part of a grant or funding provided to an outside organization	No
Program Description	To address Mental Health, this support group provides people the opportunity, in a safe and supportive environment, to share their feelings and stories with others who are going, or have gone through the loss of a loved one. It is open to any adult community member who has experienced the death of someone significant in their life.
Program Hashtags	Not Specified
Program Contact Information	Rev. Beth Loomis Pastoral Care Director 330 Mount Auburn Street Cambridge, MA 02138 617-499-5665 x8606

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide at least 3 Bereavement Support Groups for community members.	Three eight week long sessions were offered. 29 community members attended.	Process Goal	Year 1 of 1

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Not Specified
Health Issues	Not Specified
Target Populations	• **Regions Served:** Not Specified • **Environments Served:** Not Specified • **Gender:** Not Specified • **Age Group:** Not Specified • **Race/Ethnicity:** Not Specified • **Language:** Not Specified • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

Transportation as a barrier to medical care - Social Determinants of Health

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	Transportation is too often a barrier to medical care. Mount Auburn clinicians work with patients where transportation is a barrier to care. MAH responds to community requests where there is a need for transportation. Mount Auburn staff participates in Cambridge's community wide transportation task force. Mount Auburn staff participated in Cambridge's community wide transportation task force. In order to facilitate needed rides Mount Auburn Hospital contracts with SCM Transportation for transportation to medical appointments. Metro Cab vouchers and Charlie Cab cards are also available for those who qualify for transportation support.
Program Hashtags	Not Specified
Program Contact Information	Mary DeCourcey Mount Auburn Hospital 330 Mount Auburn Street Cambridge, MA 02138 617-499-5625

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Facilitate connection to health care by providing transportation connections at no cost when transportation is a barrier to medical care.	Over 3,000 rides provided free of charge to those where transportation is a barrier to medical care. Ongoing transportation is provided via SCM Transportation, Metro Cab vouchers and Charlie Cards distributed as determined by the social work staff.	Outcome Goal	Year 1 of 1
Mount Auburn staff to participate in	Ongoing - the director of community affairs attends these meetings to address	Process Goal	Year 1 of 1

Cambridge Task Force addressing transportation and environmental issues.	transportation and environmental issues in the City of Cambridge.		
Provide support to Belmont Council on Aging which will enable the COA to provide transportation for their seniors and disabled persons in need.	296 rides provided for underserved elders and disabled persons.	Outcome Goal	Year 1 of 1

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Not Specified
Health Issues	Social Determinants of Health-Access to Transportation,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** All, Elderly, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Disability Status,

Partners:

Partner Name and Description	Partner Website

Belmont Council on Aging	http://www.town.belmont.ma.us/Public_Documents/BelmontMA_Aging/index
City of Cambridge	http://www.cambridgema.gov/
SCM Community Transportation	www.scmtransportation.org/
Massachusetts Bay Transportation Authority	https://www.mbta.com/
Metro Cab of Boston	http://www.metro-cab.com/

Volunteer Services - Social Determinants of Health

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	For many years MAH volunteer department provides local high school students an opportunity for a summer internship where they can experience providing volunteer services in the hospital setting. This year the high school volunteer program was not able to run. The volunteer department also provides opportunity for older adults to volunteer. This program did run until March 2020. Mount Auburn Hospital works to increase the interest and capacity of community members to have careers in the healthcare field. The Watertown Med Science program is onsite and gives Watertown High School students an opportunity to experience different departments at the hospital by rotating through the

	areas and learning about the different disciplines. This is a semester long program and it ran in the fall of 2019.
Program Hashtags	Not Specified
Program Contact Information	Jan Anckerson, Director of Volunteer services, 330 Mount Auburn St. Cambridge, MA 02138 617-499-5016

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Support the Watertown Med Science program which is aimed at addressing the gap in STEM education. All students, regardless of background, education or zip code, should have equal opportunities in education and the sciences. These students rotate through a variety of clinical areas to learn about health care fields.	16 Students at Watertown High School attended programming which highlighted science and health care education at Mount Auburn Hospital.	Process Goal	Year 1 of 1
Provide an opportunity for older adults to give back and volunteer at the hospital in a variety of departments. This not only benefits the hospital but improves self-worth and self-confidence to the older population as well as reducing social isolation for older members of our community.	558 volunteers gave 8,843 hours of service to MAH.	Outcome Goal	Year 1 of 1

EOHHS Focus Issues	Not Specified

DoN Health Priorities	Education,
Health Issues	Social Determinants of Health-Education/Learning,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** Adults, Elderly, Teenagers, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Watertown Public School Department	www.watertown.k12.ma.us

We are Stronger Working Together - Aligns with all Health Priorities

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	As a community hospital, Mount Auburn recognizes the essential work done by many local community based organizations that assist community members in accessing services that promote

	health. Through our corporate sponsorship/donation program Mount Auburn Hospital provides funding to assist our colleagues to do their work. Funded programs align with the health priorities and or the priority populations identified in Mount Auburn Hospital Community Health Needs Assessment of 2018.
Program Hashtags	Not Specified
Program Contact Information	Mary DeCourcey 330 Mount Auburn Street Cambridge, MA 02138 617-499-5625

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide funding for local organizations that provide services or resources which align with the health priorities and/or priority populations which were identified in the most recent Community Health Needs Assessment of 2018.	Funding provided for Arlington Youth Counseling Center, Healthy Waltham, First Armenian Church of Belmont, Charles River Community Health Center, Waltham Fields Community Farms, Waltham Family School, Somerville Homeless Coalition, Cambridge Community Foundation, Somerville Cambridge Elder Services, Greek Orthodox Church, Arlington Eats, Food Link Inc., Watertown Baseball and Softball Challenger Program, Waltham Partnership for Youth, AIDS Action Committee, Greater Boston Food Bank, Belmont Veteran's Memorial	Process Goal	Year 3 of 3

EOHHS Focus Issues	Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities	Not Specified
Health Issues	Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Physical Activity, Health Behaviors/Mental Health-Stress Management, Infectious Disease-HIV/AIDS, Other-Cultural Competency, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Homelessness, Social Determinants of Health-Income and Poverty, Social Determinants

	of Health-Language/Literacy, Social Determinants of Health-Uninsured/Underinsured, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Partners include the Organizations listed above	Not Specified

Expenditures

Total CB Program Expenditure	**$2,849,806.00**

CB Expenditures by Program Type	Total Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
Direct Clinical Services	$1,434,717.00	Not Specified
Community-Clinical Linkages	$522,377.00	Not Specified
Total Population or Community-Wide Interventions	$300,346.00	$65,786.00
Access/Coverage Supports	$559,804.00	$20,000.00
Infrastructure to Support CB Collaborations Across Institutions	$32,562.00	$12,000.00

CB Expenditures by Health Need	Total Amount
Chronic Disease with a Focus on Cancer, Heart Disease, and Diabetes	$144,476.00
Mental Health/Mental Illness	$1,585,762.00
Housing/Homelessness	$15,000.00

Substance Use	$95,970.00
Additional Health Needs Identified by the Community	$1,008,598.00
Other Leveraged Resources	$31,015.00

Net Charity Care Expenditures	**Total Amount**
HSN Assessment	$4,561,598.00
HSN Denied Claims	($902,610.00)
Free/Discount Care	Not Specified
Total Net Charity Care	$3,658,988.00

Total CB Expenditures:	$6,539,809.00

Additional Information	**Total Amount**		
		Net Patient Service Revenue:	$351,164,000.00
		CB Expenditure as	1.86%

Percentage of Net Patient Services Revenue:	
Approved CB Program Budget for FY2021: (*Excluding expenditures that cannot be projected at the time of the report.)	$2,850,000.00
Comments (Optional):	Not Specified
Optional Information	
Hospital Publication Describing CB Initiatives:	Not Specified
Bad Debt:	$3,914,622.00
Bad Debt Certification:	Certified
Optional Supplement:	Not Specified

SECTION VI: CONTACT INFORMATION

Mary DeCourcey
Mount Auburn Hospital
Community Health Department
330 Mount Auburn Street
Cambridge, MA 02138
617-499-5625
mdecourc@mah.harvard.edu

SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Office of the Massachusetts Attorney General

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:

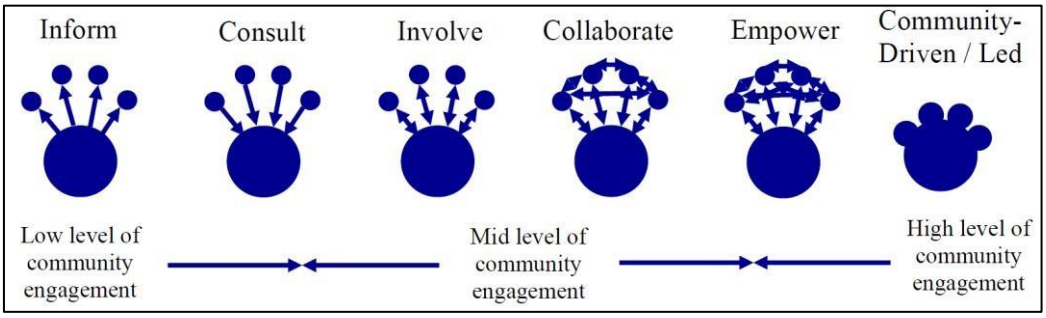
 Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? ☐ Yes ☒ No ○ If so, please list updates:

II. Community Engagement:

1. 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
CHNA 17	Stacy Carruth	Racial Justice and Mental Health	Financial Support, MAH serves on the steering committee and they participate on our CBAC
Local Health Departments	Christine Bongiorno Claude Jacobs Doug Kress Michelle Feeley Larry Ramdin Wesley Chin	Local Health Departments	Partnerships with health initiatives
Local Council on Aging	Susan Carp Nava Niv-Vogel Susan Pacheco Mary Beth Duffy Cindy Hickey Anne Marie Gagnon	Local Senior Centers	Partnerships with Health Education Programming and health screening

2. 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)

[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.

Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Involve	The community continues to be involved in giving feedback to the hospital and hospital CBAC committee.	Involve
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Consult	MAH has been working to inform and consult with its CBAC on the proportion of CB resources allocated to different priorities	Involve
Implementing Community Benefits programs	Collaborate	This year was the second year of the new implementation strategy and MAH was able to collaborate with the community on new and existing programs.	Collaborate
Evaluating progress in executing Implementation Strategy	Consult	BILH Community Benefits is working with all hospitals to build staff and community evaluation capabilities. MAH will be collaborating with the community on evaluation of CB programming and the execution of its Implementation Strategy	Collaborate
Updating Implementation Strategy annually	Consult	2020 was the second year of the new implementation strategy. MAH will be executing its CHNA this year so will create a new IS in FY21 and work with its CBAC, its community partners in creating a new IS which will be informed by our CHNA as appropriate.	Involve

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

MAH has a comprehensive implementation strategy to respond to identified community health priorities. This was a challenging year with COVID 19 creating hardships for many including hospital staff and operations. The hospital had to focus completely on a COVID 19 response for the months of March 2020 – August 2020. MAH continued to engage with the CBAC and the community to identify and select priorities during the pandemic in order to respond to our community's greatest needs. During the FY 21 CHNA process, MAH will make the IS available to participants, highlight new programs, priorities and activities, and seek input from the community.

3. 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.

No. Our plan was for our June meeting to be an open meeting to the public. Our June meeting was canceled due to the pandemic.

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.

The City of Cambridge completed it's CHNA during FY20 and is working on developing its Implementation Strategy during FY21. MAH participates in the working group developing the Implementation Strategy.

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.**

Mount Auburn Hospital is part of the Beth Israel Lahey Health (BILH) system community health improvement planning process. In 2019, BILH formed a system-wide Community Benefits Committee (CBC). This Committee provides strategic direction for all 10 BILH hospitals and its affiliates and seeks to ensure that strategies are in place to meet the health care needs of atrisk, underserved, uninsured, and government payer patient populations in the communities. Guided by the CBC, 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. As a system, BILH came together to meet the needs of patients hospitalized with COVID. In addition to treating the critically ill, BILH hospitals collaborated with one another and with many community organizations on supply and resource distribution. All BILH hospitals reacted to urgent and unforeseen needs by restructuring/realigning Community Benefits programs to meet emerging and ongoing issues and challenges related to the pandemic.

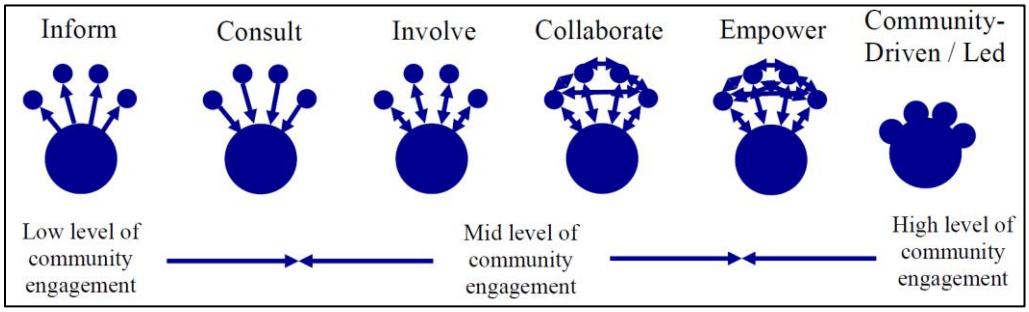
SECTION VIII: COMMUNITY REPRESENTATIVE FEEDBACK FORM

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.



[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.

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 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.