Community Benefits Report

Fiscal Year 2021

Beth Israel Lahey Health
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 Benefits program within our service area. The mission of MAH's Community Benefits department 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, priority 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's 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.

Priority Populations

MAH's CBSA includes Arlington, Belmont, Cambridge, Somerville, Waltham and Watertown. MAH's FY21 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 FY21 CHNA also identified the following high need segments of the population; Black, Indigenous, and People of Color (BIPOC), Older Adults, LGBTQ+ populations, and Immigrants and or Dual-Language Learners. 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, per the Commonwealth's updated Community Benefits guidelines, MAH's Implementation Strategy will focus on the following most at-risk priority populations in the hospitals service area – Black, Indigenous, and People of Color (BIPOC), Older Adults,

LGBTQ+ populations, Immigrants and or Dual-Language Learners and Individuals Experiencing Material Poverty.

Basis for Selection
Community health needs assessments; public health data available from government and private resources (foundations, advocacy groups) and MAH's areas of expertise.

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):

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

- Increased the capacity of Community Health Network Area 17 (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.
- Provided funding to local health departments to increase their capacity to address the top health concerns identified in MAH's most recent CHNA and in their community.
- Created a virtual healthy aging education program for older adults.
- Reduced food insecurity through providing food for distribution to those who have been severely impacted by the COVID–19 pandemic.
- Contributed to supporting an increase in SNAP Match enrollments for use at farmer's markets within our service area by collaborating with cities and towns to promote enrollment.
- Promoted transportation equity.
- Developed a partnership with Metro Housing|Boston to address housing stability
- Promoted cross-sector collaboration and partnerships.
- In order to increase access to mental health services, MAH has implemented the Collaborative Care model, a nationally recognized primary care–led program that specializes in providing behavioral health services in the primary care setting. The services, provided by a BILH licensed behavioral health clinician, include counseling sessions, phone consultations with a psychiatrist, and coordination and follow-up care. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treat a variety of medical and mental health conditions.

Plans for Next Reporting Year

In FY21, MAH conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included qualitative and quantitative data collection, robust community engagement activities, and an inclusive prioritization process. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY19. In response to the FY21 CHNA, MAH will focus its FY22 - 24 Implementation Strategy on five priority areas; these priority areas collectively address the broad range of health and social issues facing residents living in MAH's CBSA who face the greatest health disparities. These five priority areas are:

- Mental Health and Substance Use Disorder
- Chronic and Complex Conditions and their Risk Factors
- Access to Care and Community Navigation
- Social Determinants of Health
- Racial Equity

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 FY21 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions being used to inform and refine MAH's efforts. In completing the FY21 CHNA and FY22 - 24 Implementation Strategy, MAH, along with its other health, public health, social service, and community partners, is committed to improving the health status and well-being of all residents living throughout its CBSA. As discussed above, based on the CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that MAH's FY22-FY24 Implementation Strategy should prioritize certain demographic, socio-economic, and geographic population segments that have complex needs and face barriers to care and service gaps, as well as other adverse social determinants of health. These factors put these segments at greater risk, limit their access to needed services, and can often lead to disparities in health outcomes. More specifically, the FY21 CHNA identified the importance of supporting initiatives that target Black, Indigenous, and People of Color (BIPOC), Older Adults, LGBTQ+ populations, Immigrants and or Dual-Language Learners and Individuals Experiencing Material Poverty.

It is important to note that the bulk of the assessment was conducted from September 2020 through February 2021 at the time of the COVID-19 pandemic. Simultaneously, social unrest in response to racial inequities, spurred by the killing of George Floyd on March 25, 2020, highlighted the impact of racism and inequality. In fact, much of the assessment was geared

to better understanding the impacts of COVID-19, racism, and existing inequities so that MAH, along with its partners, could better tailor and target its community benefits investments.

MAH will continue to collaborate with dozens of community-based 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 organizations and 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.

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 [insert page number]. MAH's 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 (CBAC)
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 corporate and non-profit community organizations. Senior management is actively engaged in the development and implementation of the Community Benefits plan, ensuring that hospital policies and resources are allocated to support planned activities.

It is not only the Board of Trustee 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 program is 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 BILH. While MAH oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure ensures that Community Benefits efforts, prioritization, planning, and strategy align and are integrated with local and system strategic and regulatory priorities.

All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital have worked together to plan, implement, and evaluate Community Benefits programs. Staff have worked together to plan the FY22 Community Health Needs Assessment, understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH, in partnership with MGB, has developed a Community Benefits (CB) database. This database is part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.

The Director of Community Benefits spearheads the MAH Community Benefits program. 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 Diversity, Equity and Inclusion Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of underserved populations are considered every day in discussions on resource allocation, policies, and program development.

This is the structure and methodology employed to ensure that Community Benefits is not the purview of one office alone and to maximize efforts across the organization to fulfill the mission and goals of Community Benefits.

Community Benefits Advisory Committee (CBAC) Meetings
The MAH Community Benefits Advisory Committee met on the following dates:
December 4, 2020
February 25, 2021
April 30, 2021
June 25, 2021
September 30, 2021

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 currently supports dozens of educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA. In this work, MAH collaborates with many of its local community based organizations, public health, municipalities and social service organizations. MAH has a particularly strong relationship Charles River Community Health in Waltham. This relationship includes providing a strong OB/GYN and Midwifery program there particularly supporting Latina women through pre and post-natal care including outreach and home visits. Other support to CRCH includes providing financial counselors, lab tests and IT support.

CRCH is an ideal Community Benefits partner because it is rooted in its communities and, as a federally qualified health center, it is mandated to serve low-income, underserved populations.

MAH is also an active participant in the CHNA 17. Joining with such grass-roots community groups and residents, gives MAH an opportunity to participate in listening to community needs as well as helping to implement impactful change. CHNA 17's focus intersects racial justice and mental health.

MAH's Board of Trustees and leadership team, and 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 leadership team, 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 Form (Section VII, page 86).

Community Partners

American Cancer Society	Lifeline In Home Services at Mount Auburn
Arlington Youth Health and Safety Coalition	Live Well Watertown
Arlington Council on Aging	Marino Foundation
Arlington Eats	Mass. Institute of Technology EMS
Arlington Fire Department	Massachusetts Bay Transit Authority
Arlington Health and Human Services	Meadowgreen Rehabilitation and Nursing
Arlington Housing Authority	Metro Cab of Boston

Arlington Police Department	Neville Place
Arlington Youth Counseling Center	Professional Ambulance EMS
Belmont Council on Aging	Schenderian Pharmacy
Belmont Department of Public Health	SCM Community Transportation
Belmont Fire Department	Somerville Cambridge Elder Services
Belmont First Armenian Church	Somerville Center for Adult Learning Experiences (SCALE)
Belmont Food Pantry	Somerville Council on Aging
Belmont Housing Authority	Somerville Health and Human Services
Belmont Police Department	Somerville Homeless Coalition
BILH at Home	Somerville Housing Authority
Cambridge Community Foundation	Somerville Police Department
Cambridge Community Learning Center	Somerville Stakeholders Coalition
Cambridge Council on Aging	Springwell Elder Services
Cambridge Department of Public Health	Town of Arlington
Cambridge Fire Department	Town of Belmont
Cambridge Health Alliance	Town of Watertown
Cambridge Housing Authority	Waltham Connections
Cambridge Police Department	Waltham Council on Aging
Cambridge SNAP Match Coalition	Waltham Family School
CASPAR INC.	Waltham Fields Community Farm
Charles River Community Health Center	Waltham Health Department
City of Cambridge	Waltham Housing Authority
City of Somerville	Waltham Interagency Group
City of Waltham	Waltham Partnership for Youth
Community Health Network Area 17 (CHNA 17)	Waltham Police Department
Elder Services of Merrimack Valley	Watertown Cares
Food Link Inc.	Watertown Council on Aging
Greater Boston Food Bank	Watertown Fire Dept.
Harvard University EMS	Watertown Health Department
Healthy Living Center of Excellence	Watertown Housing Authority
Healthy Waltham	Watertown Police Department
Housing Corp. of Arlington	Watertown Public Schools
Lexington Fire Department	Wayside Youth and Family Services

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY21 Community Health Needs Assessment (CHNA) along with the associated FY22-FY24 Implementation Strategy was developed over a ten-month period from September 2020 to July 2021. 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 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 FY21. FY21 Community Benefits programming was informed by the FY18 CHNA and aligns with MAH's FY19 - FY21 Implementation Strategy. The following is a summary description of the FY21 CHNA approach, methods, and key findings.

Approach and Methods

In FY21 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 as well as an internal Community Benefit working group worked closely throughout the entire process with staff members from John Snow Inc. in order to complete the project.

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 and included broader community engagement activities. This included additional interviews with community stakeholders and health departments. Focus groups were conducted and included a wide range of populations and a variety of perspectives. 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 process.

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. Phase III involved the CBAC as well as hospital leadership in activities to prioritize the leading health issues and populations identified.

Key Informant Interviews with Internal and External Stakeholders. JSI conducted key stakeholder interviews with 23 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 by videoconferencing using a standard interview guide. Interviews focused on identifying major health issues and possible strategies to address those concerns and opportunities, as related to priority populations.

Focus Groups. JSI conducted a series of seven community and provider focus groups to gather critical community input from service providers, community leaders and residents within MAH's service area. 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.

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.

It is important to note the FY21 CHNA was conducted entirely during the COVID-19 pandemic and every effort was made to hear from a wide range of community members. The COVID – 19 pandemic limited opportunities to engage people in person at community settings. All meetings, interviews and focus groups were completed via video conferencing and participants were engaged in virtual activities.

The MAH CBAC was also integrally involved in providing input on community need and prioritizing the leading health issues. The CBAC met four times during the course of the assessment to refine the approach, provide input regarding the assessment, and to guide the prioritization and planning phase. MAH leadership also had an opportunity to provide input as preliminary findings were presented to them; leadership provided feedback and priority health issues were discussed. Please refer to the FY21 CHNA for a full listing of community engagement activities. It is posted on the MAH website at https://www.mountauburnhospital.org/about-us/community-health/

Summary of Key Health-Related Findings from FY21 CHNA

The key priority populations identified through the FY21 CHNA process were:

- Black, Indigenous, and People of Color (BIPOC)
- Older Adults
- LGBTQ+ Community

- Immigrant and/or Dual-Language Learners
- Individuals Experiencing Material Poverty

The key Community Health Priorities identified through the FY21 CHNA process were:

- Racial Equity

It is important to understand that achieving racial equity benefits all of society. Prioritizing the needs of certain populations should not be viewed as neglecting others, but rather prioritizing seeks to address disproportionate needs, which in turn improves overall access and quality of life for everyone. Racism is interlinked with other systemic issues, therefore in pursuing race-related concerns other health equity concerns related to gender, age, ability, etc. are not devalued, but rather more thoroughly addressed through an intersectional approach.

MAH is committed to addressing systemic racism to ensure that the root causes to inequities are addressed in a collaborative and thoughtful way, ensuring sustainability and effective change.

- Social Determinants of Health

The social determinants of health, particularly housing, transportation, and food insecurity, have a tremendous impact on residents within MAH's CBSA, especially those who are low to moderate income. The social determinants of health are often the drivers of our underlying factors that create or exacerbate mental health issues, substance misuse, and chronic and complex conditions. These social determinants of health, particularly poverty, also underlie many of the access-to-care issues that were prioritized in the assessment: navigating the health system (including health insurance), chronic disease management, and affording care.

MAH is committed to addressing social determinants and breaking down barriers to care. The hospital will continue to collaborate with community-based organizations to engage individuals in services, reduce financial burdens, increase access to appropriate primary and specialty care services, and support healthy families and communities. MAH is also committed to strengthening the local workforce and exploring opportunities for the hospital to address local unemployment issues.

- Chronic/Complex Conditions and their Risk Factors

Heart disease, stroke, and cancer continue to be the leading causes of death in the nation and the commonwealth and place a significant burden on communities. Approximately six in 10 deaths can be attributed to these three conditions combined. If respiratory disease (e.g., asthma, COPD) and diabetes, which are two of the top 10 leading causes of death across all geographies, are included, one can account for most causes of death.

Many of the risk factors for these conditions are the same – physical inactivity, poor nutrition, obesity, and tobacco/alcohol use. MAH has a long history of working with community partners to create awareness of and education about risk factors and their links to chronic and complex health conditions. The hospital will continue to support programs that provide opportunities for people to access low-cost, healthy foods. Beyond addressing the risk factors, MAH is also committed to providing screening and educational opportunities, supporting individuals and caregivers throughout the service area to engage in chronic disease management programs and supportive services (e.g., integrative therapies, support groups), and providing links to care.

- Access to Care and Community Navigation

Issues regarding health care access, navigation, and communications continue to impact residents within MAH's CBSA, especially youth, those without easily attainable transportation, and those learning English as a second language. Many key informants and focus group participants identified a lack of understanding on the various services that MAH provides as well as social services that are available in the hospital's CBSA.

MAH will continue to promote cross communication and increase access to community resource information and navigation.

- Mental Health and Substance Use Disorder

As it is throughout the Commonwealth and the nation, the burden of mental health and substance use on individuals, families, communities, and service providers in MAH's CBSA is overwhelming. Nearly every key informant interview and focus group included discussions on these topics. From a review of the quantitative and qualitative information, depression, anxiety/stress, and social isolation were the leading issues in this domain. There were concerns regarding the impact of depression, anxiety, and e-cigarette use/vaping on youth and social isolation among older adults.

MAH recognizes the importance of primary prevention – the hospital will continue to work with community partners to offer educational programs around mental health and substance misuse. The hospital will also promote collaboration, share knowledge, and coordinate activities with internal colleagues and external partners. MAH will continue to increase access to navigation and other supportive services for those with mental illness and or substance use. MAH will continue to partner and collaborate with community-based organizations that work with older adults to reduce social isolation and enhance access to supportive services.

The CHNA which was completed in FY21 will inform the work conducted in FY22, FY23 and FY24.

This Community Benefit Report is based on the FY18 CHNA and the Implementation Strategy developed for FY19, FY20 and FY21.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Community Benefits Programs

Bereavement 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	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	Support Group
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.	3 eight week long sessions were completed and 40 community members attended	Process Goal	Year 1 of 1

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Not Specified
Health Issues	Health Behaviors/Mental Health-Bereavement
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

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 an ongoing support group for caregivers.	An ongoing support group was provided for caregivers to drop in anytime	Process Goal	Year 1 of 1
Caregiver support group will meet twice a month.	The caregiver support group met two times per month for 1.5 hours per session	Process Goal	Year 1 of 1

Provide support for at least 12 caregivers.	16 caregivers attended at least one or more caregiver support group sessions	Process 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

Co-Location Program – Social Determinants of Health	
Program Type	Community-Clinical Linkages
Program is part of a grant or funding provided to an outside organization	No
Program Description	MAH began a partnership this year with Metro Housing Boston (MHB). This year was a planning year. The goal is to improve access for patients and community members to community resources and to help with case management for our most vulnerable patients. The Co-Location program will provide free counseling services to individuals and families to help them increase housing stability and economic self-sufficiency and improve their overall quality of life.
Program Hashtags	Not Specified
Program Contact Information	Kathy Howard 330 Mount Auburn Street, Cambridge, MA 02138

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Partner with Metro Housing Boston (MHB) to provide transitional assistance to patients who are housing insecure/unstable.	Met with the staff of MHB regularly to learn about the CO-Location program of MHB and to determine if community members would benefit from a partnership with MHB	Process Goal	Year 1 of 1
The project team at MAH will work with Metro Housing Boston to agree on a Memorandum of	MAH and MHB agreed on a Memorandum of Understanding and a Contract that will begin in FY22 to start the Co-Location program at MAH	Process Goal	Year 1 of 1

Understanding and a Contract in which both parties agree on the terms of the collaboration between MAH and Metro Housing Boston by September 30, 2021			

EOHHS Focus Issues	Housing Stability/Homelessness
DoN Health Priorities	Built Environment, Housing, Social Environment
Health Issues	Health Behaviors/Mental Health-Bereavement, Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Stress Management, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Homelessness, 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:** Not Specified • **Race/Ethnicity:** Not Specified • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website

Metro Housing Boston	https://www.metrohousingboston.org/

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 working group, CHNA 17, Watertown Cares, Waltham Interagency Network, Cambridge Health Alliance Community Health Advisory Committee, Cambridge Community Stakeholders, and Somerville Community Stakeholders. These meetings reach many community members and organizations. Partners listed are a sampling of organizations. Due to the pandemic many of these meetings were shifted to virtual meetings.
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

MAH staff to attend 40 community coalition and or task force meetings	MAH staff attended over 50 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	MAH staff attend community coalition and or community task force meetings in its service area	Process Goal	Year 1 of 1
Provide technical assistance and information sharing	MAH provided technical assistance and shared information in order to aid in helping community organizations and residents navigate the health care system	Process Goal	Year 1 of 1

EOHHS Focus Issues	Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities	Social Environment
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
Watertown Police Department	www.ci.watertown.ma.us/
Healthy Waltham	http://www.healthy-waltham.org/
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/
Waltham Interagency Network - Watch CDC	https://watchcdc.org/
Wayside Youth and Family Support	https://www.waysideyouth.org/

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 MAH'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.

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
To build the capacity of local DPHs (or their designee) to address health concerns identified in the 2018 community need assessment.	Provided our service area cities and towns with non-competitive grant funds to address the health concerns identified in the 2018 Community Health Needs Assessment	Process Goal	Year 1 of 1
In Arlington: Provide 10 older adults who are low-income and unable to connect to the internet with Chromebooks and access to a mobile internet hotspot.	Distributed 10 Chromebooks to those who otherwise would not be able to connect to the internet and provided hot spots for connectivity.	Outcome Goal	Year 1 of 1
In Arlington: Provide internet access to older adults who would not otherwise have the connection to virtual networks	Distributed 10 mobile hot spots to area where older adults were unable to connect to the internet because of financial hardships.	Outcome Goal	Year 1 of 1
In Arlington: Monitor data usage per hot spot	Monthly monitoring showed an average of 43 GB per month of data usage per hotspot and 7 of the 10 individuals have used the devices to access Council on Aging virtual programming.	Outcome Goal	Year 1 of 1

In Cambridge: Create a 5 year improvement plan for the Food Pantry Network	Based on analysis of this Assessment a 5 year strategic plan for the Food Pantry Network was created for the 2021 Citywide Cambridge Community Health Improvement Plan.	Outcome Goal	Year 1 of 1
In Cambridge: Create an assessment tool to evaluate the food pantry system in Cambridge	An assessment was created and administered and recommendations were created for the Food Pantry Network.	Outcome Goal	Year 1 of 1
In Somerville: Provide the weekly Ageless Grace evidenced based program to at least 30 older adults.	32 older adults participated in this program.	Process Goal	Year 1 of 1
In Somerville: At least 50% of participants will increase their physical strength	100% of participants reported that by participating in the Ageless Grace program they increased their physical strength.	Outcome Goal	Year 1 of 1
In Somerville: Provide a space for older adults to feel comfortable with a virtual program and decrease the feeling of social isolation.	100% of participants reported they felt comfortable with the program and felt more engaged with their peers therefore decreasing the feeling of social isolation.	Outcome Goal	Year 1 of 1
In Waltham: Provide food to at least 15 families who identified themselves as food insecure during a 6 week isolation period during the pandemic.	Food was provided for 20 families where English is their second language and food was difficult for them to secure both financially and logistically during this isolation period.	Outcome Goal	Year 1 of 1
In Waltham: Increase the health departments ability to provide fresh	A refrigerator was purchases to store fresh food and produce before	Process Goal	Year 1 of 1

food and produce for food insecure families.	distribution in order to increase shelf life of food.		
In Watertown: Research and create a Live Well Watertown and a Watertown Cares Brochure for distribution. These brochures goal is to educate residents on healthy living as well as substance use resources in the community.	Both Brochures completed and over 1,000 print copies as well as an electronic version created and distributed. This information shared on the website and social media handles.	Outcome Goal	Year 1 of 1
In Watertown: Support and train 25 volunteers to help with COVID - 19 vaccination clinics throughout the town of Watertown.	28 volunteers trained and supported the vaccination effort throughout the town.	Process Goal	Year 1 of 1
In Watertown: Create and support a "Walk with the Doc" health education program.	Created and managed a "Walk with the Doc" program which benefitted 30 - 40 people weekly throughout the spring and fall months.	Process Goal	Year 1 of 1

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, Infectious Diseases COVID-19, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Education/Learning, Social Determinants of Health-Homelessness, Social Determinants of Health-Racism and Discrimination, 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:** Adults, All, Elderly, • **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

Collaborative Care - Mental Health	
Program Type	Direct Clinical Services

Program is part of a grant or funding provided to an outside organization	No
Program Description	In order to increase access to mental health services, MAH has implemented the Collaborative Care model, a nationally recognized primary care led program that specializes in providing behavioral health services in the primary care setting. The services, provided by a BILH licensed behavioral health clinician; include counseling sessions, phone consultations with a psychiatrist, and coordination and follow-up care. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treat a variety of medical and mental health conditions.
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
To increase access to behavioral health services	Provided behavioral health services to 511 patients across 7 sites.	Process Goal	Year 2 of 3

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Not Specified
Health Issues	Health Behaviors/Mental Health-Mental Health,

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

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. MAH provides an EMS medical director who works with affiliated EMS services to provide credentialing, continuous review/quality assurance, and education for affiliated community EMTs and paramedics. This involves protocol reviews, medical control, monthly education sessions, and other educational opportunities.
Program Hashtags	Health Professional/Staff Training,
Program Contact Information	Dr. William Porcaro Mount Auburn Hospital 330 Mount Auburn Street Cambridge, MA 02138

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
MAH ED Physicians will 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.	MAH ED Physicians provided monthly peer review sessions.	Process Goal	Year 1 of 1
MAH Physicians serve as EMS Medical Directors to local cities and towns.	MAH physicians served 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 provided monthly education sessions to Cambridge, Arlington, Belmont Watertown Fire departments. A total of 20 - 30 staff were 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.	Emergency Department physicians served 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

Community Health and Wellness Program - Chronic and Complex Conditions	
Program Type	Total Population or Community-Wide Interventions

Program is part of a grant or funding provided to an outside organization	No
Program Description	The Community Health and Wellness program provides health education opportunities for our community members. This program offers free wellness classes. The goal of this program is to improve the health and wellbeing of the community members we serve with a particular interest in those who have been diagnosed with cancer.
Program Hashtags	Community Education, Prevention,
Program Contact Information	Mary DeCourcey 330 Mount Auburn Street, Cambridge, MA 617-499-5625

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide a series of free health and wellness classes for community members in particular for those diagnosed with or surviving cancer.	A series of classes were conducted throughout the year. A total of 85 community members participated through a Zoom platform virtually.	Process Goal	Year 1 of 1
At least 85% of those participating in at least one of the Community Health and Wellbeing classes will report that they will be able to take the knowledge and skills they learned to improve their overall health and wellbeing.	Over 90% of those participating in one or more of the classes offered reported that they will be able to take the knowledge and skills they learned to improve their overall health and wellbeing.	Outcome Goal	Year 1 of 1

Provide 2 sessions of the evidenced based Mindfulness Based Stress Reduction Class (MBSR).	Provided 2 sessions of the evidenced based MBSR Class and 100% of participants reported receiving something of lasting value by taking this class.	Outcome Goal	Year 1 of 1
At least 85% of participants in the Weight Loss Strategies for Breast Cancer Patients Class report they are able to take away at least one tip that they learned to help them maintain a healthier lifestyle.	100% of participants reported after the class that they will take away at least one tip that they learned to help them maintain a healthier lifestyle.	Outcome Goal	Year 1 of 1
At least 85% of participants in the Ancient Medicine for Modern Ailments class will report that they increased their confidence level in the alternative therapies discussed during the class.	100% of participants in Ancient Medicine for Modern Ailments class reported that they increased their confidence level in the alternative therapies discussed during the class.	Outcome Goal	Year 1 of 1
At least 50% of participants in the Nutrition and Cancer Prevention, Myths and Facts Class will report that they were more likely to change their behaviors to improve their eating habits.	Greater than 50% of participants in the Nutrition and Cancer Prevention, Myths and Facts Class reported that they were more likely to change their behaviors to improve their eating habits after taking the class.	Outcome Goal	Year 1 of 1

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Mental Illness and Mental Health,

DoN Health Priorities	Not Specified
Health Issues	Cancer-Breast, Cancer-Other, Chronic Disease-Overweight and Obesity, Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Stress Management,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** Adults, • **Race/Ethnicity:** All, • **Language:** English, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

Doula Program - Access to Healthcare

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	No

Program Description	This program offers a free certified Doula for Charles River Community Health patients for continuous physical, emotional and informational support to a mother before, during and shortly after childbirth. When a request is made through our prenatal program for Doula support from a woman who otherwise would not be able to afford a Doula the coordination of care is provided.
Program Hashtags	Community Health Center Partnership,
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 Doula support for at least 20 deliveries for those who qualify and request this support.	Provided Doula support for 15 births. We were not able to meet this goal due to the limited visitors and support persons allowed at the hospital during COVID restrictions.	Outcome Goal	Year 2 of 5
Provide a Doula for historically underserved 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 2 of 5

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Built Environment, Social Environment,
Health Issues	Maternal/Child Health-Reproductive and Maternal Health, Other-Cultural Competency, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Uninsured/Underinsured,

Target Populations	• **Regions Served:** Waltham, • **Environments Served:** Suburban, Urban, • **Gender:** Female, • **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	https://www.charlesriverhealth.org

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Food Insecurity - 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	Using our purchasing power, MAH purchases healthy foods and fresh produce and delivers to local markets in our service area which provides free food to community members in need.
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 nutritious, healthy foods including eggs to local food distribution locations to support those most affected by the pandemic.	A total of 1330 dozen eggs, 1300 loaves of whole grain bread, 684 cartons of orange juice, 216 jars of peanut butter and 624 cans of beans distributed to families in need.	Process Goal	Year 1 of 1

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Built Environment, Social Environment,
Health Issues	Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Nutrition,
Target Populations	• **Regions Served:** Waltham, • **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
Healthy Waltham	https://healthywaltham.org

Free Mammography Screening - 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.
Program Hashtags	Community Health Center Partnership, Health Screening,
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
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	Process Goal	Year 1 of 1

screening for women who have limited access to mammography screening.			
Provide free mammography screening and follow up to women who have limited access to mammography screening.	5 women screened with a mammogram and due to the results, no follow up was necessary for any of the women.	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, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Uninsured/Underinsured,
Target Populations	• **Regions Served:** Waltham, • **Environments Served:** Suburban, Urban, • **Gender:** Female, Transgender, • **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

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	Community Health Center Partnership,
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	4 full time equivalents (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

public assistance programs.			
Facilitate connection to health care by providing Certified Application Counselors to work on site at Charles River Community Health Center, Waltham.	1.81 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, Social Determinants of Health-Uninsured/Underinsured,
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

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	To address the Health Equity and Food Access, MAH provides grants for organizations who are working to reduce food insecurity. This year MAH worked with a number of food coalitions and mobile markets to help them increase their capacity to provide our service area residents with increased access to healthy foods.
Program Hashtags	Not Specified
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
Provide grant funding to local organizations for the purpose of increasing access and consumption of fresh food to food insecure customers.	Provided grant funding to local organizations for the purpose of increasing access and consumption of fresh food to food insecure customers.	Outcome Goal	Year 1 of 1

In Arlington: Greater than 50% of participants will be able to obtain foods that are not normally in their budget.	62% of participants reported eating foods that are not normally in their budget.	Outcome Goal	Year 1 of 1
In Arlington: For those who use the voucher program greater than 90% will report eating more fresh foods than they did before the voucher program was available.	91 % of respondents reported eating more fresh foods than they did before the voucher program was available.	Outcome Goal	Year 1 of 1
In Arlington: Over 50% will report eating a wider variety of foods after participating in the voucher program.	62% of respondents reported eating a wider variety of food since participating in the voucher program.	Outcome Goal	Year 1 of 1
In Arlington: Increase access and consumption of fresh food to food insecure customers.	This program served over 245 households who were clients at Arlington Eats. $15 vouchers were distributed to clients to access fresh, locally grown, produce, meat, and breads at the Arlington Farmer's Market.	Process Goal	Year 1 of 1
In Arlington: Increase the amount of food at home for participants in the voucher program.	72% of respondents reported they have more to eat at home.	Outcome Goal	Year 1 of 1
In Arlington: Support local farms by providing vouchers to the farmer's market for food insecure individuals.	Through this program, MAH supported local farms by providing vouchers to the farmer's market to food insecure individuals.	Process Goal	Year 1 of 1
In Belmont: Increase the SNAP match individual users (Belmont Food Collaborative) by 20%.	The Belmont Food Collaborative increased their SNAP Match program by 20% (compared to FY20) for those who shop at the Belmont Farmer's Market.	Outcome Goal	Year 1 of 1

In Cambridge: Increase SNAP match benefits issued to individual users by 20%.	The Cambridge SNAP Match Coalition saw an increase of SNAP Match benefits issued by 43% in 2021 compared to 2020.	Outcome Goal	Year 1 of 1
In Waltham: Support the outreach farmer funds to help purchase the seeds and pay for labor of the new seasonal position at the Waltham Fields Community Farm and who manages the free box share program to food insecure residents.	Supported the outreach farmer in order to continue the work of the box share program.	Process Goal	Year 1 of 1
In Waltham (Waltham Fields Community Farm): Contribute to the 100 box shares of fresh produce delivered weekly (13 weeks of season) to housing authority neighborhoods, which were low-income.	Contributed to the 100 box shares of fresh produce delivered weekly to housing authority neighborhoods, which were low income (13 week program).	Process Goal	Year 1 of 1
In Waltham: Provide food and staples for 10 weeks of the growing season to add to the CSA boxes WFCF provided through their prescription produce program.	Provided 10 dozen jars of peanut butter, 10 dozen cans of cannellini or black beans, 10 dozen bottles of orange juice, 10 dozens loaves of whole grain fresh bread.		
In Waltham: Provide hand sanitizer, face masks and other household items to the CSA boxes throughout the season.	Provided hand sanitizer, face masks and other household items to supplement the CSA boxes.		

In Watertown: Increase education and outreach efforts to reach food insecure residents who are not aware of the farmer's market assistance program.	Outreached to town affordable housing facilities and created and distributed additional educational materials.	Process Goal	Year 1 of 1
In Watertown: Increase SNAP match benefits issued to individual users by 50%.	In Watertown: The number of recipients of the SNAP Match program increased by 50% in 2021 compared to 2020.	Outcome 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

Arlington EATS	https://www.arlingtoneats.org/
Waltham Fields Community Farm	https://communityfarms.org/
Cambridge SNAP Match Coalition	http://cambridgecf.org/portfolio-items/snap-match-cambridge/
Charles River Community Health	https://www.charlesriverhealth.org/
Belmont Food Collaborative	https://www.belmontfood.org
Watertown Health Department	https://www.watertown-ma.gov/184/Health

Healthy Aging Program - Healthy Aging

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 program provides monthly health and wellness education specifically geared towards our older adult population. Collaboration occurs between MAH, the Councils on Aging and ASAPs within the hospitals service area.
Program Hashtags	Prevention,
Program Contact Information	Not Specified

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Host the Elder Services Provider meeting at least two times in FY2021	Met 3 times in FY21	Process Goal	Year 1 of 1
Provide at least 6 health education presentations geared towards older adults in order to increase knowledge and improve their health and wellbeing.	6 presentations were coordinated and presented over a zoom platform with a total of 198 older adults in attendance (all 6 sessions)	Process Goal	Year 1 of 1
At least 80% of participants report after the presentation that they gained new knowledge on the topic presented	80% of participants reported that they gained new knowledge on the topic presented	Outcome Goal	Year 1 of 1
At least 80% of participants will report that they will be able to take what they learned in the presentation to improve their own health and wellbeing	100% of participants reported after each presentation that they will be able to take what they learned in the presentation to improve their own health and wellbeing	Outcome Goal	Year 1 of 1

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Not Specified

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

Partners:

Partner Name and Description	Partner Website
Arlington Council on Aging	https://www.arlingtonma.gov/departments/health-human-services/council-on-aging
Belmont Council on Aging	https://www.belmont-ma.gov/council-on-aging
Cambridge Council on Aging	https://www.cambridgema.gov/dhsp/programsforadults/seniorscouncilonaging
Somerville Council on Aging	https://www.somervillema.gov/departments/health-and-human-services/council-aging

Waltham Council on Aging	https://www.city.waltham.ma.us/council-on-aging
Watertown Council on Aging	https://www.watertown-ma.gov/284/Council-on-Aging-Senior-Center
Springwell	https://springwell.com/
Somerville Cambridge Elder Services	https://eldercare.org/

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 (ASAP) and provides the emergency response services (Lifeline) below cost to over 1,000 underserved elders and disabled persons who are in need, as identified by our regional elder services agencies.
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 emergency response systems at low cost to at least 1000 lower socioeconomic elders and disabled adults.	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

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/

Infrastructure to Support Community Benefits Collaborations Across BILH Hospitals	
Program Type	Infrastructure to Support CB Collaboration
Program is part of a grant or funding provided to an outside organization	No
Program Description	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital have worked together to plan, implement, and evaluate Community Benefits programs. Staff have worked together to plan the FY22 Community Health Needs Assessment, understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH, in partnership with MGB, has developed a Community Benefits (CB) database. This database is part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.
Program Hashtags	Health Professional/Staff Training,
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
By September 30, 2021, in partnership with MGB, create and implement a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits Committee data to more accurately capture and quantify CB/CR activities and expenditures.	All 20 BILH Community Benefits staff were trained on the Community Benefits Database and began data entry for FY20 regulatory reporting.	Process Goal	Year 1 of 2
By September 30, 2021, increase the capacity of BILH Community Benefits staff to understand program evaluation through workshops and case studies.	All 20 BILH Community Benefits staff participated in 6 evaluation workshops on SMART Goals, Logic Models, process and outcome evaluations, and program improvement.	Process Goal	Year 1 of 2

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Not Specified
Health Issues	Not Specified
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown, • **Environments Served:** Suburban, Urban,

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

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

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.
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 (ASL).	Provided 15,265 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	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

Navigating the Health Care System - Access to Healthcare

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	No
Program Description	This program provides presentations to local English Language Learners programs in the hospital's service area. This presentation gives an overview of our health care system and how to navigate through the system as well as giving these adult learners information on how to advocate for themselves and their families. Information on patient rights is also reviewed. The goal is to provide an educational forum that will empower those who historically experience health disparities and help to improve access. An interpreter was provided when requested and or needed to aid in the learning experience.
Program Hashtags	Community Education,
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 education for navigating the health care system to at least 25 Adult English Language Learners.	A total of 50 English Language Learners participated in the "Navigating the Healthcare System" presentations.	Process Goal	Year 1 of 1
At least 85% of those who participated in the "Navigating the Healthcare System" presentations report that they will be able to take what they learned and use it to help them navigate the health care system better after participating in the program.	94 % of participants reported that they will be able to take what they learned and use it to help them navigate the health care system better after participating in the program.	Outcome Goal	Year 1 of 1
At least 85% of those who participated in the "Navigating the Healthcare System" presentations report that they learned some new information about how to access their doctor or the healthcare system.	89% of those who participated in the "Navigating the Healthcare System" presentations reported that they learned some new information about how to access their doctor or the healthcare system.	Outcome Goal	Year 1 of 1

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Built Environment, Social Environment,

Health Issues	Social Determinants of Health-Access to Health Care, Social Determinants of Health-Education/Learning, Social Determinants of Health-Language/Literacy,
Target Populations	• **Regions Served:** Cambridge, Somerville, Waltham, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** Adults, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
Waltham Family School	https://walthamfamilyschool.org
Cambridge Learning Center	https://www.cambridgema.gov/dhsp/programsforadults/communitylearningcenter
Somerville Center for Adult Learning Experiences (SCALE)	https://somerville.k12.ma.us/adult-learning/somerville-center-adult-learning-experiences-scale

Patient Clothing Closet - Social Determinants of 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 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 for 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.	Provided emergency clothing 24 hours a day for patients in need upon discharge from an inpatient location or the emergency department.	Process Goal	Year 1 of 1

EOHHS Focus Issues	Housing Stability/Homelessness,

DoN Health Priorities	Built Environment,
Health Issues	Social Determinants of Health-Access to Health Care, Social Determinants of Health-Homelessness, 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:** Adults, • **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 or have access to medication when being discharged from the hospital.	Provide free medications for our most vulnerable population who otherwise would not be able to pay for or have access to medication when being discharged from the hospital.	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	Yes
Program Description	This program provides a prenatal/postpartum community outreach worker at the Charles River Community Health Center who helps patients navigate the health care system and provide support and for families navigating and enrolling in government benefit programs. Along with the navigational support this outreach work provides emotional support during the post-partum period as well.

	This outreach worker is the bridge between hospital social workers and behavioral health.
Program Hashtags	Community Health Center Partnership,
Program Contact Information	Mary DeCourcey

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
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.	A Latina community outreach worker available to provide accessibility help with resources and to provide support.	Process Goal	Year 1 of 1
Provide community navigational support through a community health worker for at least 150 encounters where navigating the system is a barrier to care.	Provided 175 encounters, which provided navigational and emotional support. This included helping with governmental assistance programs, birth certificates, SSI office visits, immigration status, baby's first appointments, billing issues and helping to prepare moms for appointment and hospital follow-up visits.	Outcome Goal	Year 1 of 1
Provide infant car seats to women who are in need of transporting their newborn home after delivery.	Provided 23 women with a new infant car seat to assist in transporting their newborn safely home.	Outcome Goal	Year 1 of 1

EOHHS Focus Issues	Not Specified

DoN Health Priorities	Not Specified
Health Issues	Maternal/Child Health-Reproductive and Maternal Health, Other-Cultural Competency, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Public Safety,
Target Populations	• **Regions Served:** Waltham, • **Environments Served:** Suburban, Urban, • **Gender:** Female, • **Age Group:** Adults, Infants, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Refugee/Immigrant Status,

Partners:

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

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

Program Type	Infrastructure to Support CB Collaboration
Program is part of a grant or funding	Yes

provided to an outside organization	
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.
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
Collaborate with CHNA 17 to support racial equity and mental health.	MAH Community Benefits Director is an active participant in the CHNA 17 Steering Committee.	Outcome Goal	Year 1 of 1
Over 75% of members will improve their skills to promote racial equity in their work.	Outcome 100% of reported they improved their skills to promote racial equity in their work.	Outcome Goal	Year 1 of 1
Over 75% of learning communtiy members will Improve their confidence to promote racial equity in their work.	100% of participants reported improving their confidence to promote racial equity in their work.	Outcome Goal	Year 1 of 1

Over 75% of members increased their awareness of racial inequities in their community.	94% of participants increased their awareness of racial inequities in their community.	Outcome Goal	Year 1 of 1
Over 75% of members will increase their understanding of racial inequities in mental health in their community.	94% of participants increased their understanding of racial inequities in mental health in their community.	Outcome Goal	Year 1 of 1
Over 75% of members will improve their knowledge of programs, services, health initiatives, and other resources in our network.	94% of participants reported they improve their knowledge of programs, services, health initiatives, and other resources in our network.	Outcome Goal	Year 1 of 1

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Built Environment, Social Environment,
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:** Rural, Suburban, • **Gender:** All, • **Age Group:** All,

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

Partners:

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

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 genders and their dependents who are victims of domestic violence.	Provided a safe bed for persons of all genders and their dependents who were victims of domestic violence and were not able to go home because of an unsafe situation.	Process Goal	Year 1 of 1

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Social Environment, Violence,
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:** Not Specified • **Gender:** All, Female, Male, Transgender, • **Age Group:** Adults, All, Teenagers, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Domestic Violence History,

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

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.
Program Hashtags	Not Specified
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	Social Workers attend monthly meetings in Arlington, Belmont, Cambridge, Somerville, Waltham and Watertown.	Process Goal	Year 1 of 1

care for community members.			
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	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:** All, • **Race/Ethnicity:** All,

	• **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 provided to an outside organization	No
Program Description	This program supports a stroke-certified nurse who provides stroke education and awareness to patients, families, hospital staff, and community members. MAH also collaborates with the local private EMS and local 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 to provide patients with efficient, time-sensitive care.
Program Hashtags	Community Education, Health Professional/Staff Training, Prevention,
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 stroke education and awareness within the hospital to patients, families and staff.	Ongoing education and support is provided to patients, families and staff.	Process Goal	Year 1 of 1
Create a Stroke awareness campaign during the month of May 2021.	Developed and distributed stroke education and Act Fast materials for community members.	Process Goal	Year 1 of 1
Distribute over 1,200 pieces of stroke education in multiple languages through the local Meals on Wheels programs and other community organizations delivering food or to housing residents.	Distributed over 1600 educational pieces in 6 different languages to various community organizations for distribution to community members and for posting in common areas.	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-Stroke,
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
Not Specified	Not Specified
Cambridge Council on Aging	https://www.cambridgema.gov/dhsp/programsforadults/seniorscouncilonaging
Somerville Cambridge Elder Services	www.eldercare.org
Arlington Eats	www.arlingtoneats.org

Healthy Waltham	www.healthywaltham.org
Arlington Council on Aging	https://www.arlingtonma.gov/departments/health-human-services/council-on-aging
Belmont Council on Aging	https://www.belmont-ma.gov/council-on-aging
Waltham Council on Aging	https://www.city.waltham.ma.us/council-on-aging
Watertown Council on Aging	https://www.watertown-ma.gov/284/Council-on-Aging-Senior-Center

Substance Use Navigation and Support – Substance Use

Program Type	Community-Clinical Linkages
Program is part of a grant or funding provided to an outside organization	No
Program Description	This program provides a social work navigator in MAH ED. The navigator provides screening and referral to to offer support and treatment to any overdose patient in the ED; The Substance Treatment and Referral Team collaborates with the department of Psychiatry to help with transitions of care.
Program Hashtags	Not Specified
Program Contact Information	Kathy Howard, Director of Social Work 330 Mount Auburn Street, Cambridge, MA 02138

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide a substance use navigator to provide support and care to those patients in the ED who show signs of substance use disorder and to help with transitions of care.	Provided a substance use navigator in the ED to provide support and care to those patients in the ED who show signs of substance use disorder and to help with transitions of care.	Process Goal	Year 1 of 1

EOHHS Focus Issues	Substance Use Disorders,
DoN Health Priorities	Not Specified
Health Issues	Health Behaviors/Mental Health-Mental Health, Substance Addiction-Alcohol Use, 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
Not Specified	Not Specified

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 by 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
Organize a survivorship day for community members with cancer to celebrate and empower those affected by cancer and to improve mental health and wellbing.	Survivorship Day Event completed (virtual event) in June 2021 with 75 people participating.	Process Goal	Year 1 of 1

At least 90% of those who participated in survivorship day will report they learned something of lasting value by participating.	96% of those surveyed reported they learned something of lasting value by participating.	Outcome Goal	Year 1 of 1
At least 90% of those who participated in survivorship day will report they will be able to take what they learned or a skill they practiced during the event and use it to improve their own health and wellbeing.	96% of those surveyed reported they will be able to take what they learned or a skill they practiced during the event and use it to improve their own health and wellbeing.	Outcome Goal	Year 1 of 1
Provide a breast cancer support group to women who have completed treatment.	A Support group is provided and meets twice a month throughout the year.	Process Goal	Year 1 of 1
Improve hope, empowerment and/or confidence in community members experiencing breast cancer.	10 women are regular participants in the 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, Cancer-Cervical, Cancer-Colorectal, Cancer-Lung, Cancer-Multiple Myeloma, Cancer-Other, Cancer-Ovarian, Cancer-Prostate, Cancer-Skin,
Target Populations	• **Regions Served:** Arlington, Belmont, Cambridge, Somerville, Waltham, Watertown,

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

Partners:

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

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. 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 1500 rides provided free of charge to those where transportation was a barrier to medical care. 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 Cambridge Task Force addressing transportation and environmental issues.	The director of community affairs attends these meetings to address transportation as a barrier to care and environmental issues as it pertains to transportation.	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-Access to Transportation, 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:** Disability Status,

Partners:

Partner Name and Description	Partner Website
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/

Youth Risk Behavior Survey Collaboration - Mental 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	MAH collaborated this year with Lahey Medical Center to support the work of administering and evaluating the YRBS given to High School students in the Middlesex League Region. This included Arlington, Belmont, and Watertown School Systems. The YRBS allows the schools to better understand the extent to which middle school and high school students in the district engage in risky behaviors. MAH's support has allowed the Middlesex League to create an online, standardized test that allows the data to be processed in a timely manner and synthesized into a regional report.
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
Collaborate with LHMC to support the administration of a regional, comprehensive Youth Risk Behavior Survey.	At the district-level, survey administration occurred over 1 to 3 day period, during the student's regular class time. Given the COVID-19 public health emergency, the 2021 survey process was typically administered while students were participating in remote learning, although some districts had students take the it in the school-setting. The survey was administered to 7,337 middle school students and 8,852 high school students across the Middlesex League towns.	Process Goal	Year 1 of 1
Identify mental health risk factors for youth in the Middlesex League.	29% of HS and 21% of MS students reported that their mental health was not good most of the time or always. Genderqueer students were more likely to report experiencing overwhelming stress, depression, and suicidal ideations than male or female students. School demands and expectations continued to cause students the most negative stress, with keeping up with schoolwork reported as	Outcome Goal	Year 1 of 1

	the primary contributing factor. Suicidal ideation and attempts were reported at similar rates compared to prior YRBS data. Students in 8thgrade are at particularly high risk for planning and attempting suicide. Students most often identified a parent as their support network.		
Identify potential health and social impacts to youth from COVID-19.	Over one-third of HS students and about one-fourth of MS students reported that their mental health was not good most of the time or always. Genderqueer students were significantly more likely to report experiencing poor mental health. While the majority of students did not experience any adverse financial or health-related effects of COVID-19, 11% of HS students and 6% of MS students experienced a family financial problem and 23% of HS students and 22% of MS students had a family member or close friend who died. More than half of HS and MS students reported experiencing feelings of anger, sadness, worry, numbness, or frustration in reaction to the coronavirus. Just over half of HS and MS students reported feeling close to people in their school (52% and 53%, respectively).	Outcome Goal	Year 1 of 1
Identify risk factors and rates of substance use in Middlesex League youth.	Overall, substance use increased as students increased in grade. Alcohol was most commonly used by HS and MS students. About one-fifth of HS students report having drank alcohol in the past 30 days. White and female HS students were more likely to report drinking alcohol. Hispanic HS students were more likely to report marijuana and electronic vapor product use. HS students generally accessed substances through friends or family members. Smoking cigarettes was perceived as the most risky and marijuana use the least among HS students. Trend data between 2019 and 2021 shows a decline in overall alcohol consumption amongst HS students by 12% and a 3% decline amongst MS students. Similar trend data across marijuana use was reported, with a 10% decline in usage amongst HS	Outcome Goal	Year 1 of 1

	students and a 1% decline amongst MS students.		
Identify risk factors for sexual activity in Middlesex League youth.	Overall, 19% of HS students and 2% of MS students reported that they had ever had sexual intercourse. Hispanic, Multi-Racial, and genderqueer students were more likely to report drinking alcohol or using drugs before sexual intercourse. Trend data indicates an overall decrease in the number of Middlesex HS students who report having had sexual intercourse. This decreased from 28% in 2017 to 26% in 2019 to now 19% in 2021. HS students reported that condoms were the most common method used to prevent pregnancy.	Outcome Goal	Year 1 of 1
Identify the risk factors and rates of unintentional injury and violence for youth in the Middlesex League.	Overall, HS students are more likely to report driving under the influence of marijuana than alcohol. Hispanic and Multi-Racial students are most likely to report driving under the influence of alcohol or marijuana. About one-fifth of HS students report that they check their cell phone while driving. White and female students are most likely to report that they check their cell phone while driving. Forced sexual behavior was consistent across reporting years. Genderqueer students were significantly more likely to experience electronic bullying than male or female students. Trend data shows a 10% decline in experiencing electronic bullying amongst Middlesex MS students from 30% in 2019 to 20% in 2021. Trend data indicates the number of HS students who reported having been forced to do sexual things they did not want to do as similar to previous years (7-8% across 2017, 2019 and 2021).	Outcome Goal	Year 1 of 1
Identify the risk factors for physical health and chronic disease in Middlesex League youth.	About 7% of HS students were obese (>= 95th percentile for body mass index, based on sex-and age-specific reference data from the 2000 CDC growth charts) and 14% were overweight (>= 85th percentile but <95th percentile for body mass index).	Outcome Goal	Year 1 of 1

	The percent of HS students who were obese decreased from 8% to 7% while overweight rates increased from 13% to 14% compared from 2019 to 2021. The majority of MS and HS students report that they are about the right weight. HS students reporting eating fruit in the past 7 days slightly more often in 2021 compared to 2019 (95% vs 92%) and similar rates of vegetable consumption (94% vs 95%). The majority of HS students did not drink soda (53%) or an energy/sports drink (69%) in the past 7 days. White students were most likely to have drunk soda or an energy/sports drink in the past 7 days, while Asian students were least likely. Physical activity per week decreased while average screen time per day increased as students increased in age. Amongst MS Middlesex Students there was a 5% increase in students who reported not trying to do anything about my weight from 31% in 2019 to 36% in 2021.		

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Not Specified
Health Issues	Health Behaviors/Mental Health-Depression, Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Physical Activity, Health Behaviors/Mental Health-Responsible Sexual Behavior, Health Behaviors/Mental Health-Stress Management, Substance Addiction-Alcohol Use, Substance Addiction-Smoking/Tobacco Use, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Arlington, Belmont, Watertown, • **Environments Served:** Suburban, Urban, • **Gender:** All, • **Age Group:** Teenagers,

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

Partners:

Partner Name and Description	Partner Website
John Snow Inc.	https://www.jsi.com
Middlesex League	NA

SECTION V: EXPENDITURES

Total CB Program Expenditure	**$3,117,488.00**

CB Expenditures by Program Type	Total Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
Direct Clinical Services	$1,587,167.00	0
Community-Clinical Linkages	$450,225.00	0
Total Population or Community-Wide Interventions	$473,846.00	$75,626.00
Access/Coverage Supports	$572,532.00	0
Infrastructure to Support CB Collaborations Across Institutions	$33,718.00	0

CB Expenditures by Health Need	Total Amount
Chronic Disease with a Focus on Cancer, Heart Disease, and Diabetes	$189,430.00
Mental Health/Mental Illness	$1,715,969.00

Housing/Homelessness	$10,980.00
Substance Use	$124,260.00
Additional Health Needs Identified by the Community	$1,076,849.00
Other Leveraged Resources	0

Net Charity Care Expenditures	**Total Amount**
HSN Assessment	$2,867,159.00
HSN Denied Claims	$2,667,010.00
Free/Discount Care	Not Specified
Total Net Charity Care	$5,534,169.00

Total CB Expenditures:	$8,651,657.00

Additional Information	**Total Amount**	**Net Patient Service Revenue:**	$322,358,000.00

CB Expenditure as Percentage of Net Patient Services Revenue:	2.68%
Approved CB Program Budget for FY2022: (*Excluding expenditures that cannot be projected at the time of the report.)	$3,100,000.00
Hospital Publication Describing CB Initiatives:	Not Specified
Bad Debt:	$3,483,309.00
Bad Debt Certification:	Certified
Optional Supplement:	Not Specified

Optional Information:
In FY 21, Beth Israel Lahey Health and its member hospitals, in collaboration with Mass General Brigham, designed, built, and launched a new Community Benefits Reporting Tool (CBRT). The CBRT allows our teams and community partners to more accurately capture, track, and report data related to community benefits programs and initiatives. As part of our design and launch of the CBRT, the BILH and MGB teams undertook a multi-faceted quality improvement project to improve the alignment of definitions and categories for program expenditure reporting across our member hospitals; this may be a contributing driver for differences in trend with AGO reporting categories.

SECTION VI: CONTACT INFORMATION

Mary DeCourcey, Director of Community Benefits
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 Form - Year 1

Note: This form is to be completed in the Fiscal Year in which the hospital completed its triennial Community Health Needs Assessment

I. Community Benefits Process:

1. Community Benefits in the Context of the Organization's Overall Mission:
   - Are Community Benefits planning and investments part of your hospital's strategic plan? ☒ Yes ☐ No
     - If yes, please provide a description of how Community Benefits planning fits into your hospital's strategic plan. If no, please explain why not.
     - Mount Auburn Hospital (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 Diversity Equity and Inclusion Officer. This structure ensures that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with MAH and system strategic and regulatory priorities.

2. Community Benefits Advisory Committee (CBAC):
   - Members (and titles):
     Mary DeCourcey, Director of Community Benefits and Chair of MAH CBAC, MAH; Carla Beaudoin, Director of Development, Metro Housing Boston; Christine Bongiourno, Director of Arlington Health and Human Services; Diane Bono, VP of Human Resources, MAH: Elizabeth Browne, CEO Charles River Community Health; Renee Cammarata Hamilton, Director of Community Health Improvement Team, Cambridge Health Alliance; Stacy Carruth, Planning Director, CHNA 17; Yvonne Cheung, MD, Chair of Quality and Safety, MAH; Patty Contente, Director, Community Outreach, Help and Recovery, Somerville Police Department; Lisa Cook, Executive Director, Somerville Center for Adult Learning Experiences, (SCALE); Heather Gibbons-Perez, Director of Performance Improvement and Regulatory Affairs, MAH; Rich Guarino, Chief Operating Officer, MAH; Doug Kress, Director, Somerville Health and Human Services; Laura Kurman, Senior Program Director, Wayside Youth and Family Support Network; Mike

Libby, Executive Director, Somerville Homeless Coalition; Julia Londergan, Esq., Director of Development, CASPAR Inc. Marie McCune, RN Stroke Nurse Coordinator, MAH; Myriam Michel, Executive Director, Health Waltham; Colleen Morrissey, Director of Volunteers and Special Projects, Somerville Cambridge Elder Services; Nava Niv-Vogel, Director, Belmont Council on Aging; Larry Ramdin, Director, Watertown Public Health Department; Robert Torres, Boston Regional Manager, Community Benefits, BILH; Stephanie Venizelos, Community Wellness Program Manager, Town of Watertown; Jose Wendel, Director, Population Health Initiatives, Cambridge Health Department

- Leadership:
  Nancy Kasen, VP of Community Benefits and Community Relations, BILH; Robert Torres, Boston Regional Manager for Community Benefits, BILH; Rich Guarino, Chief Operating Officer, MAH; Diane Bono, VP, Human Resources, MAH; Yvonne Cheung, MD, Chair of Quality and Safety, MAH

- Frequency of meetings:
  The MAH Community Benefits Advisory Committee (CBAB) met quarterly with an additional meeting during FY 2021. Meeting Dates: December 4, 2020, February 25, 2021, April 30, 2021, June 25, 2021 and September 30, 2021

3. Involvement of Hospital's Leadership in Community Benefits:
   Place a checkmark next to each leadership group if it is involved in the specified aspect of your Community Benefits process:

	Review Community Health Needs Assessment	*Review Implementation Strategy*	*Review Community Benefits Report*
Senior leadership	☒	☒	☒
Hospital board	☒	☒	☒
Staff-level managers	☒	☒	☒
Community Representatives on CBAC	☒	☒	☒

For any check above, please list the titles of those involved and describe their specific role:

At BILH and Mount Auburn Hospital our belief that everyone deserves high-quality, affordable health care is at the heart of who we are and what drives our work with our community partners. MAH has always been deeply committed to serving our communities. Working collaboratively with our community partners, our CBAC and the Community Benefits team, such commitment is shared by staff at all levels within MAH. Those who are on our CBAC, previously listed, are involved as described in the check boxes above. The senior leadership team at MAH was also kept informed of the CHNA/IS process and was able to provide input during at senior leadership meetings. The CBAC guided the community engagement process and helped inform the selected health priorities. The Hospital Board of Trustees reviewed the CHNA and

Implementation Strategy Report, and voted to approve it. Approval was voted on through a virtual presentation to the Board of Trustees.

Hospital Board of Trustees:
James Rafferty, Chair – provided input on CHNA
MAH Board of Trustees – reviewed, approved and adopted CHNA and Implementation Strategy, and reviewed the Community Benefits Report.

Senior Leadership Team – provided input and reviewed the CHNA and adopted the Implementation Strategy; was informed of process for the CHNA and Implementation Strategy.
Jeanette Clough, President
Rich Guarino, COO
Bill Sullivan, CFO
Beb Baker, RN, VP Patient Care Services
Yvonne Cheung, MD, Chief Quality Officer
Amit Powar, MD, Executive VP of MAH Professional Services
Mitchell Chan, MD, Chair, Department of Surgery
Chris Fischer, MD, Chair Department of Emergency Medicine
Ed Huang, MD, Chair Department of OB/GYN
Katherine Rafferty, Director, Community Affairs

Staff Level Managers Team – designed, managed and conducted CHNA, managed prioritization process, drafted Implementation Strategy, oversaw the CHNA and Implementation Strategy process and review of Community Benefits Report.
Nancy Kasen – BILH VP, Community Benefits and Community Relations
Lilia Karapetyan, Coordinator, Interpreter Services
Kathy Howard, Director, Social Work and Interpreter Services
Mary DeCourcey, Director, Community Benefits
Robert Torres, BILH, Boston Regional Manager, Community Benefits

CBAC: (see list above) Guided community engagement process and selected/recommended priorities.

4. <u>Hospital Approach to Assessing and Addressing Social Determinants of Health</u>
   - How does the hospital approach assessing community needs relating to social determinants of health? (150-word limit)
     MAH undertook a robust, collaborative and transparent assessment and planning process. The approach involved extensive quantitative (age, race, ethnicity, language, sexual orientation/gender identity, income, food access, housing, transportation, etc.) and qualitative (focus groups, key informant interviews, community forum) data collection and substantial efforts to engage community residents. MAH's Implementation Strategy reflects the hospital and CBAC's prioritization of Social Determinants of Health as one of the priorities identified to be incorporated in the newly developed Implementation Strategy. In order to make a sustained impact on overall well-being of those in the service area MAH

recognizes that MAH and its partners must address the underlying social determinants, inequities, and injustices that are at the root of many health status issues that exist.

- How does the hospital incorporate health equity in its approach to Community Benefits? (150-word limit)
  MAH and BILH are committed to health equity and the attainment of the highest level of health for all people. This requires an ongoing focus on societal efforts to address avoidable inequalities, socioeconomic barriers to care, and both historical and contemporary injustices. Throughout MAH's assessment process, MAH worked to understand the needs of populations that are often disadvantaged, face disparities in health-related outcomes, and are deemed most vulnerable. This assessment was conducted entirely during the COVID 19 pandemic and thus an emphasis on conducting the assessment with a racial equity lens was a priority. MAH's Implementation Strategy that was developed as a result of these processes, focused on reaching the geographic, demographic and socioeconomic segments of populations most at risk, as well as those with physical and behavioral health needs in the hospital's Community Benefits Service Area.

- How does the hospital approach allocating resources to Total Population or Community-Wide Interventions? (150-word limit)
  The MAH Implementation Strategy includes a diverse range of programs and resources to addresses the prioritized needs within the MAH community benefits service area. The majority of MAH's community benefits initiatives are focused on cohorts and sub-populations due to identified disparities or needs. MAH's strategies include working to improve health care and behavioral health access, programs that support critical partnerships with Charles River Community Health (Federally funded Health Center), healthy eating and increasing food access and working with programs to increase housing stability. Additionally, MAH collaborates with many community partners to own, catalyze and/or support total population and community-wide interventions.

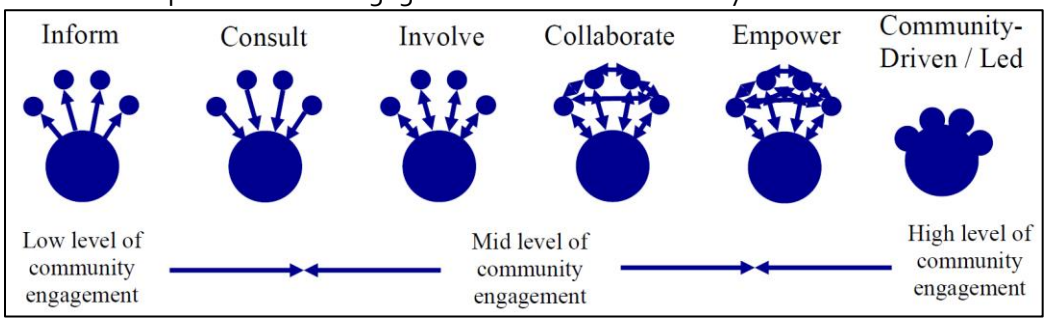
II. Community Engagement:

1. Organizations Engaged in CHNA and/or Implementation Strategy
   Use the table below to list the key partners with whom the hospital collaborated in assessing community health needs and/or implementing its plan to address those needs and provide a brief description of collaborative activities with each partner. Note that the hospital is not obligated to list every group involved in its Community Benefits process, but rather should focus on groups that have been significantly involved. Please feel free to add rows as needed.

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)

CHNA 17	Stacy Carruth, Planning Director	Local health community organizations (CHNAs)	Participated as a member of the CBAC. Involved in the prioritization process. Helped to coordinate a community-wide listening session/focus group including CHNA 17 Steering Committee members.
Healthy Waltham	Miriam Michel, Executive Director	Social service organizations	Participated as a member of the CBAC. Participated on prioritization exercise to help make decisions on health priorities.
Area Councils on Aging Directors	Susan Pacheco, group organizer of COA in the service area	Other	Organized a focus group with key service providers; helped to inform needs of our older population.
Local Health Departments in the CBSA	Directors of six Health Departments	Local Health Department	Participated as members of the CBAC; provided input on community engagement and prioritization of health priorities and strategies.
Charles River Community Health Center	Amy Knudsen, Grants Manager	Community Health Centers	Participates as a member of the CBAC; Provides input on community engagement and prioritization of health priorities and strategies

2. Level of Engagement Across CHNA and Implementation Strategy
Please use the spectrum below from the Massachusetts Department of Public Health[1] to assess the hospital's level of engagement with the community.



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
Please assess the hospital's level of engagement in developing its CHNA and the effectiveness of its community engagement process.

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in assessing community health needs	Collaborate	yes	Empower

[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.

Collecting data	Collaborate	yes	Empower
Defining the community to be served	Involve	yes	Collaborate
Establishing priorities	Collaborate	yes	Empower

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

MAH remains committed to community engagement. During FY21 MAH undertook its triennial community health needs assessment and prioritization process. Guided by the MAH CBAC Committee and conducted in collaboration with community partners, this initiative employed a comprehensive community engagement process despite conducting the assessment during the COVID-19 pandemic.

- Optional FY20 Question: Please describe how the COVID-19 pandemic impacted the hospital's process for engaging its community and developing responsive Community Benefits programs.

  MAH dedicated a great deal of 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. Clinical staff provided infection control expertise to local health departments during their reopening plans. MAH worked to expand community testing access and worked with BILH as a system to develop and distribute written material (in nine languages) to the communities most impacted by COVID-19, to help slow the spread. MAH redeployed staff and procured tangible necessities for both the community at large and hopstal staff, such as personal protective equipment (PPE), food, hand sanitizer, and other critical items.

  While in-person meetings were hindered in the community, MAH sought creative ways to engage with our community including being present during local community and coalition Zoom meetings, conducting seven focus groups with different hard to reach populations in order to gather input and data regarding health priorities and connecting periodically with local health departments in the CBSA.

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

B. Implementation Strategy:

Please assess the hospital's level of engagement in developing and implementing its plan to address the significant needs documented in its CHNA and the effectiveness of its community engagement process.

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Collaborate	yes	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Consult	yes	Consult
Implementing Community Benefits programs	Collaborate	yes	Collaborate
Evaluating progress in executing Implementation Strategy	Collaborate	yes	Collaborate
Updating Implementation Strategy annually	Collaborate	yes	Collaborate

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

  Click or tap here to enter text.

3. Opportunity for Public Feedback

   Did the hospital hold a meeting open to the public (either independently or in conjunction with its CBAC or a community partner) at least once in the last year to solicit community feedback on its Community Benefits programs? If so, please provide the date and location of the event. If not, please explain why not.

   MAH held 2 public forums. One was in conjunction with its Community Health Needs Assessment on January 7, 2021 (community partner was CHNA 17). The other was a public meeting in conjuction with its CBAC on September 30, 2021. Both of these events were virtual meetings set up on Zoom.

4. Best Practices/Lessons Learned
The AGO seeks to continually improve the quality of community engagement.

- What community engagement practices are you most proud of? (150-word limit)
MAH is most proud of our committed CBAC, the long-standing relationships we have with many community-based organizations, and our local public health departments. We are most proud of the long standing collaboration MAH has with CHNA 17 where we share in its mission of racial equity and mental wellness. We are especially proud to have been able to conduct 7 focus groups with hard to reach populations including youth leaders at Waltham High School and adult English Language Learners at Cambridge Learning Center.

- What lessons have you learned from your community engagement experience? (150-word limit)
Working collaboratively with other hospitals, community-based organizations, public health departments and CHNA 17, enhances the level and quality of our community engagement efforts. It is important to include and engage a diversity of voices and experiences.

III. Regional Collaboration:

1. Is the hospital part of a larger community health improvement planning process?
☒ Yes ☐ No
   - If so, briefly describe it. If not, why?
   MAH is part of the joint BILH Community Health Needs Assessment and Implementation Strategy planning process. All BILH hospitals are part of the strategic planning of community benefits processes and programs.

2. If the hospital collaborates with any other filer(s) in conducting its CHNA, Implementation Strategy, or other component of its Community Benefits process (e.g., as part of a regional collaboration), please provide information about the collaboration below.
   - Collaboration:
   These are not filers but we collaborate together: Cambridge Health Alliance and CHNA 17

   - Institutions involved:
   Cambridge Health Alliance and CHNA 17

   - Brief description of goals of the collaboration:
   Our goal was to share data and information about the communities we serve to enhance our experiences and to be more inclusive. This also served to broaden our knowledge of our shared communities and helps us to work together towards improving the health and wellbeing of our community members.

   - Key communities engaged through collaboration:
   Cambridge Health Alliance's shared CBSA is Cambridge and Somerville. For CHNA 17

the shared CBSA's are Arlington, Belmont, Cambridge, Somerville, Waltham and Watertown

- If you did not participate in a collaboration, please explain why not:
  Click or tap here to enter text.

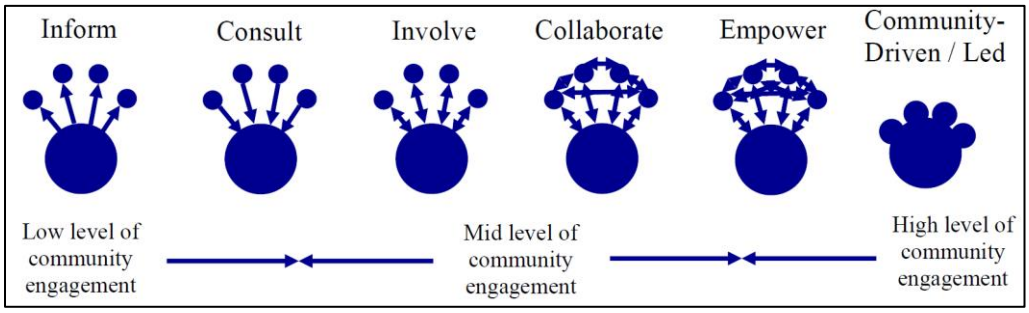
SECTION VIII: COMMUNITY REPRESENTATIVE FEEDBACK FORM

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.



C. 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.

D. 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.

[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.

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.