Mount Auburn Hospital

Mount Auburn Hospital
Implementation Strategy
September 2021

This report provides a summary of the health priorities and priority populations that were identified through the most recent Community Health Needs Assessment (CHNA), which was conducted during the period of September 2020 – June 2021.

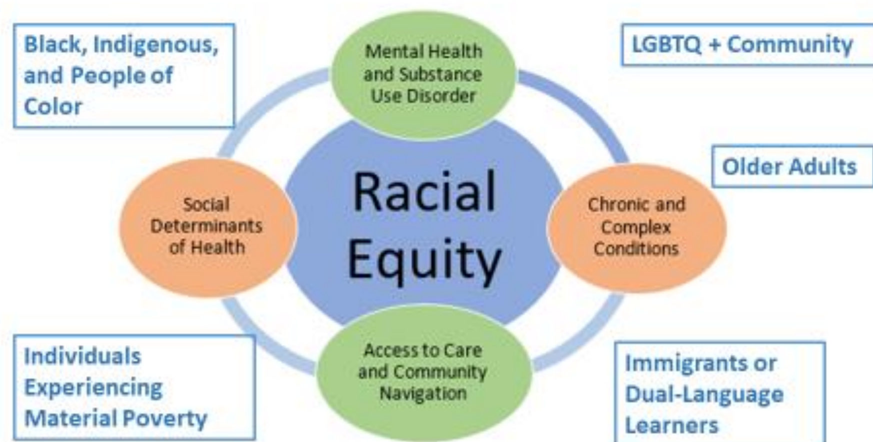
The FY 2021 CHNA was designed as a population-based assessment, meaning the goal was to identify a full range of community health issues across demographic and socioeconomic segments of the population. The issues identified were framed in a broad context to ensure that the breadth of unmet needs and community health issues were recognized.

In developing the Implementation Strategy, care was taken to ensure that MAH's community health priorities were aligned with the Commonwealth of Massachusetts priorities as set by the MDPH and the MA AGO. MAH also made efforts to ensure that the Implementation Strategy was aligned with literature on how to best promote community health improvement and prevention efforts. The priority populations and community health issues were prioritized by the Steering Committee with input from the CBAC and other stakeholders at MAH and in the Community. Senior management and the Board of Trustees are committed to assessing information and updating the plan as needed. This plan was approved by the MAH Board of Trustees on 09/14/2021.

Priority Health Issues

An integrated analysis of all assessment activities including a comprehensive community engagement process including key informant interviews, focus groups and stakeholder input helped to inform the CHNA. The leading health issues were identified through an inclusive prioritization process with MAH's Community Benefits Advisory Committee (CBAC). This work framed the leading community health issues into five priority areas.

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. This increased awareness of longstanding injustices, along with the disproportionate impact of COVID-19 on racial and ethnic minority populations, led to many discussions regarding the impacts of COVID-19, racism, and inequities. Despite these unique circumstances, MAH is confident the core findings and recommendations articulated in this report are valid now and will remain relevant even as the COVID-19 public health emergency abates in the coming months and year. The follow diagram depicts the priority areas and priority populations identified based on an integrated analysis of quantitative and qualitative data and results of a prioritization process with the CBAC.



Priority Populations

All segments of the population face challenges that may limit the ability to access health services, regardless of age, race/ethnicity, income, family history, or health status. However, there are specific communities that have been systematically marginalized and under-resourced that require a focused approach to address existing health inequities. In the body of the full CHNA report, there is a comprehensive review of the full breadth of quantitative and qualitative data that was compiled as part of this assessment effort; this review includes findings that touch on common challenges cited among community residents throughout the service area, as well as specific populations and focus areas of high concern.

Implementation Strategy

The following is a list of the goals, objectives and activities/strategies that have been established for each priority area in MAH's Implementation Strategy.

MAH FY22 – FY24 Priority Areas, Objectives and Strategies/Activities

Priority Area 1: Racial Equity

- GOAL 1: PROMOTE HEALTH EQUITY AND REDUCE DISPARITIES FOR THOSE FACING RACISM AND DESCRIMINATION, PARTICULARLY FOR COMMUNITIES OF COLOR
  - *Priority Populations:* Black, Indigenous, and People of Color, Immigrants and Dual-Language Learners, Older Adults, LGBTQ+ Community, Individuals Experiencing Material Poverty
  - *Programmatic Objectives:*
    - i. Work internally at MAH and externally with community partners to identify and implement projects to promote racial equity and improve outcomes, particularly for prioritized population segments
    - ii. Support and partner with CHNA 17 to help them build their capacity by supporting their work to promote racial equity in the mental health field and practice.
  - *Community Activities/Strategies:*
    - i. Collaborate with internal committees at MAH, determine a goal and objective for improving racial health disparities
    - ii. Research options for staff orientation that includes content on understanding and addressing racial equity
    - iii. Participate as a member of the steering Committee for CHNA 17
    - iv. Provide grant support to CHNA 17 to promote its fellowship grant program
    - v. Provide grant support and funding for local public health departments to promote racial equity

- *Metrics:*
    1. Collect and analyze hospital data
    2. # of initiatives
    3. # of trainings
    4. # of participants
    5. Evaluation of trainings
- *Community Partners:* CHNA 17, MAH Disparities Committee, MAH Patient Family Advisory Committee, CHNA 17, community organizations focused on racial equity, Men's Health League, Faith based organizations

---

Priority Area 2: Mental Health and Substance Use Disorders

- GOAL 1: REDUCE THE IMPACT OF MENTAL HEALTH AND SUBSTANCE USE DISORDERS AMONG RESIDENTS OF MAH'S COMMUNITY BENEFITS SERVICE AREA
    - *Priority Populations:* Black, Indigenous, and People of Color, Immigrants and Dual-Language Learners, Older Adults, LGBTQ+ Community, Individuals Experiencing Material Poverty
    - *Programmatic Objectives:*
        1. Expand access to mental health and substance use disorder treatment/support services
        2. Expand access to linguistically/culturally sensitive mental health and substance use treatment/support services
        3. Increase and enhance support for those affected by trauma, and or emotional stress
        4. Increase access to "care navigation" services for those with mental illness and substance use disorders
        5. Promote collaboration, share knowledge, and coordinate activities internally at MAH and externally with community partners
    - *Community Activities/Strategies:*
        1. ED Social Work Navigator to support the START program (Substance Treatment and Referral Team)
        2. Organize and facilitate support groups to address emotional distress, mental health, and substance use recovery and or peer support groups for those in relationships with substance users
        3. Organize and support mindfulness based programs for community members in response to COVID 19
        4. Social workers to attend community meetings where they share best practices, identify opportunities to improve collaborations and optimize health for vulnerable community members
        5. Provide grant support and funding for local public health departments to support evidence-based programs that promote mental health and substance use education and prevention services
        6. Support CHNA 17 with funding in its efforts to address mental health in African American/Black population and other vulnerable segments facing discrimination

- *Metrics:*
  1. # of Bridge Clinic referrals
  2. # patients screened by social work navigator
  3. # Support groups organized
  4. # participants
  5. Evaluation data from support groups
  6. Number of community meetings Social Workers attended
- *Community Partners:* CHNA 17, community based organizations and coalitions, Local police and fire departments, Wayside Youth and Family Services, Arlington Youth Counseling Center, Watertown Cares, Local DPH departments, Middlesex DA Office

---

Priority Area 3: Chronic and Complex Conditions and Risk Factors

- GOAL 1: ENHANCE ACCESS TO HEALTH EDUCATION, SCREENING, AND REFERRAL SERVICES IN CLINICAL AND NON-CLINICAL SETTINGS
  - *Priority Populations:* Black, Indigenous, and People of Color, Immigrants and Dual-Language Learners, Older Adults, LGBTQ+ Community, Individuals Experiencing Material Poverty
  - *Programmatic Objectives:*
    1. Increase the number of adults who receive health education and screening, for chronic/complex conditions
    2. Increase the number of adults participating in cancer education, screening, and referral events
    3. Promote healthy aging and one's ability to Age in Place
  - *Community Activities/Strategies:*
    1. Provide adults with health education regarding risk factors and healthy behaviors in settings convenient to those community members who are most vulnerable
    2. Facilitate an elder service provider working group in order to share best practices, listen to needs to improve programing and to promote healthy aging
    3. Partner with area COA and ASAPs to provide monthly health education and venue space for older adults
    4. Collaborate with CRCH to provide free mammogram event/s for those who are uninsured or underinsured
    5. Organize blood pressure screening events in the community
    6. Provide emergency response services (Lifeline) at below cost to underserved elders and disabled persons who are in need, as identified by regional elder services agencies
    7. Provide an opportunity for older adults to volunteer at the hospital

viii. Provide grant support and funding for local public health departments to support evidence-based programs that increase access to health education, screening, and chronic disease management

- *Metrics*
  i. # of health education events
  ii. # of participants
  iii. Evaluation data from events
  iv. # of elder service provider meetings
  v. # of community members receiving Lifeline at reduced cost or below rate.
  vi. # of volunteers
  vii. # volunteer hours
- *Community Partners:* Local COA's, CASPAR, Lifeline Services, SCES, Springwell, Local Health Departments, MAH volunteer services, BILH at Home, Healthy Living Center of Excellence

❖ GOAL 2: ENHANCE ACCESS TO SELF-MANAGEMENT AND OTHER SUPPORTIVE SERVICES FOR INDIVIDUALS WITH OR RECOVERING FROM CHRONIC/COMPLEX CONDITIONS AND THEIR CAREGIVERS

- *Priority Populations:* Black, Indigenous, and People of Color, Immigrants and Dual-Language Learners, Older Adults, LGBTQ+ Community, Individuals Experiencing Material Poverty
- *Programmatic Objectives:*
  i. Enhance access and promote equitable care for vulnerable individuals with chronic and complex conditions
  ii. Increase access to supportive services to reduce stress and anxiety, reduce negative symptoms and side effects, and increase overall wellbeing
  iii. Increase the ability of older adults to live independently and age in place
- *Community Activities/Strategies:*
  i. Provide a survivorship day event for patients and community members
  ii. Provide an ongoing support group for breast cancer patients and community members
  iii. Provide an ongoing support group for caregivers of those with Alzheimer's and dementia
  iv. Stroke Nurse Navigator provides ongoing stroke education and support for patients and their families
- *Metrics:*
  i. *# of participants*
  ii. *Evaluation of support groups*
  iii. *# patients stroke nurse provides education and support*
- *Community Partners:* American Cancer Society, SCES, Local COA's, CRCH, Springwell

Priority Area 4: Social Determinants of Health

- GOAL 1: PROVIDE SUPPORTIVE SERVICES FOR THOSE WHO ARE UNSTABLY HOUSED
  - *Priority Populations:* Black, Indigenous, and People of Color, Immigrants and Dual-Language Learners, Older Adults, LGBTQ+ Community, Individuals Experiencing Material Poverty
  - *Programmatic Objectives:*
    - i. Work internally at MAH and with community partners to identify those who are experiencing housing insecurity
    - ii. Increase access to housing and eviction prevention services
  - *Community Activities/Strategies:*
    - i. Provide screening for patients in order to identify housing insecurity
    - ii. Contract with Metro Housing Boston (MHB) to facilitate case management and to support those who are struggling with housing insecurity or homelessness
    - iii. Provide housing stability resources and information for community members
    - iv. Increase partnerships and collaborations with community-based organizations to address the lack of safe and affordable housing
  - *Metrics:*
    - i. # referrals to MHB
    - ii. # families/residents receiving referrals to community resources
    - iii. # families receiving housing counseling/services to remain in their current home or found new stable, affordable housing
  - *Community Partners:* Metro Area Planning Council, Metro Housing Boston, Local Housing Authorities, Housing Corp. of Arlington, CASPAR, City of Cambridge, City of Somerville

- GOAL 2: IMPROVE ACCESS TO HEALTHY AND NUTRITIOUS FOOD FOR THOSE WHO EXPERIENCE FOOD INSECURITY
  - *Priority Populations:* Black, Indigenous, and People of Color, Immigrants and Dual-Language Learners, Older Adults, LGBTQ+ Community, Individuals Experiencing Material Poverty
  - *Programmatic Objectives:*
    - i. Work internally at MAH and with community partners to identify those who are experiencing food insecurity
    - ii. Increase access to healthy foods for those who are experiencing food insecurity
  - *Community Activities/Strategies:*
    - i. Partner with community based organizations/programs that address food insecurity and promote access to healthy foods.
    - ii. Provide funding for local organizations which are supporting food insecure families/residents
    - iii. Provide funding to support SNAP Match programs
    - iv. Provide healthy and nutritious food that can be delivered to food distribution locations

- *Metrics:*
    1. Quantities of food provided
    2. # of people benefitting from the SNAP match program
- *Community Partners:* Local food pantries, Arlington Eats, SNAP Match programs, SNAP Match Coalition of Cambridge, Cambridge Community Foundation, farmers markets, MAH food service department, Healthy Waltham, Waltham Fields Community Farm Mobile Outreach Market

❖ GOAL 3: PROMOTE TRANSPORTATION EQUITY

- *Priority Populations:* Black, Indigenous, and People of Color, Immigrants and Dual-Language Learners, Older Adults, LGBTQ+ Community, Individuals Experiencing Material Poverty
- *Programmatic Objectives:*
    1. Work internally at MAH and with community partners to identify those who have limited access to safe, affordable, accessible transportation
    2. Increase access to safe, affordable, accessible transportation where transportation is a barrier to health care
    3. Participate in the Cambridge Transportation task force
- *Community Activities/Strategies:*
    1. Provide transportation vouchers to priority populations (e.g., low income, older adults, and other segments)
    2. Participate in Cambridge's transportation task force
- *Metrics:*
    1. # of vouchers, cab rides, Charlie cards given to those where transportation is a barrier
    2. # of meetings
- *Community Partners:* Cambridge transportation task force, MBTA, Metro Cab, SCM Transportation

---

Priority Area 5: Access to Care and Community Navigation

❖ GOAL 1: ADDRESS THE SOCIAL DETERMINANTS OF ACCESS TO CARE

- *Priority Populations:* Black, Indigenous, and People of Color, Immigrants and Dual-Language Learners, Older Adults, LGBTQ+ Community, Individuals Experiencing Material Poverty
- *Programmatic Objectives:*
    1. Work internally at MAH and with community partners to identify the community assets and barriers that either promote or hinder access to needed services
- *Community Activities/Strategies:*

i. Support enrollment assistance activities to assist community members to assess eligibility and apply for public assistance programs.
ii. Support CHNA 17's work to address racism, particularly with respect to behavioral health services
iii. Collaborate with CHNA 17 in its efforts to provide grant opportunities/funding for community based organizations to increase awareness and break down barriers for priority populations
iv. Provide grant support and funding for local public health departments to support evidence-based programs that address access, community navigation or improved communications

➢ *Metrics:*
i. *# of new enrollees*
ii. *# of people receiving enrollment assistance*
iii. *evaluation of CHNA 17 funded work*
iv. *evaluation data from health department grants*

➢ *Community Partners:* CRCH, CHNA 17, Local Health Departments,

❖ GOAL 2: PROMOTE EQUITABLE CARE AND SUPPORT FOR THOSE WHO ARE DUAL-LANGUAGE LEARNERS

➢ *Priority Populations:* Black, Indigenous, and People of Color, Immigrants and Dual-Language Learners, Older Adults, LGBTQ+ Community, Individuals Experiencing Material Poverty

➢ *Programmatic Objectives:*
i. Promote health literacy internally at MAH and externally with community partners

➢ *Community Activities/Strategies:*
i. Provide health education including navigating the health care system to our community partners, and other organizations which work with those with limited English proficiency.
ii. Conduct health equity/diversity trainings at MAH and include other clinical and non-clinical partners, as possible and appropriate
iii. Provide access to interpreter services internally at MAH and work to improve access for patients and community members

➢ *Metrics:*
i. *# of health education programs*
ii. *# of participants in health education programs*
iii. *program evaluation data*
iv. *# trainings*
v. *# participants trained*
vi. *# of interpreter services encounters*

➢ *Community Partners:* SCALE, Cambridge Community Learning Center, Waltham Family School, CRCHC

❖ GOAL 3: PROMOTE HEALTH EQUITY FOR LGBTQ+ POPULATIONS

- *Priority Population:* LGBTQ+ community
- *Programmatic Objectives:*
    i. Promote best practices with respect to collecting accurate information on sexual orientation and gender identity internally at MAH and externally with community partners
    ii. Reduce barriers to health care and disparities in health outcomes
    iii. Share LGBTQ+ resources with external partners
- *Community Activities/Strategies:*
    i. Provide or support programs and initiatives to improve health and wellbeing of the LGBTQ+ population
    ii. Continue to meet the standards for Leader status for the Human Rights Commission for the LGBTQ+ Healthcare Equality Index
    iii. Partner with community organizations which support the LGBTQ + community
- *Metrics:*
    i. # of resources shared with external partners
- *Community Partners:* Fenway Health Center, Y2Y, Local LGBTQ+ organizations, AIDS Action Committee

- GOAL 4: PROMOTE RESILIENCE AND EMERGENCY PREPAREDNESS
    - *Priority Populations:* Black, Indigenous, and People of Color, Immigrants and Dual-Language Learners, Older Adults, LGBTQ+ Community, Individuals Experiencing Material Poverty
    - *Programmatic Objectives:*
        i. Support cities/towns to promote resilience, emergency care and emergency preparedness
    - *Community Activities/Strategies:*
        i. Provide Emergency Services training to local City/Town police and fire departments.
        ii. Serve as EMS Medical Directors for Cambridge, Arlington and Belmont Medical Dispatchers, MIT EMS and Harvard University EMS
        iii. Serve on State and regional EMS advisory boards to lend medical oversight to the region
    - *Metrics:*
        i. # of trainings provided to first responders and community partners.
    - *Community Partners:* Local Health Departments, ProEMS, MIT EMS, Local Police and Fire Departments

- GOAL 5: PROMOTE RESILIENCY FOR NEW MOMS
    - Priority Populations: *:* Black, Indigenous, and People of Color, Immigrants and Dual-Language Learners, Older Adults, LGBTQ+ Community, Individuals Experiencing Material Poverty
    - *Programmatic Objectives:*
        i. Support outreach and assistance to new moms to increase awareness about how to create a healthy and safe environment for babies and families

- *Community Activities/Strategies:*
    i. Organize and/or support programs to support prenatal patients and new moms that promote a healthy and safe environment and/or foster healthy births and growth and development for newborns and infants
    ii. Provide Doula support during delivery
    iii. Collaborate with the CRCH pre/postnatal department to address access issues that may affect their care.
- *Metrics:*
    i. # Doula births, evaluation of Doula program
    ii. # car seats distributed to new moms who otherwise do not have a safe way to transport their newborn
    iii. # community outreach visits to pre/postnatal patients
- *Community Partners:* CRCH