Beth Israel Lahey Health
Mount Auburn Hospital

2022 Community Health Needs Assessment

Acknowledgments

This 2022 Community Health Needs Assessment report for Mount Auburn Hospital (MAH) is the culmination of a collaborative process that began in September 2021. At the foundation of this endeavor was a desire to meaningfully engage and gather important input from residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership, and other key collaborators from throughout MAH's Community Benefits Service Area. Substantial efforts were made to provide community residents with opportunities to participate, with an intentional focus on engaging cohorts who have been historically underserved.

MAH appreciates all who invested time, effort, and expertise to develop this report and the Implementation Strategy. This report summarizes the assessment and planning activities and presents key findings, community health priorities, and strategic initiatives that are the results of this work.

MAH thanks the MAH Community Benefits Advisory Committee and the residents who contributed to this process. Hundreds of residents throughout the hospital's Community Benefits Service Area shared their needs, experiences and expertise through interviews, focus groups, a survey, and community listening sessions. This assessment and planning process would not have been possible or as successful had it not been for the time and effort of the residents who engaged in this work.

Mount Auburn Hospital Community Benefits Senior Leadership Team 2022

Chad Wable, President
Diane Bono, Vice President of Human Resources
Yvonne Cheung, MD, Chair of Quality and Safety
Mary DeCourcey, Director of Community Benefits
Heather Gibbons-Perez, Director of Performance Improvement and Regulatory Affairs
Rich Guarino, Chief Operating Officer
Kathy Howard, Director of Social Work and Interpreter Services
Marie McCune, Stroke Nurse Coordinator

Mount Auburn Hospital 2022 Community Benefits Advisory Committee

Carla Beaudoin, Director of Development, Metro Housing Boston

Christine Bongiorno, Director, Arlington Health and Human Services

Liz Browne, CEO, Charles River Community Health

Renee Cammarata Hamilton, Director of the Community Health Improvement Team, Cambridge Health Alliance

Stacy Carruth, Planning Director, CHNA17

Wesley Chin, Director, Belmont Health Department

Patty Contente, Director of Community Outreach, Help, and Recovery, Somerville Police Department

Lisa Cook, Director, Somerville Center for Adult Learning Experience

Mary DeCourcey, Director of Community Benefits, Mount Auburn Hospital

Michelle Feeley, Director, Waltham Health Department

Nancy Bacci, 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, Director of Development, Cambridge and Somerville Programs for Addiction Recovery, Inc.

Myriam Michel, Executive Director, Healthy Waltham

Colleen Morrissey, Director of Volunteers and Special Projects, Somerville Cambridge Elder Services

Nava Niv-Vogel, Director, Belmont Council on Aging

Larry Ramdin, Director of Public Health, Town of Watertown

Jackie Spencer, MD, Director of Primary Care, VA New England Healthcare System

Robert Torres, Director of Community Benefits, Boston Region, Beth Israel Lahey Health

Stephanie Venizelos, Manager of Community Wellness, Town of Watertown

Jose Wendel, Director of Population Health Initiatives, Cambridge Public Health Department

Laura Wiener, Senior Transportation Planner, Community Development and Planning, Town of Watertown

Table of Contents

Introduction

Background

Mount Auburn Hospital (MAH) is a 217-bed acute-care, Harvard-affiliated community teaching hospital. MAH was founded in 1886, and for over 100 years has been dedicated to maintaining the highest standards of excellence in care for its patients, while also educating the caregivers of tomorrow and participating in critically important research. MAH offers comprehensive inpatient and outpatient medical, surgical, obstetrical, and psychiatric services as well as specialized care in bariatrics, cardiology, cardiac surgery, orthopedics, neurology, vascular surgery, and oncology. In addition, MAH also offers a network of satellite primary care practices in several surrounding communities, as well as a range of community-based programs, BILH at Home, outpatient specialty services, and rehabilitation services. Medical education and clinical research play an important part in the hospital's mission and are considered necessary to maintain high-quality care for its patients. MAH's dual mission is to provide excellent and compassionate health care and to teach students of medicine and the health professions.

MAH is committed to being an active partner and collaborator with the communities it serves. In 2019, as part of a merger of two health systems in the greater Boston region, MAH became part of Beth Israel Lahey Health (BILH) - a system of academic medical centers, teaching hospitals, community hospitals and specialty hospitals with more than 35,000 caregivers and staff who are collaborating in new ways across professional roles, sites of care, and regions to make a difference for our patients, our communities, and one another. MAH, in partnership with the BILH system, is committed to providing the very best care and strives to improve the health of the people and families in its Community Benefits Service Area (CBSA). MAH's last Community Health Needs Assessment (CHNA) was completed in 2021, however, the hospital participated in this collaborative 2022 assessment and planning process with other BILH hospitals to integrate efforts and align timelines moving forward.

This 2022 CHNA report is an integral part of MAH's population health and community engagement efforts. It supplies vital information that is applied to make sure that the services and programs that MAH provides are appropriately focused, delivered in ways that are responsive to those in its CBSA, and address unmet community needs. This assessment, along with the associated prioritization

planning processes, also provides a critical opportunity for MAH to engage the community and strengthen the community partnerships that are essential to MAH's success now and in the future. The assessment engaged more than 300 people from across the CBSA, including local public health officials, clinical and social service providers, community-based organizations, first responders (e.g., police, fire department and ambulance officials), faith leaders, other government officials, and community residents.

The process that was applied to conduct the CHNA and develop the associated Implementation Strategy (IS) exemplifies the spirit of collaboration and community engagement that is such a vital part of MAH's mission. Finally, this report allows MAH to meet its federal and Commonwealth community benefits requirements per the federal Internal Revenue Service, as part of the Affordable Care Act, the Massachusetts Attorney General's Office, and the Massachusetts Department of Public Health.

Purpose

The CHNA is at the heart of MAH's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address the inequities and socioeconomic barriers to accessing care as well as the current and historical discrimination and injustices that underlie existing disparities. Throughout the assessment process, efforts were made to understand the needs of the communities that MAH serves, especially the population segments that are often disadvantaged, face disparities in health-related outcomes, and who have been historically underserved.

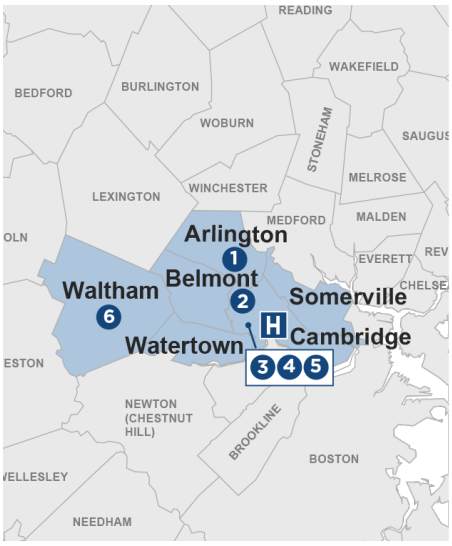
Prior to this current CHNA, MAH completed its last assessment in the fall of 2021 and the report, along with the associated IS, was approved by the MAH Board of Trustees on September 14, 2021. The 2021 CHNA report was posted on MAH's website before September 30, 2022 and, per federal compliance requirements, made available in paper copy, without charge, upon request. The assessment and planning work for this current report was conducted between September 2021 and September 2022 and MAH's Board of Trustees approved the 2022 report and adopted the 2023-2025 IS, included as Attachment E, on September 13, 2022.

Definition of Community Served

The federal government and the Commonwealth require that nonprofit hospitals engage their communities and conduct comprehensive CHNAs that identify the leading health issues, barriers to care, and service gaps for people who live and/or work within the hospital's designated CBSA. Understanding the geographic and demographic characteristics of MAH's CBSA is critical to recognizing inequities, identifying priority cohorts, and developing focused strategic responses.

Description of Community Benefits Service Area

MAH's CBSA includes the six municipalities of Arlington, Belmont, Cambridge, Somerville, Waltham, and Watertown to the west of the City of Boston. Collectively, these cities and towns are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education, and employment), and geography (e.g., urban and suburban). There is also diversity with respect to



Beth Israel Lahey Health
Mount Auburn Hospital

Community Benefits Service Area

- H Mount Auburn Hospital
- 1 Mount Auburn Hospital Radiology at Arlington
- 2 Mount Auburn Hospital MRI Center
- 3 Mount Auburn Hospital Rehabilitation Services; Outpatient Physical & Occupational Therapy
- 4 Mount Auburn Hospital Mobile PET Unit
- 5 Mount Auburn Hospital Employee Assistance Program, Occupational Health & Rehabilitation Services
- 6 Mount Auburn Hospital Imaging and Specimen Collection

community needs. There are segments of MAH's CBSA population that are healthy and have limited unmet health needs, and other segments that face significant disparities in access, underlying social determinants, and health outcomes. MAH is committed to promoting health, enhancing access, and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identity, sexual orientation, disability status, immigration status, or age. MAH is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

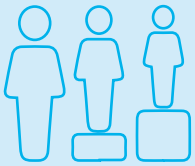
MAH's CHNA focused on identifying the leading community health needs and priority cohorts within the CBSA. The activities that will be implemented as a result of this assessment will support all of the people who live in the CBSA. However, in recognition of the health disparities that exist for some residents, MAH focuses the bulk of its community benefits resources on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved. By prioritizing these cohorts, MAH is able to promote health and well-being, address health disparities, and maximize the impact of its community benefits resources.

Assessment Approach & Methods

Approach

It would be difficult to overstate MAH's commitment to community engagement and a comprehensive, data-driven, collaborative and transparent assessment and planning process. MAH's Community Benefits staff and Community Benefits Advisory Committee (CBAC) dedicated hours to ensuring a sound, objective, and inclusive process. This approach involved extensive data collection activities, substantial efforts to engage the hospital's partners and community residents, and thoughtful prioritization, planning, and reporting processes. Special care was taken to include the voices of community residents who have been historically underserved, such as individuals who speak a language other than English, immigrants, and those who experience barriers and disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

The CHNA and IS development process was guided by the following principles: equity, collaboration, engagement, capacity building, and intentionality.

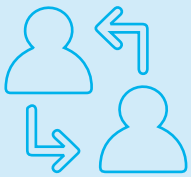


Equity:

Work toward the systemic, fair, and just treatment of all people.

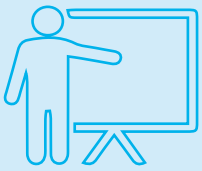
Collaboration:

Leverage resources to achieve greater impact by working with community residents and organizations.



Engagement:

Intentionally outreach to and interact with hardly reached populations; including but not limited to people impacted by trauma, people with disabilities, people most impacted by inequities, and others.



Capacity Building:

Build community cohesion and capacity by co-leading community listening sessions and training community residents on facilitation.

Intentionality:

Be deliberate in requests for and use of data and information; be purposeful and work collaboratively to identify and leverage resources for maximum benefit.

The assessment and planning process was conducted between September 2021 and September 2022 in three phases, which are detailed in the table below.

Phase I: Preliminary Assessment & Engagement	Phase II: Focused Engagement	Phase III: Strategic Planning & Reporting
Engagement of existing CBAC	Additional interviews	Presentation of findings and prioritization with CBAC and MAH leadership
Collection and analysis of quantitative data	Facilitation of focus groups with community residents and community-based organizations	Draft and finalize CHNA report and IS document
Interviews with key collaborators	Dissemination of community health survey, focusing on resident engagement	Presentation of final report to CBAC and MAH leadership
Evaluation of community benefits activities	Facilitation of community listening sessions to present and prioritize findings	Presentation to MAH's Board of Trustees
Preliminary analysis of key themes	Compilation of resource inventory	Distribution of results via hospital website

In July of 2021, BILH hired John Snow, Inc. (JSI), a public health research and consulting firm based in Boston, to assist MAH and other BILH hospitals to conduct the CHNA. MAH worked with JSI to ensure that the final MAH CHNA engaged the necessary community constituents, incorporated comprehensive quantitative information for all communities in its CBSA, and fulfilled federal and Commonwealth community benefits guidelines.

Methods

Oversight and Advisory Structures

The CBAC greatly informs MAH's assessment and planning activities. MAH's CBAC is made up of staff from the hospital's Community Benefits Department, other hospital administrative/clinical staff, and members of MAH's Board of Trustees. Perhaps more importantly, the CBAC includes representatives from:

- Local public health departments/boards of health
- Additional municipal staff (such as elected officials, planning, etc.)
- Education
- Housing (such as community development corporations, local public housing authority, etc.)
- Social services
- Regional planning and transportation agencies
- Private sectors
- Community health centers
- Community-based organizations.

These institutions are committed to serving everyone throughout the region and are particularly focused on meeting the needs of those who are medically underserved, those experiencing poverty, and those who face inequities due to their race, ethnicity, language spoken, national origin, religion, gender identity, sexual orientation, age, or other personal characteristics.

Demographic, SES* & SDOH** Data	Commonwealth/National Health Status Data	Hospital Utilization Data	Municipal Data Sources
Age, SOGI***, race, ethnicity	Vital statistics	Inpatient discharges	Public school districts
Poverty, employment, education	Behavioral risk factors	Emergency department discharges	Local assessments and reports
Crime/violence	Disease registries		
Food access	Substance use data		
Housing/transportation	COVID-19 Community Impact Survey		

*Socioeconomic status **Social determinants of health ***Sexual orientation and gender identity

The involvement of MAH's staff in the CBAC promotes transparency and communication and ensures that there is a direct link between MAH and many of the community's leading health and social service organizations. The CBAC meets quarterly to support MAH's community benefits work and met six times during the course of the assessment and planning process. During these meetings, the CBAC provided invaluable input on the assessment approach and community engagement strategies, vetted preliminary findings, and helped to prioritize community health issues and the cohorts experiencing or at-risk for health inequities.

Quantitative Data Collection

To meet the federal and Commonwealth community benefits requirements, MAH collected a wide range of quantitative data to characterize the communities served across the hospital's CBSA. MAH also gathered data to help identify leading health-related issues, barriers to accessing care and service gaps. Whenever possible, data is collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs for specific communities. The data was tested for statistical significance whenever possible and compared against data at the regional, Commonwealth, and national levels to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments, and other sources. A databook that includes all the quantitative data gathered for this assessment, including MAH Community Health Survey data, is included in Appendix B.

Community Engagement and Qualitative Data Collection

Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing cohorts most at-risk, and crafting a collaborative, evidence-informed IS. Accordingly, MAH applied Massachusetts Department of Public Health's Community Engagement Standards for Community Health Planning to guide engagement.[1]

To meet these standards, MAH employed a variety of strategies to help ensure that community members were informed, consulted, involved, and empowered throughout the assessment process. Between October 2021 and February 2022, MAH conducted 18 one-on-one interviews with key collaborators in the community, facilitated three focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 250 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 300 community residents, clinical and social service providers, and other key community partners. Appendix A of this report contains a comprehensive community engagement summary detailing how these activities were conducted, who was involved and what was learned. Also included in Appendix A are copies of the interview, focus group, and listening session guides, notes, and other materials.

18 interviews

with community leaders

267 survey respondents

3 focus groups

- LGBTQIA+
- English language learners
- Residents who identify Black, Indigenous, People of Color (BIPOC).

Inventory of Community Resources

Community Benefits staff created a resource inventory of services available to address community needs. The inventory includes resources across the broad continuum of services, including:

- Domestic violence
- Food assistance
- Housing
- Mental health and substance use

- Senior services
- Transportation.

The resource inventory was compiled using information from existing resource inventories and partner lists from MAH. Community Benefits staff reviewed MAH's prior annual report of community benefits activities submitted to the Massachusetts Attorney General's Office, which included a listing of partners, as well as publicly available lists of local resources. The goal of this process was to identify key partners who may or may not be already collaborating with MAH. The resource inventory can be found in Appendix C.

Prioritization, Planning, and Reporting

At the outset of the strategic planning and reporting phase of the project, community listening sessions were organized with the public-at-large, including community residents, representatives from clinical and social service providers, and other community-based organizations that provide services throughout the CBSA. This was the first step in the prioritization process and allowed the community the opportunity to discuss the assessment's findings and formally identify the issues that they believed were most important, using an interactive and anonymous polling software. These sessions also allowed participants to share their ideas on existing community assets and strengths, as well as the services, programs, and strategies that should be implemented to address the issues identified.

After the community listening sessions, the MAH CBAC was engaged. The CBAC was updated on the assessment's progress and was provided the opportunity to vet and comment on preliminary findings. The CBAC then participated in their own prioritization process using the same set of interactive and anonymous polls, which allowedthem to identify a set of community health priorities andpopulation cohorts that they believed should be considered for prioritization as MAH developed its IS.

After the prioritization process, a CHNA report was developed and MAH's existing IS was augmented, revised, and tailored. In developing the IS, MAH's Community Benefits staff took care to retain the community health initiatives that worked well and that aligned with the identified priorities from the 2022 assessment but also pose new strategies to address the newly identified priorities.

After drafts of the CHNA report and IS were developed, they were shared with MAH's senior leadership team for input and comment. MAH Community Benefits staff then reviewed these inputs and incorporated elements, as appropriate, before the final 2022 CHNA report and 2023-2025 IS were submitted to MAH's Board of Trustees for approval.

After the Board of Trustees formally approved the 2022 CHNA report and adopted the 2023-2025 IS, these documents were posted on MAH's website, alongside the 2021 CHNA report and 2020-2022 IS, for easy viewing and download. As with all MAH CHNA processes, these documents were made available to the public whenever requested, anonymously and free of charge. It should also be noted that MAH Community Benefits staff have mechanisms in place to receive written comments on the most recent CHNA and IS, although no comments have been received since the last CHNA and IS were made available.

Questions regarding the 2022 assessment and planning process or past assessment processes should be directed to:

Mary DeCourcey
Director of Community Benefits
Mount Auburn Hospital
330 Mount Auburn St.
Cambridge, MA 02138
Mdecourc@mah.harvard.edu
617-499-5625

Robert Torres
Director of Community Benefits
Boston Region
Beth Israel Lahey Health
330 Brookline Ave.
Boston, MA 02115
Robert.Torres@bilh.org
617-975-5475

Assessment Findings

This section provides a comprehensive review of the findings from this assessment. This section draws on quantitative data from a variety of sources and qualitative information collected from local public health officials, clinical and social service providers, community-based organizations, first responders (e.g., police, fire department, and ambulance officials), faith leaders, other government officials, and community residents engaged in supporting the health and well-being of residents throughout MAH's CBSA. Findings are organized into the following areas:

- **Community Characteristics**
- **Social Determinants of Health**
- **Systemic Factors**
- **Behavioral Factors**
- **Health Conditions.**

Each section begins with a highlight of key findings. This introduction is followed by graphs and other data visuals. It is important to note that these five sections do not review all the findings collected during the assessment, rather they draw out the most significant drivers of health status and health disparities. A summary of interviews, focus groups, and community listening sessions and a databook that includes all of the quantitative data gathered for this assessment are included in Appendices A and B.

Community Characteristics

A description of the population's demographic characteristics and trends lays the foundation for understanding community needs and health status. This information is critical to recognizing health inequities and identifying communities and population segments that are disproportionately impacted by health issues and other social, economic, and systemic factors. This information is also critical to MAH's efforts to develop its IS, as it must focus on specific segments of the population that face the greatest health-related challenges. The assessment gathered a range of information related to age, race/ethnicity, nation of origin, gender identity, language, sexual orientation, disability status, and other characteristics.

Based on the assessment, community characteristics that were thought to have the greatest impact on health status and access to care in the MAH CBSA were issues related to age, race, ethnicity, language, and immigration status. While the majority of residents in the MAH CBSA were predominantly white and born in the United States, there were non-white, people of color, recent immigrants, non-English speakers, and foreign-born populations in all communities.

There was consensus among interviewees and focus group participants that people of color, recent immigrants, and non-English speakers were more likely to have poor health status and face systemic challenges to accessing care and services. These segments of the population are impacted by language, cultural barriers, and racism that limit access to appropriate services, pose health literacy challenges, exacerbate isolation, and may lead to discrimination and disparities in access and health outcomes.

One issue to be noted was the lack of data available by gender identity and sexual orientation at the community or municipal level. Research shows that those who identify as lesbian, gay, bisexual, transgender, and/or queer/questioning experience health disparities and challenges accessing services.

Population Growth

Between 2010 and 2020, the population in MAH's CBSA increased by 10%, from 341,036 to 373,598 people. Cambridge saw the greatest percentage increase (13%) and Somerville saw the lowest (7%).

Population Changes by Municipality, 2010 to 2020

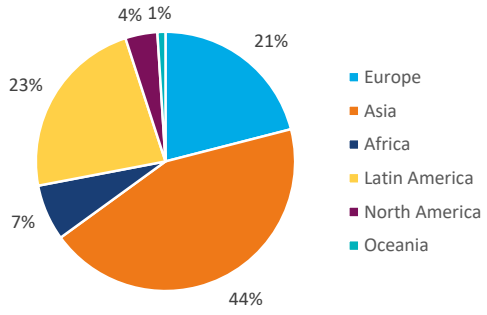
Source: US Census Bureau, 2010 and 2020 Decennial Census

Nation of Origin

Immigration status is linked to health in many ways; individuals who are foreign-born are less likely to have access to health care and are more likely to forgo needed care due to fear of interacting with public agencies.[2]

25% of the MAH CBSA population was foreign-born.

Region of Origin Among Foreign-Born Residents in the CBSA, 2016-2020



Source: US Census Bureau American Community Survey, 2016-2020

Language

Language barriers pose significant challenges to receiving and providing effective and high-quality health and social services. Studies show that health outcomes improve when patients and providers speak the same language.[3]

31% of MAH CBSA residents 5 years of age and older spoke a language other than English at home and of those,

30% spoke English less than "very well."

Source: US Census Bureau American Community Survey, 2016-2020

Age

Age is a fundamental factor to consider when assessing individual and community health status. Older individuals typically have more physical and mental health vulnerabilities and are more likely to rely on immediate community resources for support compared to young people.

13%

of residents in the MAH CBSA were 65 years of age or older. The proportion of older adults is expected to increase by 2030, which may have implications for the provision of health and social services.

15%

of residents in the MAH CBSA were under 18 years of age.

Source: US Census Bureau American Community Survey, 2016-2020

Gender Identity and Sexual Orientation

Massachusetts has the second largest lesbian, gay, bisexual, transgender, queer/questioning, intersex and asexual (LGBTQIA+) population of any state in the nation. LGBTQIA+ individuals face issues of disproportionate violence and discrimination, socioeconomic inequality, and health disparities.

5%

of adults in Massachusetts identified as LGBTQIA+. Data was unavailable at the municipal level.

21%

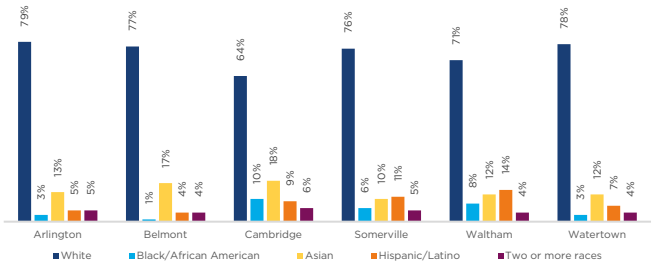
of LGBTQIA+ adults in Massachusetts were raising children.

Source: Gallup/Williams 2019

Race and Ethnicity

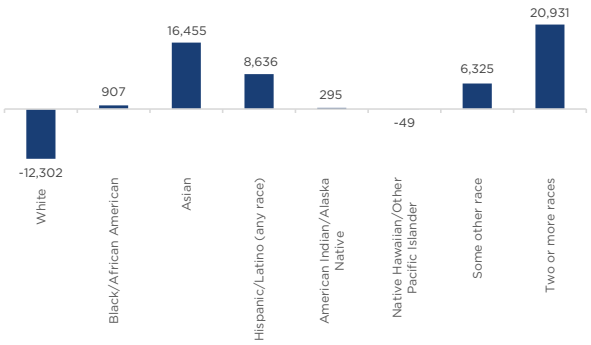
In the CBSA overall, the number of residents who identified as white and Native Hawaiian or other Pacific Islander has decreased since 2010, while there was an increase in other census categories. Interviewees reported that they felt the MAH CBSA was increasingly diverse, though the CBSA was predominantly white.

Race/Ethnicity by Municipality, 2016-2020



Source: US Census Bureau American Community Survey, 2016-2020

CBSA Population Changes by Race/Ethnicity, 2010 to 2020



Source: US Census Bureau, 2010 and 2020 Decennial Census

Note: The US Census Bureau reports that the 2020 Decennial Census significantly undercounted Black/African American, American Indian or Alaska Native, Some Other Race alone, and Hispanic or Latino populations. The Census significantly overcounted the white, non-Hispanic white, and Asian populations.

Household Composition

Household composition and family arrangements may have significant impacts on health and well-being, particularly as family members act as sources of emotional, social, financial and material support.[4]

21% of MAH CBSA households included one or more people under 18 years of age.

24% of MAH CBSA households included one or more people over 65 years of age.

Source: US Census Bureau American Community Survey, 2016-2020

Social Determinants of Health

The social determinants of health are "the conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks."[5] These conditions influence and define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to housing, food insecurity, economic insecurity, access to care/navigation issues, and other important social factors.

There was limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, listening sessions, and the MAH Community Health Survey indicated that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, economic insecurity, and food insecurity/ nutrition.

Interviewees, focus groups, and listening session participants shared that access to safe and affordable housing was a significant challenge for residents in MAH's CBSA. This was particularly true for older adults, those living in poverty, and individuals living on inadequate fixed incomes. Interviewees and listening participants shared that there were segments of the population, especially in Cambridge and Somerville, who were resource insecure, but that high housing costs were also affecting those in middle and upper-middle income brackets.

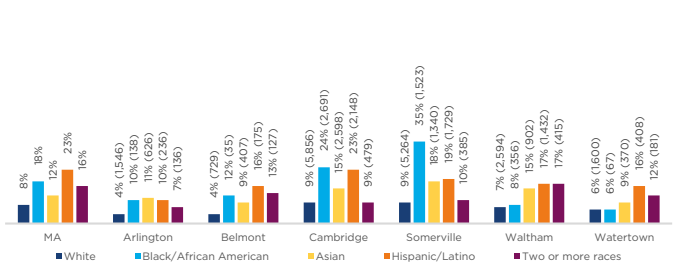
Food insecurity, food scarcity, and hunger were identified as significant challenges for individuals and families experiencing economic insecurity. These issues were tied to job loss, the inability to find employment that paid a livable wage, or having an inadequate fixed income, which impacted the ability of individuals to eat a healthy diet. Interviewees, focus group and listening session participants, and survey respondents also shared that transportation was a critical factor to maintaining one's health and accessing care, especially for those that did not have a personal vehicle or were without caregivers, family, or support networks. Other social factors that were highlighted in a more limited way during the assessment included lack of access to affordable childcare and domestic violence.

Economic Stability

Economic stability is affected by income/poverty, financial resources, employment and work environment, which allow people the ability to access the resources needed to lead a healthy life.[6] Lower-than-average life expectancy is highly correlated with low-income status.[7] Those who experience economic instability are also more likely to be uninsured or to have health insurance plans with very limited benefits. Research has shown that those who are uninsured or have limited health insurance benefits are substantially less likely to access health care services.[8]

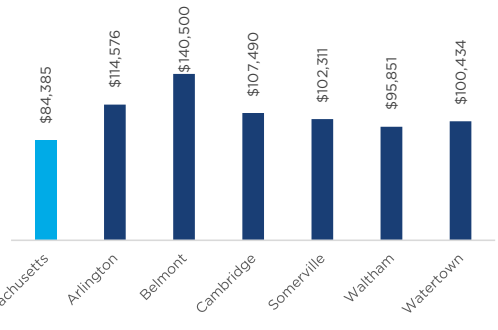
COVID-19 exacerbated many issues related to economic stability; individuals and communities were impacted by job loss and unemployment, leading to issues of financial hardship, food insecurity, and housing instability.

Percentage of Residents Living Below the Poverty Level, 2016-2020



Source: US Census Bureau American Community Survey, 2016-2020

Median Household Income, 2016-2020

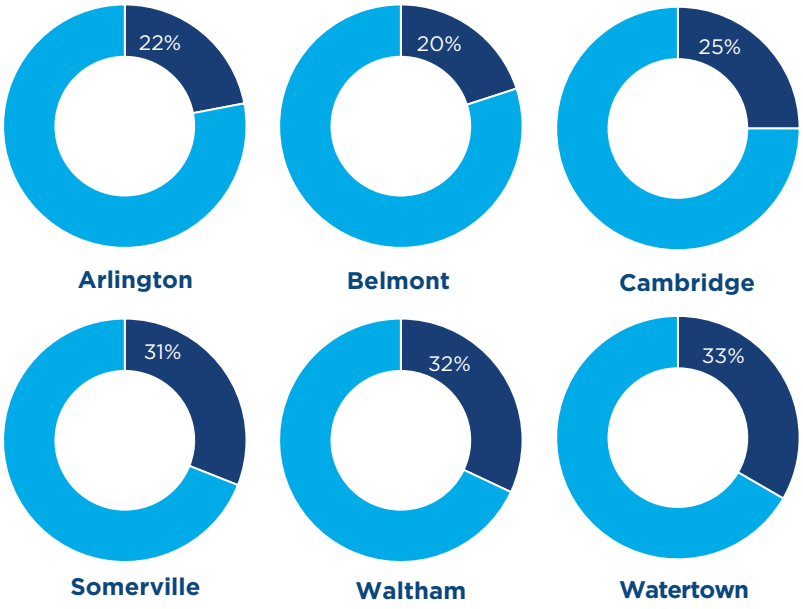


Source: US Census Bureau American Community Survey, 2016-2020

Across the MAH CBSA, the percentage of individuals living below the poverty level tended to be higher among non-white cohorts. Research shows that racial disparities in poverty are the results of systemic racism, discrimination, and cumulative disadvantage over time.[9] Median household income is the total gross income before taxes, received within a one-year period by all members of a household. Median household income was higher than the Commonwealth in all MAH CBSA communities.

The Massachusetts Department of Public Health (MDPH) conducted the COVID-19 Community Impact Survey in the fall of 2020 to assess emerging health needs. More than 20% of survey participants in MAH CBSA communities indicated that they were concerned about paying one or more bills in the fall of 2020.

Percentage* Worried About Paying for One or More Type of Expenses/Bills in Coming Weeks (Fall 2020)



***Unweighted percentages displayed**

Source: MDPH COVID-19 Community Impact Survey, Fall 2020

Education

Research shows that those with more education live longer, healthier lives.[10] Patients with a higher level of educational attainment are able to better understand their health needs, follow instructions, advocate for themselves and their families, and communicate effectively with health providers.

94% of MAH CBSA residents 25 years of age and older had a high school degree or higher.

70% of MAH CBSA residents 25 years of age and older had a bachelor's degree or higher.

Source: US Census Bureau, American Community Survey, 2016-2020

Social Determinants of Health

Food Insecurity and Nutrition

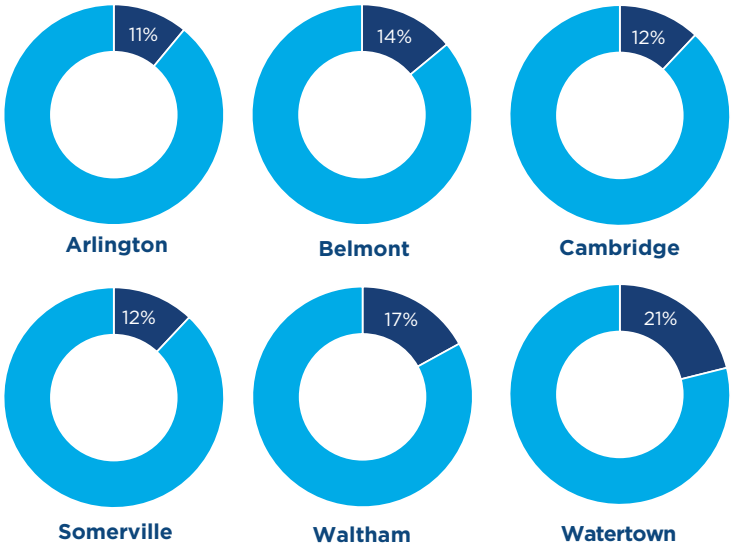
Many families, particularly families who are low-resourced, struggle to access food that is affordable, high-quality, and healthy. Issues related to food insecurity, food scarcity, and hunger are factors contributing to poor physical and mental health for both children and adults.

While it is important to have grocery stores placed throughout a community to promote access, there are other factors that influence healthy eating, including quality and price of fruits and vegetables, marketing of unhealthy food, and cultural appropriateness of food offerings. Food pantries and community meal programs have evolved from providing temporary or emergency food assistance to providing ongoing support for individuals, families, seniors living fixed incomes, and people living with disabilities and/or chronic health conditions.

6%

of MAH CBSA households received SNAP benefits (formerly food stamps) within the past year. SNAP provides benefits to low-income families to help purchase healthy foods. More than 10% of MDPH COVID-19 Community Impact Survey respondents in each MAH CBSA community reported that they were worried about getting food or groceries in the fall of 2020.

Percentage* Worried About Getting Food or Groceries in the Coming Weeks, Fall 2020



***Unweighted percentages displayed**

Source: MDPH COVID-19 Community Impact Survey, Fall 2020

Neighborhood and Built Environment

The conditions and environment in which one lives have significant impacts on health and well-being. Access to safe and affordable housing, transportation resources, green space, sidewalks and bike lanes improve health and quality of life.[11]

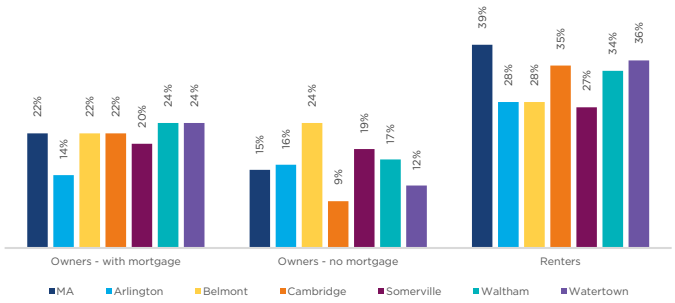
Housing

Lack of affordable housing and poor housing conditions contribute to a wide range of health issues, including respiratory diseases, lead poisoning, infectious diseases and poor mental health.[12] At the extreme are those without housing, including those who are unhoused or living in unstable or transient housing situations who are more likely to delay medical care and have mortality rates up to four times higher than those who have secure housing.[13]

Interviewees, focus groups, listening session participants, and MAH Community Health Survey respondents expressed concern over the limited options for affordable housing throughout the CBSA.

The percentage of owner-occupied housing units (with a mortgage) with housing costs in excess of 35% of household income was higher than the Commonwealth in Waltham and Watertown, and lower or similar in other CBSA communities. Among owner-occupied units without a mortgage, percentages were higher than the Commonwealth in all communities except Cambridge and Watertown. Among renter-occupied units, the percentage was lower than the Commonwealth in all MAH CBSA communities.

Percentage of Housing Units With Monthly Owner/ Renter Costs Over 35% of Household Income



Source: US Census Bureau, American Community Survey, 2016-2020

When asked what they'd like to improve in their community,

56% of MAH Community Health Survey respondents said "more affordable housing."

53% of MAH Community Health Survey respondents said that housing in the community was not affordable for people with different income levels.

Transportation

Lack of transportation has an impact on access to health care services and is a determinant of whether an individual or family can access the basic resources that allow them to live productive and fulfilling lives. Access to affordable and reliable transportation widens opportunity and is essential to addressing poverty and unemployment; it allows access to work, school, healthy foods, recreational facilities, and other community resources.

Transportation was identified as a significant barrier to care and needed services, especially for older adults who longer drove or who did not have family or caregivers nearby.

When asked what they'd like to improve in their community:

25% of MAH Community Health Survey Community Survey respondents wanted more access to public transportation.

12% of housing units in the MAH CBSA did not have an available vehicle.

Source: US Census Bureau American Community Survey, 2016-2020

Roads/Sidewalks

Well-maintained roads and sidewalks offer many benefits to a community, including safety and increased mobility. Sidewalks allow more space for people to walk or bike, which increases physical activity and reduces the need for vehicles on the road. Respondents to the MAH Community Health Survey prioritized these improvements to the built environment.

31% of MAH Community Health Survey respondents identified a need for better roads.

27% of MAH Community Health Survey respondents identified a need for better sidewalks and trails.

Systemic Factors

In the context of the health care system, systemic factors include a broad range of considerations that influence a persons ability to access timely, equitable, and high-quality services. There is a growing appreciation for the importance of these factors as they are critical to ensuring that people are able to find, access, and engage in the services they need, communicate with clinical and social service providers, and transition seamlessly from one service setting to another. The assessment gathered information related to perceptions of service gaps, barriers to access (e.g., cost of care, health insurance status, language access, cultural competence), care coordination, and information sharing. The assessment also explored issues related to diversity, equity, and inclusion and the impacts of racism and discrimination.

Systemic barriers affect all segments of the population, but have particularly significant impacts on people of color, non-English speakers, recent immigrants, individuals with disabilities, older adults, those who are uninsured, and those who identify as LGBTQIA+.

Findings from the assessment highlighted the challenges that residents throughout the MAH CBSA face with respect to accessing care. The most common concerns were related to the cost of care and barriers to obtaining health insurance, particularly for those who were not stably employed, recent immigrants, and those facing language and cultural barriers.

Findings from the assessment also reflected the intense challenges that nearly all residents face accessing care and navigating the system due to workforce shortages and gaps in capacity, particularly for those who are uninsured, Medicaid insured, recent immigrants, non-English speakers, and other segments who are often discriminated against (e.g., people of color, LGBTQIA+). These factors often led to long wait-times and scheduling challenges, which impacted peoples ability to navigate the health care system and access services in a timely manner. This was particularly true with respect to primary care, behavioral health, medical specialty care, and dental care services.

Racial Equity

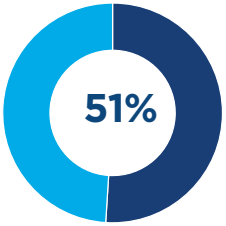
Racial equity is the condition where one's racial identity has no influence on how one fares in society.[14] Racism and discrimination influence the social, economic and physical development among Black, Indigenous and People Of Color (BIPOC), resulting in poorer social and physical conditions in those communities today.[15] Race and racial health differences are not biological in nature. However, generations of inequity create consequences and differential health outcomes because of structural environments and unequal distribution of resources.

"We need to have better understanding and more embracing of the massive diversity in this town. I hope we can do a better job of being aware of one another."

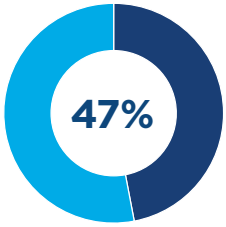
- MAH Interviewee

Interviewees reported that their communities were increasingly diverse in terms of race, ethnicity, sexual orientation, and gender identity. This diversity was identified as a strength. However, interviewees, focus groups, and listening session participants expressed concerns about racism, discrimination, and varying levels of acceptance and recognition of diversity in the community.

Among MAH Community Health Survey respondents:



reported that built, economic, and educational environments in the community were impacted by **systemic racism.**



reported that environments in the community were impacted by **individual racism.**

Accessing and Navigating the Health Care System

Interviewees, focus groups, and listening session participants identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system level, meaning that the issues stemmed from the ways in which the system did or did not function. System-level issues included providers not accepting new patients, long wait lists, and an inherently complicated health care system that was difficult for many to navigate.

There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forgo or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication and issues of patient safety.[16] Finally, transportation was also identified as a significant barrier, particularly for those without a personal vehicle or those with mobility issues who had challenges accessing public transportation.

"Requests [for care] were not responded to in a timely manner, and what was provided (much later than requested) was not helpful."

– MAH Community Health Survey respondent

Populations facing barriers and disparities:

- Individuals best served in a language other than English
- Older adults without caregivers
- Individuals with disabilities
- Individuals with limited economic means.

Some providers began offering care via telehealth over the course of the pandemic to mitigate COVID-19 exposure and retain continuity of care. This strategy removed barriers for some but created new hardships for those who lacked technical resources or technical savvy to take advantage of such programs.[17]

Community Connections and Information Sharing

Interviewees reported that there were a number of strong community collaboratives and task forces that met to tackle issues collaboratively. However, interviewees shared that there needed to be stronger referral systems between organizations, and a better understanding of resources and capacities.

Interviewees, focus groups, and community listening session participants reported that some segments of the population required more targeted outreach and navigation support to connect to health and social services. These populations included individuals who were homeless or unstably housed, individuals who spoke a language other than English, and individuals who were undocumented.

Behavioral Factors

The nation, including the residents of Massachusetts and MAH's CBSA, face a health crisis due to the increasing burden of chronic medical conditions. Underlying these health conditions are a series of behavioral risk factors that are known to help prevent illness and are the early signs or contributors of the leading causes of death (e.g., heart disease, cancer, stroke, and diabetes). According to the National Centers for Disease Control and Prevention, the leading behavioral risk factors include an unhealthy diet, physical inactivity, and tobacco, alcohol, and marijuana use. Engaging in healthy behaviors and limiting the impacts of these risk factors is known to improve overall health status and well-being and reduces the risk of illness and death due to the chronic conditions mentioned above.[18]

When considering behavioral factors, the assessment reflected on a range of mostly quantitative information related to nutrition, physical activity, tobacco use and alcohol use. Those who participated in the assessment's community engagement activities were also asked to identify the health issues that they felt were most important. While these issues were ultimately not selected during MAH's prioritization process, the information from the assessment supports the importance of incorporating these issues into MAH's IS.

Nutrition

Adults who eat a healthy diet have increased life expectancy and decreased risk of chronic diseases and obesity; children require a healthy diet to grow and develop properly.[19] Access to affordable healthy foods is essential to a healthy diet.

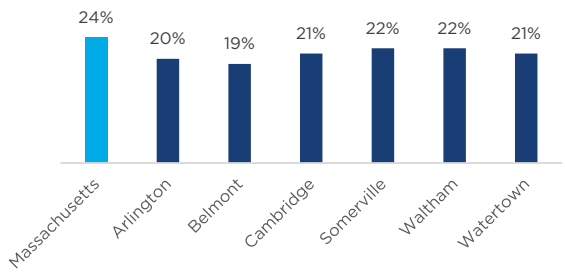
23% of MAH Community Health Survey respondents said they would like their community to have better access to healthy food.

Physical Activity

Access to opportunities for physical activity was not identified as a significant need in the MAH CBSA, though there was recognition that lack of physical fitness is a leading risk factor for obesity and a number of chronic health conditions.

More than 20% of adults in all of MAH's CBSA communities, with the exception of Belmont, were obese, defined as having a body mass index over 30.

Percentage of Adults Who Were Obese, 2018



Source: Behavioral Risk Factor Surveillance System, 2018

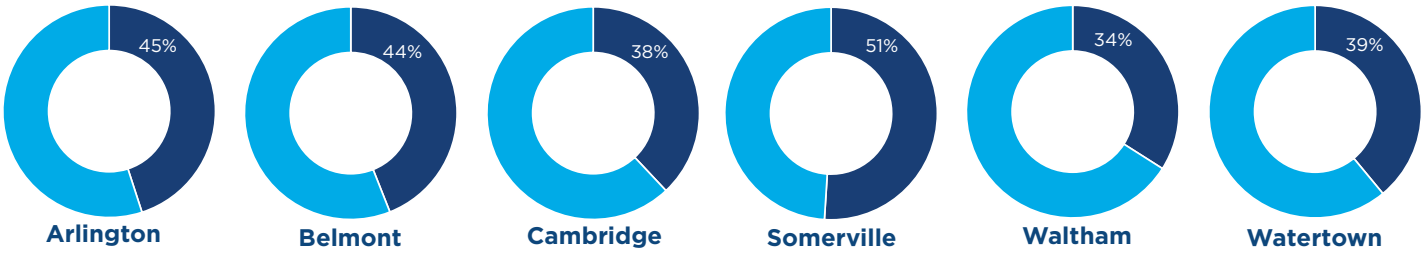
Alcohol, Marijuana and Tobacco Use

Though legal in the Commonwealth for those aged 21 and older, long-term and excessive use of alcohol, marijuana, and tobacco can lead to the development and exacerbation of chronic and complex conditions, including high blood pressure, cardiovascular disease, and cancer.

Clinical service providers reported an increase in substance use and relapse since the onset of the pandemic, potentially caused by increased stress and isolation and lapses in treatment.

Among MDPH COVID-19 Community Impact Survey respondents in MAH's CBSA communities who were current substance users, more than 30% reported that they used more substances in the fall of 2020 than before the pandemic.

Percentage* of Substance Users Who Said They Used More Substances Since the Start of the Pandemic, Fall 2020



***Unweighted percentages displayed**

Source: MDPH COVID-19 Community Impact Survey, Fall 2020

Health Conditions

The assessment gathered information related to the conditions that are known to be the leading causes of death and illness. These conditions include chronic and complex medical conditions as well as mental health and substance use disorders. As discussed in the introductory sections of this report, the assessment gathered quantitative data to assess the extent that these issues were a concern in MAH's CBSA.

To augment and clarify this information, the assessment efforts included community engagement activities and specific requests for participants to reflect on the issues that they felt had the greatest impact on community health. Efforts were made to ensure that participants reflected on a broad range of issues, including chronic and communicable medical conditions and behavioral health disorders.

Given the limitations of the quantitative data, specifically that it is often old data and is not stratified by age, race and ethnicity, the qualitative information from interviews, focus groups, listening sessions, and the MAH Community Health Survey was of critical importance.

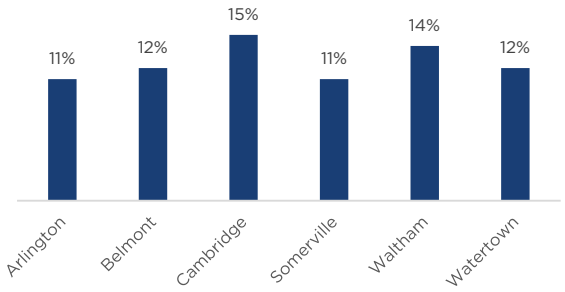
Mental Health

Anxiety, chronic stress, depression, and social isolation were leading community health concerns. There were specific concerns about the impact of mental health issues for youth and young adults, and social isolation among older adults. These difficulties were exacerbated by COVID-19.

In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services. Interviewees, focus group, and community listening session participants reflected on stigma, shame, and isolation that those with mental health challenges face that limit their ability to access care and cope with their illness.

Youth mental health was a critical concern in the MAH CBSA, including the significant prevalence of chronic stress, depression, anxiety, and behavioral issues. These conditions were exacerbated over the course of the pandemic, as a result of isolation, uncertainty, remote learning, and family dynamics.

Percentage of High School Students Reporting Suicidal Ideation, 2021



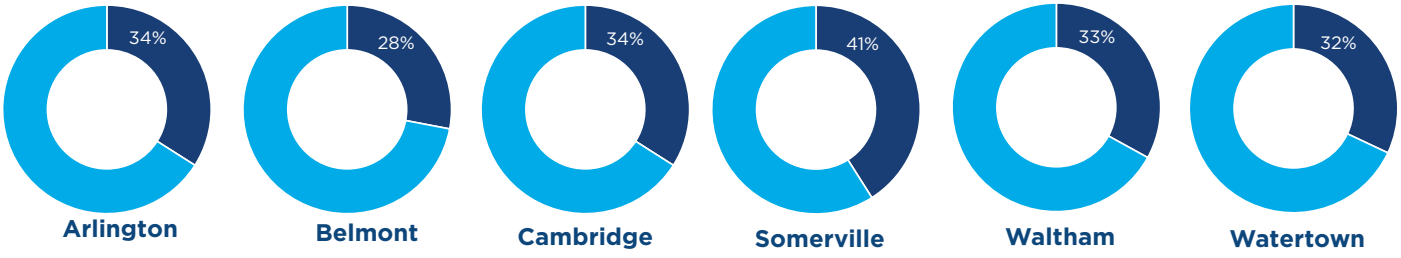
Source: Youth Risk Behavior Survey, 2021

Results of the 2021 Youth Risk Behavior Survey revealed that over 10% of high schoolers in all of MAH's CBSA communities reported suicidal ideation.

"We now have waitlists of over 100 families seeking mental health services. The wait times for people to access these services are significant, especially for children and teens."

–MAH interviewee

Percentage* of Individuals with 15 or More Poor Mental Health Days in the Past Month (Fall 2020)



Unweighted* percentages displayed

Source: MDPH COVID-19 Community Impact Survey, Fall 2020

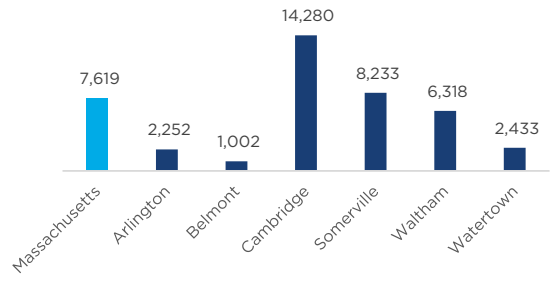
Health Conditions

Substance Use

Substance use continued to have a major impact on the CBSA. The opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities. Interviewees reported a need for programs that address common co-occurring issues, including mental health issues and homelessness. Interviewees also reflected on the need for transitional housing and other recovery support services.

The rate of emergency department discharges for substance use disorder among those 45-64 years of age was nearly double the Commonwealth in Cambridge.

Emergency Department Discharge Rates (per 100,000) for Substance Use Disorder Among Those 45-64 Years of Age, 2019



Source: Center for Health Information and Analysis, 2019

"Substance use is what limits [some people's] ability to access housing, maintain housing, and get all the other services that they want and need."

- MAH interviewee

Chronic and Complex Conditions

Chronic conditions such as cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease contribute to 56% of all mortality in Massachusetts and over 53% of all health care expenditures ($30.9 billion a year). Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.[20]

Looking across the four most common cancer types, inpatient discharge rates among those 65 years of age and older were higher than the Commonwealth in several communities, most notably in Waltham and Watertown.

Inpatient Discharge Rates (per 100,000) for Cancer Types Among Those 65 Years of Age and Older, 2019

	MA	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
Breast	1,253	1,664	1,300	1,322	979	1,474	1,421
Colorectal	271	263	189	290	203	445	430
Lung	1,347	1,293	1,237	1,084	1,272	1,697	1,569
Prostate	1,270	982	1,237	1,039	934	1,156	1,388

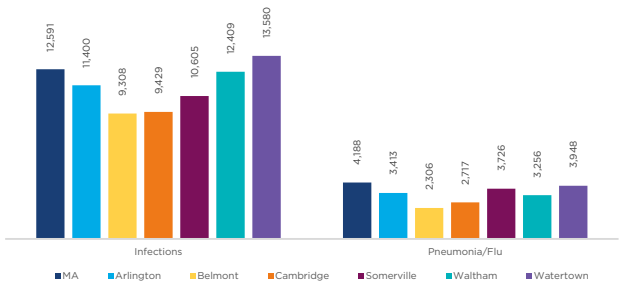
Source: Center for Health Information and Analysis, 2019

Communicable and Infectious Disease

Though great strides have been made to control the spread of communicable diseases in the U.S., they remain a major cause of illness, disability and even death - as evidenced by the COVID-19 pandemic. Though not named as a major health concern by interviewees or participants at listening sessions and focus groups, it is and focus groups, it is important to track data to prevent outbreaks and identify patterns in morbidity and mortality.

Data from the Center for Health Information and Analysis indicated that older adults in Watertown had higher rates of inpatient discharges due to infections compared to the Commonwealth overall, and inpatient discharge rates for pneumonia/flu among older adults were lower than the Commonwealth in all of MAH's CBSA communities.

Inpatient Discharge Rates (per 100,000) Among Those 65 Years of Age and Older, 2019



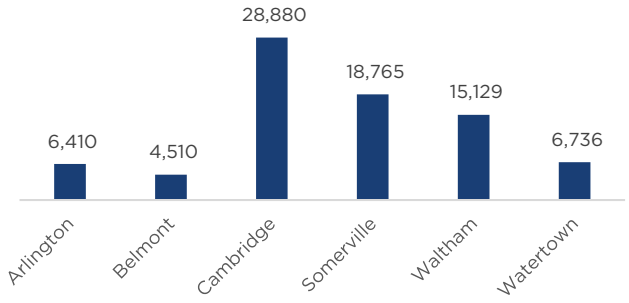
Source: Center for Health Information and Analysis, 2019

COVID-19

On March 11, 2020, the World Health Organization (WHO) declared the novel coronavirus a global pandemic. Society and systems continue to adapt and frequently change protocols and recommendations due to new research, procedures and policies. Interviewees and focus group participants emphasized that COVID-19 is a priority concern that continues to directly impact nearly all facets of life, including economic stability, food insecurity, mental health (stress, depression, isolation, anxiety) substance use (opioids, marijuana, alcohol) and one's ability to access health care and social services.

COVID-19 presents significant risks for older adults and those with underlying medical conditions because they face a higher risk of complications from the virus. Several interviewees described how COVID-19 exacerbated poor health outcomes, inequities and health system deficiencies.

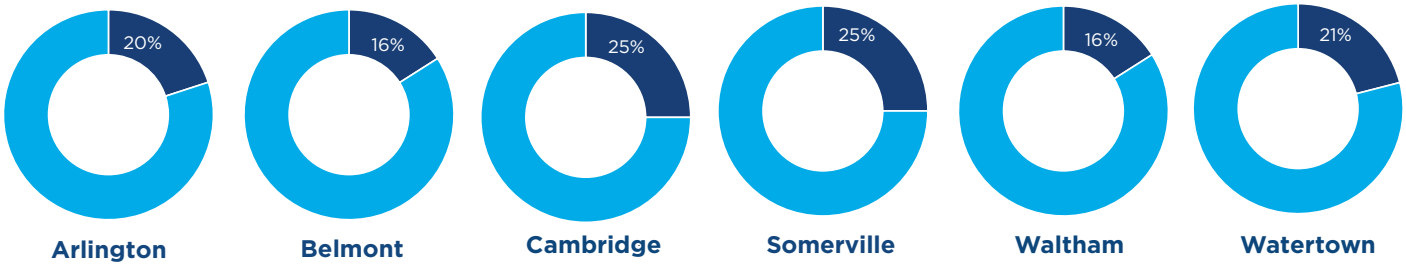
Total COVID-19 Case Counts Through June 23, 2022



Massachusetts Department of Public Health, COVID-19 Data Dashboard

In Arlington, Cambridge, Somerville, and Watertown, more than 20% of MDPH COVID-19 Community Impact Survey respondents reported that they had not gotten the medical care they needed since July of 2020. Lapses in medical care may lead to increases in morbidity and mortality.

Percentage* Who Have Not Gotten the Medical Care They Need Since July 2020 (as of Fall 2020)



***Unweighted percentages displayed**

Source: MDPH COVID-19 Community Impact Survey, Fall 2020

Priorities

Federal and Commonwealth community benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its IS. By analyzing assessment data, hospitals can identify the health issues that are particularly problematic and rank these issues in order of priority. This data can also be used to identify the segments of the community that face health-related disparities. Accordingly, using an interactive, anonymous polling software, MAH's CBAC and community residents, through the community listening sessions, formally prioritized the community health issues and cohorts that they believed should be the focus of MAH's IS. This prioritization process helps to ensure that MAH maximizes the impact of its community benefits resources and its efforts to improve health status, address disparities in health outcomes, and promote health equity.

The process of identifying MAH's community health issues and prioritized cohorts is also informed by a review and careful reflection on the Commonwealth's priorities set by the Massachusetts Department of Public Health's Determination of Need process and the Massachusetts Attorney General's Office.

Massachusetts Community Health Priorities

Massachusetts Attorney General's Office	Massachusetts Department of Public Health
• Chronic disease - cancer, heart disease, and diabetes • Housing stability/homelessness • Mental illness and mental health • Substance use disorder.	• Built environment • Social environment • Housing • Violence • Education • Employment.
Regulatory Requirement: Annual AGO report; CHNA and Implementation Strategy	*Regulatory Requirement: Determination of Need (DoN) Community-based Health Initiative (CHI)*

Community Health Priorities and Priority Cohorts

MAH is committed to promoting health, enhancing access and delivering the best care for those in its CBSA. Over the next three years, the hospital will work with its community partners to develop and/or continue programming geared to improving overall well-being and creating a healthy future for all individuals, families, and communities. In recognition of the health disparities that exist for certain segments of the population, investments and resources will focus on improving the health status of the following cohorts within the community health priority areas.

MAH Community Health Needs Assessment: Priority Cohorts

- Youth
- Older Adults
- Low-Resourced Populations
- Racially, Ethnically and Linguistically Diverse Populations
- LGBTQIA+

MAH Community Health Needs Assessment: Priority Areas

Community Health Needs Not Prioritized by MAH

It is important to note that there are community health needs that were identified by MAH's assessment that were not prioritized for investment or included in MAH's IS. Specifically, addressing the digital divide (i.e., promoting equitable access to the internet), supporting education across the lifespan, racial equity, and strengthening the built environment (i.e., improving roads/sidewalks and enhancing access to safe recreational spaces/activities) were identified as community needs but were not included in the hospital's IS. While these issues are important, MAH's CBAC and leadership team decided that these issues were outside of the hospital's sphere of influence and investments in other areas were both more feasible and likely to have greater impact. and/or being address by MAH's existing or funded programs. As a result, MAH recognized that other public and private organizations in its CBSA and the Commonwealth were better positioned to focus on these issues. MAH remains open and willing to work with community residents, other hospitals, and other public and private partners to address these issues, particularly as part of a broad, strong collaborative.

Community Health Needs Addressed in MAH's IS

The issues that were identified in the MAH CHNA and are addressed in some way in the hospital IS are housing issues, food insecurity, transportation, economic insecurity, build capacity of workforce, navigation of healthcare system, linguistic access barriers, cost and insurance barriers, youth mental health, stress, anxiety, depression, isolation, specialists for older adults, mental health stigma, culturally appropriate/competent health and community services, outreach/ engagement for specific populations (e.g. non English speakers), resource inventory, and cross sector collaboration/ partnerships/information sharing/referrals.

Implementation Strategy

MAH's current IS was developed in 2021 and addressed the priority areas identified by the 2022 CHNA. The 2022 CHNA provides updated guidance and insight on the characteristics of MAH's CBSA population, as well as the social determinants of health, barriers to accessing care and leading health issues, which informed and allowed the hospital to develop its 2023-2025 IS. MAH is conducting this 2022 assessment so that timelines and processes are aligned with other BILH hospitals.

Included below, organized by priority area, are the core elements of MAH's 2023-2025 IS. The IS is designed to address the underlying social determinants of health and barriers to accessing care, as well as promote health equity. The content addresses the leading community health priorities, including activities geared toward health education and wellness (primary prevention), identification, screening, referral (secondary prevention), and disease management and treatment (tertiary prevention).

Below is a brief discussion of the resources that MAH will invest in to address the priorities identified by the CBAC and MAH's senior leadership team. Following the discussion of resources are summaries of each of the selected priority areas and a listing of goals that were established for each priority area.

Community Benefits Resources

MAH expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by MAH and/or its partners to improve the health of those living in its CBSA. Additionally, MAH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, MAH supports residents in its CBSA by providing "charity" care to individuals who are low-resourced and unable to pay for care and services. Moving forward, MAH will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

Recognizing that community benefits planning is ongoing and will change with continued community input, MAH's IS will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies and other issues that may arise, which may require a change in the IS or the strategies documented within it. MAH is committed to assessing information and updating the plan as needed.

Following are brief descriptions of each priority area, along with the goals established by MAH to respond to the CHNA findings and the prioritization and planning processes. Please refer to the full IS in Appendix E for more details.

Summary Implementation Strategy

EQUITABLE ACCESS TO CARE

Goal: Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic, and economic barriers.

Strategies to address the priority:

- Provide and promote career support services and career mobility programs to hospital employees.
- Promote access to healthcare, health insurance, patient financial counselors, and needed medications for patients who are uninsured or underinsured.
- Support partnerships with regional transportation providers and community partners to enhance access to affordable and safe transportation.
- Promote equitable care, health equity, health literacy, and cultural humility for patients, especially those who face cultural and linguistic barriers.
- Promote resiliency for new moms.
- Support cities/towns to promote resilience, emergency care and emergency preparedness.

SOCIAL DETERMINANTS OF HEALTH

Goal: Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

Strategies to address the priority:

- Provide community health grants to support impactful programs that address issues associated with the social determinants of health.
- Participate in multi-sector community coalitions to convene stakeholders to identify and advocate for policy, systems, and environmental changes to address the social determinants of health.
- Support education, systems, programs, and environmental changes to increase healthy eating and access to affordable, healthy foods.
- Screen, assess, and connect patients with health-related social needs.
- Support programs that stabilize or create access to affordable housing.

MENTAL HEALTH AND SUBSTANCE USE

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.

Strategies to address the priority:

- Address the unique mental health needs of historically underserved youth.
- Provide access to high-quality and culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation, and treatment.
- Promote collaboration, share knowledge, and coordinate activities internally at MAH and externally with community partners.
- Advocate for and support policies and systems that improve behavioral health services.

COMPLEX AND CHRONIC CONDITIONS

Goal: Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications, and other resources.

Strategies to address the priority:

- Ensure older adults have access to coordinated health and support services and resources to support overall health and age in place.
- Provide preventive health information, services, and support for those at risk for complex and/or chronic conditions and support evidence-based chronic disease treatment and self-management programs.

Evaluation of Impact of 2020-2022 Implementation Strategy

As part of the assessment, MAH evaluated its current IS. This process allowed the hospital to better understand the effectiveness of their community benefits programming and to identify which programs should or should not continue. Moving forward with the 2023-2025 IS, MAH and all BILH hospitals will review community benefit programs through an objective, consistent process using the BILH Program Evaluation and Assessment Tool. Created with Community Benefits staff across BILH hospitals, the tool scores each program using criteria focused on CHNA priority alignment, funding, impact, and equity to determine fit and inclusion in the IS.

Since 2020, many of the programs that would normally be conducted in-person were postponed or canceled because of COVID-19. When possible, programs were delivered virtually to ensure the community was able to receive services to improve their health and wellness.

For the 2020-2022 IS process, MAH planned for a comprehensive strategy to address the prioritized health needs of the CBSA as outlined in the 2019 CHNA report. These strategies included grantmaking, in-kind support, partnerships, internal hospital programming, and charity care. Below is a summary of accomplishments and outcomes for a selection of community benefits programs for Fiscal Year (FY) 2020 and 2021. MAH will continue to monitor efforts through FY 2022 to determine its impact in improving the health of the community and inform the next IS. A more detailed evaluation is included in Appendix D.

Priority Area	Summary of Accomplishments and Outcomes
Cross-cutting Issues of Social Determinants of Health and Health System Strengthening /Access to Care	Racial Justice and Mental Health Collaboration: I ncreased the grant funding to Community Health Network Area 17 (CHNA 17) to promote its fellowship program as well as support its work on racial equity in mental health. Metro Housing Boston Co-Location Program: MAH formed a new partnership with Metro Housing Boston (MHB) and have implemented a Co-Location program for ease of transition for patients and to connect our housing unstable patients to a case manager. This case manager is available to continue support and guide residents to opportunities to help facilitate and secure stable housing for individuals and families. Food to the Community: Using our purchasing power MAH was able to purchase food and deliver it to the Healthy Waltham Emergency food pantry program once a month. Healthy Waltham saw an increase of those in need during the pandemic from serving 400 families once a month to serving 3,000 families per month at its emergency food pantry. MAH is dedicated to providing food monthly for these food insecure families and residents.
Reduce the Burden of Mental Health and Substance Use/Misuse	Substance Use Navigation and Support: Our Emergency Department Substance Treatment and Referral Team (START) works to provide transitions of care that are appropriate for all patients identified with behavioral health needs. To address the growing number of overdose patients in the emergency department, patients who present in the ED with an overdose are given a three-day supply of suboxone (as appropriate) until they can be seen in the outpatient clinic (Bridge Clinic) for follow-up. Mindfulness Based Stress Reduction Class (MBSR): The evidenced based program MBSR© was offered free of charge to the community. This program has been shown to complement traditional medical and psychological treatments and general wellness. Offered three times this past year, 100 % of participants reported that they will be able to take what they learned/skills practiced and use them to improve their own health and wellbeing.
Reduce Prevalence and Burden of Chronic and Complex Conditions	MAH Lifeline Services: MAH continued to provide emergency response services through the Lifeline program. This program offers installation and monthly payments at below cost to underserved elders and disabled persons who are in need, as identified by our regional elder service agencies. MAH provided over 2,000 eligible seniors and or disabled persons with personal response systems installed at below cost. Monthly bills are for the system are also at below cost to these individuals.

References

1 Massachusetts Department of Public Health: Community Engagement Standards for Community Health Planning. Retrieved from https://www.mass.gov/doc/community-engagement-guidelines-for-community-health-planning-ms-word-doc/download

2 Robert Wood Johnson Foundation. Immigration, Health Care and Health. Retrieved from https://www.rwjf.org/en/library/research/2017/09/immigration-status-and-health.html

3 Diamond, L., Izquierdo, K., Canfield, D., Matsoukas, K., Gany, F. (2019). A systematic review of the impact of patient-physician non-English language concordance on quality of care and outcomes. Journal of General Internal Medi-cine, 34(8), 1591-1606. DOI: 10.1007/s11606-019-04847-5

4 Hewitt, B., Walter, M. (2020). The consequences of household composition and household change for Indigenous health: evidence from eight waves of the Longitudinal Study for Indigenous Children. Health Sociology Review. DOI: 10.1080/14461242.2020.1865184

5 US Department of Health and Human Services - Healthy People 2030. Social determinants of health. Retrieved from https://health.gov/healthypeople/priority-areas/social-determinants-health

6 Rural Health Information Hub. Programs that focus on improving economic stability. Retrieved from https://www.ruralhealthinfo.org/toolkits/sdoh/2/economic-stability

7 Chetty, R., Stepner, M., Abraham, S. (2016). The association between income and life expectancy in the United States, 2001-2014. *The Journal of the American Medical Association, 315(16)*, 1750-1766. DOI: 10.1001/jama.2016.4226

8 National Center for Health Statistics. (2017). Health insurance and access to care. Retrieved from https://www.cdc.gov/nchs/data/factsheets/factsheet_hiac.pdf

9 Williams, D., Rucker, T. (2000). Understanding and addressing racial disparities in health care. *Health Care Financing Review, 21(4)*, 75-90. PMID: 11481746

10 Virginia Commonwealth University. Why education matters to health. Retrieved from https://societyhealth.vcu.edu/work/the-projects/why-education-matters-to-health-exploring-the-causes.html

11 US Department of Health and Human Services - Healthy People 2030. Neighborhood and built environment. Retrieved from https://health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment

12 Krieger, J., Higgins, D. (2002). Housing and health: Time again for public health action. American Journal of Public Health, 92(5), 758-768

13 Henwood, B., Byrne, T., Scriber, B. (2015). Examining mortality among formerly homeless adults enrolled in Housing First: An observational study. BMC Public Health, 15, 1209. DOI: 10.1186/s12889-015-2552-1

14 Racial Equity Tools. Racial equity. Retrieved from https://www.racialequitytools.org/resources/fundamentals/core-concepts/racial-equity

15 De Souza, R., Iyer, L. (2019). Health care and the competitive advantage of racial equity: How advancing racial equity can create business value. Retrieved from https://corporateracialequityalliance.org/sites/default/files/Health%20Care%20and%20the%20Competitive%20Advantage%20of%20Racial%20Equity_0.pdf

16 Sulaiman, A. (2017). The impact of language and cultural barriers on patient safety and health equity. Retrieved from from https://www.qualityhealth.org/wpsc/2017/10/13/impact-of-language-cultural-barriers-on-patient-safety-health-equi-ty

17 United States Department of Health and Human Services. (2022). What is telehealth? Retrieved from https://telehealth.hhs.gov/patients/understanding-telehealth/

18 Linarkardis, M., Papadaki, A., Smpokos, E., Micheli, K., Vozikaki, M., Philalithis, A. (2015). Association of behavioral risk factors for chronic diseases with physical and mental health in European adults aged 50 years or older. Prevention of Chronic Disease, 12. DOI: http://dx.doi.org/10.5888/pcd12.150134

19 National Center for Chronic Disease Prevention and Health Promotion. Poor nutrition. Retrieved from https://www.cdc.gov/chronicdisease/resources/publications/factsheets/nutrition.htm

20 Massachuetts Executive Office of Health and Human Services. Chronic disease data. Retrieved from https://www.mass.gov/chronic-disease-data

Appendices

Appendix A: Community Engagement Summary

Appendix B: Data Book

Appendix C: Resource Inventory

Appendix D: Evaluation of 2020-2022 Implementation Strategy

Appendix E: 2023-2025 Implementation Strategy

Appendix A:
Community Engagement Summary

Interviews

- Interview Guide
- Interview Summary

Beth Israel Lahey Health Community Health Assessment

Interview Guide

Please complete this section for each interview:

Date:	Start Time:	End time:
Name of Interviewee:		
Name of Organization:	Affiliate Hospital:	
Facilitator Name:	Note-taker Name:	
Did all participants agree to audio recording?		
Did anything unusual occur during this interview? (Interruptions, etc.)		

Thank you for taking the time to speak with me today. Beth Israel Lahey Health (BILH) and [Hospital and any collaborators] are conducting a community health needs assessment and creating an implementation plan to address the prioritized needs identified. For the first time, all 10 hospitals in the BILH system are conducting this needs assessment together. Our hope is that we will create a plan at the individual hospital level as well as the system level that will span across the hospitals.

During this interview, we will be asking you about the strengths and challenges of the community you work in and the populations that you work with. We also want to know what BILH should focus on as we think about addressing some of the issues in the community. The data we collect during the assessment is analyzed, prioritized, and then used to create an Implementation Strategy. The Implementation Strategy outlines how the Hospital and System will address the identified priorities in partnership with community organizations. For example, if social isolation is identified as a priority, we may explore partnering with Councils on Aging on programs to engage older adults, and support policies and system changes around mental health supports.

Before we begin, I would like you to know that we will keep your individual contributions anonymous. That means no one outside of this interview will know exactly what you have said. When we report the results of this assessment, no one will be able to identify what you have said. We will be taking notes during the interview, but your name will not be associated with your responses in any way. Do you have any questions before we begin?

If you agree, we would like to record the interview for note taking purposes to ensure that we accurately capture your thoughts and obtain exact quotes to emphasize particular themes in our final report. Do you agree?"

[*<u>if interviewee does not agree to be recorded, do not record the interview</u>]

Question	Direct Answer	Additional Information
Community Characteristics, Strengths, Challenges		
What communities/populations do you mainly work with?		
• How would you describe the community (or population) served by your organization?		
• How have you seen the community/population change over the last several years?		
What do you consider to be the community's (or population's) strengths?		
How has COVID affected this community/population?		
What are some of its biggest concerns/issues in general? What challenges does this community/population face in their day-to-day lives?		
Health Priorities and Challenges		
What do you think are the most pressing health concerns in the community/among the population you work with? Why?		
• How do these health issues affect the populations you work with? [Probes: In what way? Can you provide some examples?]		
We understand that there are differences in health concerns, including inequalities for ethnic and		

racial minority groups **/** the impacts of racism. Thinking about your community, do you see any disparities where some groups are more impacted than others?		
• What contributes to these differences?		
What are the biggest challenges to addressing these health issues?		
What barriers to accessing resources/services exist in the community?		
Community-Based Work		
What are some of the biggest challenges your organization faces while conducting your work in the community, especially as you plan for the post-COVID period?		
Do you currently partner with any other organizations or institutions in your work?		
Suggested Improvements		
When you think about the community 3 years from now, what would you like to see?		
• What would need to happen in the short term?		
• What would need to happen in the long term?		
How can we tap into the community's/population's strengths to improve the health of the community?		

In what way can BILH and [Hospital] work toward this vision? What should be our focus to help improve the health of the community/population?		
Thank you so much for your time and sharing your opinions. Before we wrap up, is there anything you want to add that you did not get a chance to bring up earlier?		

I want to thank you again for your time. Once we finish conducting survey, focus groups and interviews, we will present the data back to the community to help determine what we should prioritize. We will keep you updated on our progress and would like to invite you to the community listening sessions where we will present all of the data. Can we add you to our contact list? After the listening sessions, we will then create an implementation plan to address the priorities. We want you to know that your feedback is valuable, and we greatly appreciate your assistance in this process.

Interviewees

- Liz Aguilo, Executive Director, Paine Senior Services
- Arlington Municipal Leaders
- Jackie Caseres, Visiting Mom and Group Leader, Jewish Family & Children's Services
- Wesley Chin, Public Health Director, Belmont
- Gregg Cothias, Colocation Manager, MetroHousing Boston
- Susan Dorson, Program Manager, Arlington EATS
- Michelle Feeley, Waltham
- Ann-Marie Gagnon, Senior Services Director, Watertown Council on Aging
- Lisa Gibalerio, Prevention Specialist, Wayside Youth and Family Support Network
- Shameka Gregory, Director of Equity and Justice, Transition House Inc.
- Doug Kress, Public Health Director, Somerville
- Myriam Michel, Executive Director, Healthy Waltham
- Carolyn Montalto, Executive Director, Community Day Center of Waltham
- Juliet Najjumba, Executive Director and Founder, Africano Waltham
- Larry Ramdin, Public Health Director, Watertown
- Katie Teague, Program Manager, Cambridge Health Alliance
- Laura Weiner, Senior Transportation Planner, Watertown Department of Community Development and Planning
- Josefine Wendel, Associate Chief of Population Health, Cambridge Public Health Department

Key Findings

Community characteristics

- Significant diversity – race, ethnicity, culture
- Culture of community and neighborhood collaboration
- Urban communities (Cambridge, Somerville) are resource rich

Specific populations facing barriers

- Youth
- BIPOC
- Older adults
- Individuals with limited economic means
- LGBTQIA+
- Homeless/unstably housed
- Non English Speakers
- Immigrants

Social Determinants of Health

- Housing is a major concern – lack of affordable housing, displacement
- Economic insecurity – cost of living continues to rise; pandemic had significant impact on many people financially
- Childcare is unaffordable

- Food insecurity
- Transportation and mobility

Mental health

- Significant prevalence of stress, anxiety, depression, isolation (especially among older adults) and behavioral issues that were exacerbated throughout the pandemic
    - Major emphasis on youth mental health
- Over the course of the pandemic, people reported that it was more difficult to find providers who were taking on new patients
    - Gaps in the workforce – need more providers specifically trained to work with young people.
    - *"We now have waitlists of over 100 families seeking mental health services. The wait times for people to access these services are significant, especially for children and teens."*
- Stigma (societal/cultural) prevent people from seeking care and treatment
- Need more providers who reflect diversity of patients

Access to care

- People face difficulties navigating the health care system, including insurance
    - Language and cultural barriers contribute to these difficulties
- Need more provider education on how to best serve diverse populations, including affirming care for LGBTQIA+, undocumented individuals, non-English speakers
- Barriers include cost/insurance barriers, difficulty accessing services because of long wait times and lack of providers (especially over COVID)
    - This affects all sectors of healthcare system – primary care, behavioral health, dental care, specialties. Most acutely being felt in the behavioral health space

Diversity, Equity, Inclusion

- Discussions of the impacts of racism (systemic and individual), police brutality, racial and ethnic health disparities in incarceration rates
- Increasing conversation/dialogue around issues of equity
    - *"We need to have better understanding and more embracing of the massive diversity in this town. I hope we can do a better job of being aware of one another."*
- Lack of representation among health care providers – people could be better served by those who understand their language and culture
- There is historic mistrust and fear around healthcare among immigrant communities – e.g., undocumented folks fear having to disclose their immigration status as a condition of care
- Need housing supports and social services that are culturally appropriate

Community Connections & Info Sharing

- There may be many community resources – but how do residents know about them?

    - Need more targeted outreach and navigation for certain segments of the population, including non-English speakers, individuals who are undocumented, those who are homeless or unstably housed
- Community organizations working in silos – not working with one another. Little understanding of each others capacities and programs which limits referral and stifles collaboration

Focus Groups

- Focus Group Guide
- Focus Group Summary Notes

BILH Community Health Needs Assessment: Focus Group Guide

Opening Script (10 Minutes)

Thank you for participating in this discussion on health in your community. I'm going to review some information about the purpose and ground rules for the discussion, then we'll begin.

We want to hear your thoughts about things that impact health in your community. The information we collect will be used by Beth Israel Lahey Health to create a report about community health. We will share the results with the community in the winter and identify ways that we can work together to improve health and wellbeing. The is used to put together a plan that outlines how the Hospital and System will address the identified priorities in partnership with community organizations.

We want everyone to have the chance to share their experiences. Please allow those speaking to finish before sharing your own comments. To keep the conversation moving, I may steer the group to specific topics. I may try to involve people who are not speaking up as much to share their opinions, especially if one or more people seem to be dominating the conversation. If I do this, it's to make sure everyone is included. We are here to ask questions, to listen, and to make sure you all have the chance to share your thoughts.

We will keep your identity and what you share private. We would like you all to agree as a group to keep today's talk confidential as well. We will be taking notes during the focus group, but your names will not be linked with your responses. When we report the results of this assessment, no one will be able to know what you have said. We hope you'll feel free to speak openly and honestly.

With your permission, we would like to audio record the focus group to help ensure that we took accurate notes. No one besides the project staff would have access to these recordings, and we would destroy them after the report is written. Does everyone agree with the audio recording?

If all participants agree, you can record the Zoom. If one or more person does not agree or are hesitant, do not record the focus group.

Does anyone have any questions before we begin?

Section One: Community Perceptions

1. To get started, let's talk about what affects our health. When you think about your community, what are some of the things that help you to be healthy?

2. What are some of the things that make it hard for you, and your community members, to be healthy?

3. Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] impact health for you. Did I capture that correctly?

   If yes, move on to Section 2.

   If no, ask for clarification on key factors and come to consensus on the 3-4 factors that will shape the rest of the conversation)

   Let's talk more deeply about these concepts.

Section Two: Key Factors

In this section, ask participants to go more in depth about the factors they brought up in the previous section. For example, if they brought up the lack of affordable healthy foods, ask "are healthy foods available to some people, if so who? And why do you think they are not available to everyone?"

For each issue they identified:

- Are these (things that keep you healthy) available to everyone or just a few groups of people?

- Why do you think they (things that make it hard to be healthy) exist? / Why is this a challenge?

Section Three: Ideas and Recommendations

4. **Ideas:** Thinking about the issues we discussed today, what ideas do you have for ways hospitals can work with other groups or services to address these challenges?
    1. Based on what you shared in the beginning about the things that keep you healthy, what of the things you mentioned would you like to see more of?

5. **Priorities**: What do you think should be the top 3 issues that Hospitals and community organizations should focus on to make your community healthier?

MAH Focus Group Summary: Rainbow Commission (LGBTQIA+

Date: 10/27/21	Start Time: 6pm	End time: 7pm
Group Name and Location: Rainbow Commission in Arlington (virtual meeting)		

Section 1: Community Perceptions	
Healthy: To get started, let's talk about what affects our health. When you think about your community, what are some of the things that help you to be healthy?	Provision of care that's responsive and considerate of LGBT community - Mental health important - Support groups that serve as safe spaces - Sexual health important (STI/STD testing) - Receiving appropriate referrals to specialists - Access to overall care, mental health, sexual health care that's affirming - Providers in the community with a baseline training for working with LGBT community and not adhering to status quo behaviors Community support and sense of safety - Support for the LGBT community from community at large - Safer spaces, notably in the workplace where people don't need to hide their identity Healthy Living Access - Exercise opportunities outdoors because of the pandemic - Healthy food options, or options in general at restaurants and other places

Unhealthy: What are some of the things that make it hard for you to be healthy?	COVID-19
	- reduced access to gyms / fitness
	- reduced access to doctor's office, fears of COVID-19 safety
	  - Postponed gender affirmation surgeries caused people to feel less positive about themselves
	  - Appointments resuming lately
	- generally higher levels of anxiety

	- Coupled with anxiety about an anti-LGBT presidency and administration - Less anxiety with a change of presidency - harder to meet others, socialize, more isolation Other Health Factors - Smoking, drug use - Being able to have a balanced died - Lack of sleep and working a lot/multitasking Healthcare-related Factors - Discrimination from providers, fear of rejection from providers - Lack of insurance or insurance coverage
Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] impact health for you. Did I capture that correctly? *If yes, move on to Section 2.* *If no, ask for clarification on key factors and come to consensus on the 3-4 factors that will shape the rest of the conversation)* Let's talk more deeply about these concepts.	Top Factors 1. **Affirming care:** Providers that are better trained and equipped to work with LGBTQ+ communities, across care in all areas of health (mental health, sexual health); interactions with the healthcare system 2. **Supports in the community:** Isolation and mental health, active discrimination, US politics and hostility from administration 3. **Health factors**: food, exercise, substance use
<u>Section 2: Exploring Key Factors</u> Social networks/Trust. Racism.	
Is **affirming care, community support, healthy food, opportunities for**	Affirming Care ● Providers not learning or getting trained because the need for LGBTQ+ care isn't clear. Patients not coming out to their providers or being offered a

exercise available to everyone or just a few groups of people?	welcoming space to do so, creating a cycle where providers don't think they need to get trained or knowledgeable about LGBT communities. Assumptions that the LGTB community is small in number ● Providers raising awareness of their biases (cisgender, straight, etc) and just developing the mindset to ask and question status quo ● Creating signs of being welcoming (pronouns listed on name tags, etc) Health factors ● Opportunities for exercise ● Healthy food choices - limited by finances, access to stores or locations, availability at nearby stores
Why do you think they **(things that make it hard to be healthy)** exist? - Why is this a challenge?	● Easier for providers to work off assumptions than to actively learn and understand their biases ● LGBT support and existence is not a norm, but making it more of a status quo is important especially from the general community. Lots of negative viewpoints that requries a paradigm shift ○ Examples: assumptions that people are straight/cisgender doesn't promote inclusion
What are some examples of how these challenges impact someone's health?	● Community not seeking or trusting healthcare services
<u>Section 3: Ideas and Priorities</u>	
Ideas: - Thinking about what we have all talked about, what ideas do you have for ways hospitals can work with other groups or services to address the challenges of your community at this time? - Based on what you shared in the beginning about the things that	Healthcare: ● Frequent trainings for both providers and all other health center employees on the needs of the LGBT community ○ Making these efforts known so people are aware of the steps they are taking towards inclusive care ● Clearly explain and demonstrate anti-discrimination policies and efforts to be fair and nondiscriminatory ● Attention to caring for older LGBT folks ● Creating signs of a welcoming space (pronouns listed on name tags, etc) ● Creating opportunities to identify providers with interests, knowledge of LGBT

keep you healthy, what of the things you mentioned would you like to see more of?	issues ○ Ex. using alwayshealthplan search tool to filter out providers and connect with providers that meet patient preferences and needs. BILH does not have a comparable system for this ○ Doctors that are willing to be out, would allow patients to also connect Potential Partners: ● Fenway Health is a great local resource/model for LGBT care ● Boston Children's has gender identity program for adolescents ● Boston University Anti-Racism lab addresses intersections of race/gender
Priorities: - What do you think should be the top 3 issues service providers should focus on to make your community healthier?	● Difficult to prioritize given interrelatedness of issues, would prefer a holistic approach but if had to choose one area one person noted mental health and the need for more providers ● Focus on where hospital has the most agency and where they can work effectively at a systematic level ● Lobbying for more insurance coverage, for example services for people transitioning
<u>Section 4: Final Remarks & Closing</u>	
Are there other factors that influence your health that we have not discussed tonight that you feel are important?	● Support for nontraditional family structures ● Supporting families with children who are nonconforming or gender expansive ○ Allows parents environment to speak with providers about how to better support their children with gender and sexuality ○ Transform the health center to be a place where you can listen and be supported

MAH Focus Group Summary: SCALE

Date: November 3, 2021	Start Time: 6:15M	End time: 7:30pm
Group Name and Location: SCALE Focus Group		

Characteristics of Group

Race/Ethnicity
1 Hispanic
2 Asians
1 White
3 African American/Black
1 Other

Age
1 19-29
1 30-39
2 40-49
3 50-59
1 60-69

Gender Identity
2 Male
6 Female
0 Other

Section 1: Community Perceptions	
Healthy: To get started, let's talk about what affects our health. When you think about your community, what are some of the things that help you to be healthy?	● Having good access to health services ● Access to healthy food ● Housing ● Having a community around you to socialize with and support you
Unhealthy: What are some of the things that make it hard for you to be healthy?	● Isolation ● COVID ● Unfriendly ● Hard to find services ● Fear of deportation ● Lack of transportation
Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] impact health for you. Did I capture that correctly? *If yes, move on to Section 2.* *If no, ask for clarification on key factors and come to consensus on the 3-4 factors that will shape the rest of the conversation)* Let's talk more deeply about these concepts.	Top Factors 1. Transportation 2. Communication with your doctor 3. Mental Health 4. Housing 5. Navigating the systems, finding resources,
Section 2: Exploring Key Factors *In this section, ask participants to go more in depth about the factors they brought up in the previous section.*	

Are these **(things that keep you healthy)** available to everyone or just a few groups of people?	• All of these challenges are worse for those who:
	  ○ Face financial resource challenges,
	  ○ Face language barriers
	  ○ Have physically or cognitively disabled, or

	○ Do not have a strong support network. • If you do not have a car, can't afford to own one, or do not know how to drive transportation is hard • Everyone struggles with traffic and congestion
Why do you think they **(things that make it hard to be healthy)** exist? - Why is this a challenge?	**TRANSPOTATION** - **Lyft and uber and taxis** not always available and expensive - Not enough drivers, much more unreliable than it used to be - Very expensive - **Public buses** do not go frequently enough and the routes do not always take you where you need to go. - Public bus stops have no shelters so when it is raining or snowing you get soaking wet and cold, which is really bad when you are headed to your job - Public buses are also often very crowded which is unsafe during COVID - Wheel chair accessibility is not acceptable and there are only two spots to put wheel chairs safely on buses which is not enough - Traffic is also really bad and so if you take a taxi/uber/lyft or bus it can take a long long time - **MBTA "RIDE"** is totally unreliable and expensive and requires that you plan very far in advance. You can't be spontaneous with the RIDE - Not a good value for the price - It you have a personal care attendant with you there is sometimes not enough space in the vehicle. ***ACCESS TO CARE & NAVIGATING THE SYSTEM*** • Need more case management and support to navigate the system • Primary care and specialty care access can be challenging • Often it is the front desk staff who are rude and not "customer friendly" ○ Need to listen to patients carefully and be respectful
What are some examples of how these challenges impact someone's health?	***HOUSING*** • Housing (rental or ownership) is much too expensive

	• Does not allow people to live in safe housing that are close to their support networks and their work • Housing so expensive that they can not afford other necessities in life, such as food, social activities, transportation, cloths, etc. • Not enough money to take care of emotional heatlh. No time to go out, take vacations • Not a livable wage. Have to work multiple jobs in order to survive • Challenges dealing with Landlords who do not do what they are supposed to ensure that the housing is safe • Long wait lists for public, subsidized housing, bureaucracy is really confusing, especially for people who are new to the country and/or do not speak English • Gentrification is making people have to move. Can't afford the housing, displacing workers • Can't buy a house • Having to go farther and farther away to find housing that they can afford and then the commute to work is really difficult. Long travel times to family, friend, and jobs **<u>Mental Health</u>** • Depression, stress, anxiety • Fear of deportation • Isolation, many people do not have strong family and friend social support network • Sleep problems • Lonely, feeling along • Not enough to do, makes people sad, depressed and anxious • MH challenges are particularly problematic for recent immigrants, people who are experiencing material poverty, disabled, mental health challenges • Often mental health and substance use go together. People turn to substances to control their mental health • COVID has made mental health and substance use much work • People have been forced out of their normal routines and its hard to develop new routines • Access to MH services are a major problem for:

	○ Medicaid insured because lots of providers do not take insurance ○ Expensive ○ Not enough providers ○ Especially problem for people have ○ Need case managers to help support referral networks **<u>Healthy Lifestyles Coaching and Education</u>** • Need nutrition education • Food is too expensive, especially healthy foods and vegetables • Some people do not know what to buy, need to educate people on how to live healthily on a fixed income • People are often too proud to ask for help when it comes to access food and housing and transportation…TOO PROUD • Too much sugar and salt in food
<u>Section 3: Ideas and Priorities</u>	
Ideas: - Thinking about what we have all talked about, what ideas do you have for ways hospitals can work with other groups or services to address the challenges of your community at this time? - Based on what you shared in the beginning about the things that keep you healthy, what of the things you mentioned would you like to see more of?	● Mental health ○ Education and awareness programs ○ Screening and assessment programs for those who are at risk ○ Peer support groups ○ Community health worker programs to support those with MH problems ○ More access to services, especially for those who do not speak English or are from other cultures ○ ● Transportation ○ More case management to support those who struggle with access and transportation ○ Subsidized transportation programs ○ More bus shelters ○ Better systems to support people scheduling rides ○ More flexible scheduling ● Housing ○ More affordable housing units

	○ Support to help people with landlords ○ Help with down payment on new homes ○ Reduce confusion regarding the housing wait lists ● Healthy Lifestyles ○ More education programs ○ Vouchers for fresh food ○ Home delivery programs ○ Reduce stigma and judgement about those seeking support ○
Priorities: - What do you think should be the top 3 issues service providers should focus on to make your community healthier?	● ***Mental health*** ● ***Navigating the system*** ● ***Healthy Lifestyles (food, nutrition, exercise, risk factors for chronic disease)*** ● ***Transportation*** ● ***Housing***
<u>Section 4: Final Remarks & Closing</u>	
Are there other factors that influence your health that we have not discussed tonight that you feel are important?	

MAH Focus Group Summary: BIPOC

Date: November 17, 2021	Start Time: 7pm	End time: 8pm
Group Name and Location: BIPOC		

Healthy Factors	

When we talk about health, we mean anything that affects your physical, emotional, mental, spiritual health, anything that impacts your well-being.
 	
Before we talk about challenges, we want to know what is currently working in your community. To start off very broadly, could you tell us what helps you and others stay healthy?
	- Health education, information, programming, choices
	  - Addressing mental health stigma
	  - Programs tailored to cultures, language groups, or that build trust with those communities that are most impacted
	- Routine healthcare visits
	- Faith
	- Community, socializing
	  - Having good peers who are making healthy choices, good role models
	- Getting enough sleep
	- Exercising
	- Having money, being employed helps
	
	Verbatim notes--
	● Getting as much information as I can to stay healthy
	● Not missing doctor's appointments, making sure I get my annual check-ups, "Just like you weigh yourself you can keep track of when you are not eating well, going to the doctor helps to know if you are healthy.
	● Being around people, socializing. The pandemic has been really hard because we have been isolated. Missing my family.
	● Sleep is really important. Being more vigilant to get the sleep that I need.
	● Having a job helps (BUT IT ALSO IS HARD SOMETIMES TO Get to appointments when you have a job)
	● Making sure you go to the doctors and that you are around people who also appreciate the doctors.

	● Peers that are good models ● Programs that help people educate themselves about the factors that keep them healthy. Health education and awareness programs. Physical health education AND mental and emotional health education. Programs to address MH stigma. ○ Especially programs that are tailored to those of other cultures and language groups and building trust and supporting communities that are most impacted ○ Matching of services and program to the culture and language of the people they are serving. Really hard to communicate and provide quality care and build trust if you don't trust and have a rapport with your providers. ○ Need to make sure that people understand that they have a choice of who they ● Faith ● Exercise ● Socialising, having community
Does everyone have access to these things? **Are there ways you'd like to see these resources/services improve for BIPOC?**	- Inaccessible because of lack of information and complicated system - People going in circles trying to get answers, sharing their info repetitively, and getting tired - Lack of strong patient-provider relationships or continuity of care - Difficult to establish good communication, trust, and quality of care - Improve by better matching providers and patients with cultural backgrounds, immigrant histories - Improve my letting people know they have a choice about their providers - Inaccessible to those uninsured who have reduced options and long lines - Inaccessible to recent immigrants due to fears of deportation, knowing who and where can support them - COVID increased social isolation Verbatim notes-- ● Lot of people do not have access to the services they need ● Hard for some people to navigate the system, get tired and give up ● Sometimes the doctor will "drop them", which can be discouraging and people get warn out and frustrated

	● Some people have a hard time navigating the system, lots a questions, and then when you are referred to another provider you get more questions or have to repeat yourself. ● Lots of people do not have insurance and when you are uninsured you can only go to a small number of places which usually have long lines and that is a huge barriers ● Recent immigrants often face challenges, due to lack of papers, fear being deported, lack of counseling and knowledge to support people who are recent immigrants ● Hospitals working more with community centers like Africano, ● Ways patients are matched with doctors, people with cultural backgrounds, immigrant histories ● The Africano organization is fantastic group, providing a ton of support.
<u>Unhealthy Factors</u>	

Next, we want to dive deeper into understanding the health challenges and barriers Black, Indigenous, People of Color face.
 	
To start broadly, what is making or keeping people unhealthy?
- **What are some barriers to healthcare or social services?**
	- Lack of time and balance, managing multiple jobs or responsibilities keeps people from maintaining appointments but also attending to their health and spending time with family/community
	  - Especially for immigrants working many jobs and hours
	  - Workforce burnout for health center staff being overworked, they need self-care and less pressure to overwork as well
	- Lack of information, health education, and trust, this is occurring generationally
	  - Partnerships with local orgs can support this
	  - Beliefs that check-ups are unnecessary, doctors trying to change your daily lifestyle and bill you through medications, etc, to keep you coming back
	- Medical system is also dismissive and seems to not be interested in helping
	  - Need for better sensitivity, cultural competency, and patient-centered care
	  - Unlearning learned behaviors, partnering with nontraditional organizations to get to the root of the problem so that health system isn't alone doing it
	- Lack of insurance leads people to getting lower quality of care or increases difficulty accessing care locally
	- Mental health - depressions, suicidality

	- Lack of mental health counselors and available treatment, information about how to get support - Stigma about seeking support and sharing their mental health concerns - prioritizing mental health as much as physical health, impacts everyone not just low SES groups - Mental health practitioners quick to diagnose people and label people which makes it seems like there's a hidden agenda, when it's about people's circumstances, environments, life events, and results of navigating systems and changes - Substance use - Folks self-medicating to cope with stress - Generational living can be crowded Verbatim notes-- ● Jobs keeping people from appointments ● Needing to work many jobs, many hours ○ Especially affecting immigrants ● Appointments falling on work days/work hours ● Belief that they don't need check-ups ● Sentiments that doctors always want to change things and add medications to keep going back ot the doctors ● Lack of information is a barrier for many to keep themselves healthy ● Lack of trust between health systems and POC, partnerships with local orgs can support this ○ Generational mistrust, thinking about sustainable changes ● Need more MH counselors. Need more access to MH treatment, not just physical health ● Depression, suicidal thoughts ● MH impacts everyone regardless of who you are and yoru SES status. ● Overworking. People have to work so many jobs to make enough money to take care of themselves. Need to address their financial needs so that they don't have to work so hard. ● Overworking also does not allow them to look after their families ● Lack of health insurance or insurance that forces you to go to places that are too far away or perhaps not quality care.

	● The physical and Mental health systems overwork their employees. Health care workers need a break. Need for self-care. Too much pressure to work more and more shifts. ● Need to look after health care workers ● Need more education about nutrition. "You are what you eat" Need more information and knowledge and the ability to make healthy decisions ● Immigrants are forced to work too hard ● Substance use is a problem...Self-medicating due to stress and MH challenges. They are using drugs or alcohol to alleviate stress ● People are rarely living in a "nuclear" family, they have to live communally in cramped quarters which is not healthy ● Most of us are unhealthy because fear of the unknown ● People are depressed and overworked and scared of people knowing they are depressed. Fear that sharing their circumstances will make them lose their jobs. Have to keep everything to themselves and suffer. "Fear of the unknown and lack of information about how to get the services they need. ● Mental health stigma ● Mental health quick to diagnose people when its circumstances, events. Eager to diagnose and label people, feels like there's a hidden agenda. Some people need to change their environment, other lifestyle changes rather than being diagnosed or medicated, sends people on their way instead of taking time to understand where they're coming from ○ over medication happens a lot in the black community ● The medical system is dismissive ● Striving for life balance and really make major decisions to get themselves off the treadmill of overworked and not eating healthy. ● Unlearning learned behaviors, partnering with nontraditional organizations to get to the root of the problem so that health system isn't alone doing it ● we appreciate the health system but sometimes I feel like the health system seems not invested enough in helping,,,,, they talk too much and do little. They have the biggest ability to move things around but they tend to crawl instead of walking where needed. partnering, listening to other views. ● Providers need to caring and understanding and be more patient to their patients. Need for person-centered care. If people are rude and not treated respectfully without judgement than they are not going to come back

How does racism and discrimination impact people's health?	- Generational lack of trust between people of color and health systems - Mental health not encompassing people's experiences holistically - Poor quality of care and continuity of care - Overmedication happens often in the Black community
Section 3: Ideas and Priorities	
Of the issues we've named, what would be the top issues that you would like hospitals to focus on?	- Access to information and health education - Quality of care: patient-centered care, culturally competent and sensitive care - Mental health - Financial burdens and folks overworking - Immigrant experiences navigating care without insurance, information, fears of deportation
What is important to consider and include if we want to see change for these issues?	- Generational mistrust between people of color and systems, build trust with those communities that are most impacted - Tailoring changes to cultures, language groups, etc. - Hospitals and health systems need to look to address the underlying issues rather than giving medication and treating a physical disease. Underlying issues might be stress, access to food, etc.
Do you have any specific suggestions for how the hospital can improve the health of Black, Indigenous, People of Color?	- Increase number of therapists/mental health providers - Unlearning learned behaviors, partnering with nontraditional organizations to get to the root of the problem so that health system isn't alone doing it - Partnering with community organizations to build trust, reducing the amount of referrals and being transferred around to different orgs for support - Improve patient-provider matching, letting people know they have a choice, and finding ways to pair folks with cultural backgrounds, immigrant histories
Section 4: Final Remarks & Closing	

Community Listening Sessions

- Presentation from Facilitation Training for community partners
- Facilitation guide for listening sessions
- Listening Session presentation
- Priority vote results and notes from January 20, 2022
- Priority vote results and notes from January 25, 2022

John Snow Research and Training Institute, Inc.

Beth Israel Lahey Health

FACILITATION TRAINING

Best Practices on Inclusive Facilitation

October 07, 2021
Virtual Room

AGENDA

- What is facilitation?
- Inclusive facilitation
- Creating inclusive space
- Characteristics of a good facilitator
- Let's practice!

WHAT IS FACILITATION?

Facilitation is a dance, an artform.

INCLUSIVE FACILITATION

inclusive means including everyone

Provide space and identify ways participants can engage at the start of the meeting

Depending on the size of the group, ask participants to share their name, pronouns, and in one word describe how they're feeling today.

Dedicate time for personal reflection

Normalize silence. It’s okay if folks are quiet, don’t interpret as non-participation. Encourage people to take the time to reflect on the information presented to them.

Establish community agreements

Create common ground. This helps with addressing power dynamics that may be present in the space.

CREATING INCLUSIVE SPACE

move at the speed of trust

Identify ways to make people feel welcomed

We shouldn't assume everyone feels comfortable enabling their video. Make this an option as opposed to a request.

Design for different learning and processing styles

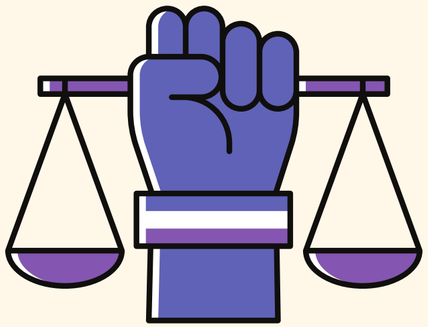
Support visual learners with a slideshow or other images. Real-time note-taking or tools that allow people to see how information is being processed and documented help each person stay engaged in the conversation.

Consider accessibility

Some folks may join through the dial in number, so consider walking through your agenda as if you were only on the phone. Consider language interpretation and closed captioning services.

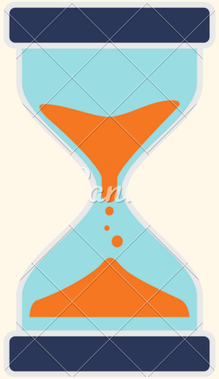
CHARACTERISTICS OF A GOOD FACILITATOR

Impartial



Active listener

Authentic



Patient

Enthusiastic

LET'S CONSIDER THE FOLLOWING

1

A participant seems to dominate the conversation.

2

A participant has a lot of experience in the topic but is too shy to share them in a group setting.

3

A participant is talking about something not related to the topic of discussion.

THANK YOU FOR YOUR PARTICIPATION!

Beth Israel Lahey Health

Feel free to send in any questions to **corina_pinto@jsi.com.**

BILH Community Listening Session: Breakout Discussion Guide

Session name, date, time: [Filled in by notetaker]
Community Facilitator: [Filled in by notetaker]
Notetaker: [Filled in by notetaker]

Mentimeter link:
Jamboard link:

Ground rules and introductions (5 minutes)

Facilitator: "Thank you for joining the Community Listening Session today. We will be in this small breakout group for approximately 45 minutes. Let's start with brief introductions and some ground rules for our time together. I will call on each of you. If you're comfortable, please share your name, your community, and one word to describe how you're feeling today. If you don't want to share, just say pass. I'll start. I'm ____ from ____ and today I'm feeling _____."
(Facilitator calls on each participant)

"Thanks for sharing. I'd like to start with some ground rules to be sure we get the most out of our discussion today:

- Make space and take space. We ask that you try to speak and listen in equal measure
- Be open to learning about experiences that don't match with your own
- What is said here stays here; what is learned here leaves here. [Notetaker's name] will be taking notes during our conversation today, but will not be marking down who says what. None of the information you share will be linked back to you specifically.

Are there other ground rules people would like to add for our discussion today?"

Question 1 (5 minutes)

Facilitator: What is your reaction to data and preliminary priorities we saw today?

- *Probe: Did anything from the presentation surprise you, or did this confirm what you already know?*
- *Probe: What stood out to you the most?*

Notes:

Question 2 (15 minutes)

Part 1: 10 minutes

Notetaker: *List preliminary priority areas from presentation in the Zoom chat.*

Facilitator: "We're going to move on to Question 2. Our notetaker has listed the preliminary priority areas from the presentation in our Zoom chat. Looking at this list – are there any priority areas that you think are missing?"

Notes on missing priority areas:

[After 5 minutes, the Meeting Host will pop into your Breakout Room to collect any additional priority areas.]

Part 2: 5 minutes

[Meeting host will send Broadcast message when it's time to move on to Part 2]

Facilitator: "We want to know what priority areas are most important to you. Right now, our notetaker is going to put a link into the Zoom chat. (Notetaker copies & pastes Mentimeter link: <<**https://www.menti.com/yqztahwt4c**>>. When you see that link, please click on it.

"Within this poll, we want you to choose the 4 priority areas that are most concerning to you. The order in which you choose is not important. We'll give you a few minutes to make your selections.

"If you're unable to access the poll, go ahead and put your top 4 priority areas into the chat, or you can say them out loud and we can cast your vote for you.

After a few minutes, the poll results will be screen shared to our group."

[Meeting Host will pop in to your room to ensure all votes have been cast. After confirmation, Meeting Host will broadcast poll results to all Breakout Groups]

Facilitator: "It looks like (A, B, C, D) are the top four priority areas for this session. Our Notetaker will type these into the Chat box so we can reference them during our next activity."

Question 3 (25 minutes)

Facilitator: "Next, we'd like to discuss how issues within these priority areas might be addressed. We know that no single entity can address all of these priorities, and that it usually takes many organizations and individuals working together. For each priority area we want to know about existing resources and assets – what's already working? – and gaps and barriers – what is most needed to be able to successfully address these issues."

Let's start with [Priority Area 1].

- What resources and assets exist to address this issue?
- What are the gaps and barriers within this priority area?

Let's move on to [Priority Area 2].

- What resources and assets exist to address this issue?
- What are the gaps and barriers within this priority area?

Let's move on to [Priority Area 3].

- What resources and assets exist to address this issue?
- What are the gaps and barriers within this priority area?

Let's move on to [Priority Area 4].

- What resources and assets exist to address this issue?
- What are the gaps and barriers within this priority area?"

Notetakers will be taking notes within Jamboard.

[Meeting Host will send a broadcast message when there are 2 minutes left in the Breakout Session]

Wrap Up (1 minute)

Facilitator: "I want to thank you all for sharing your experiences, perspectives, and knowledge. In a minute we're going to be moved back into the Main Zoom room to hear about some of the things discussed in the groups today, and to talk about the next steps in the Needs Assessment process. Is there anything else people would like to share before we're moved out of the breakout room?"

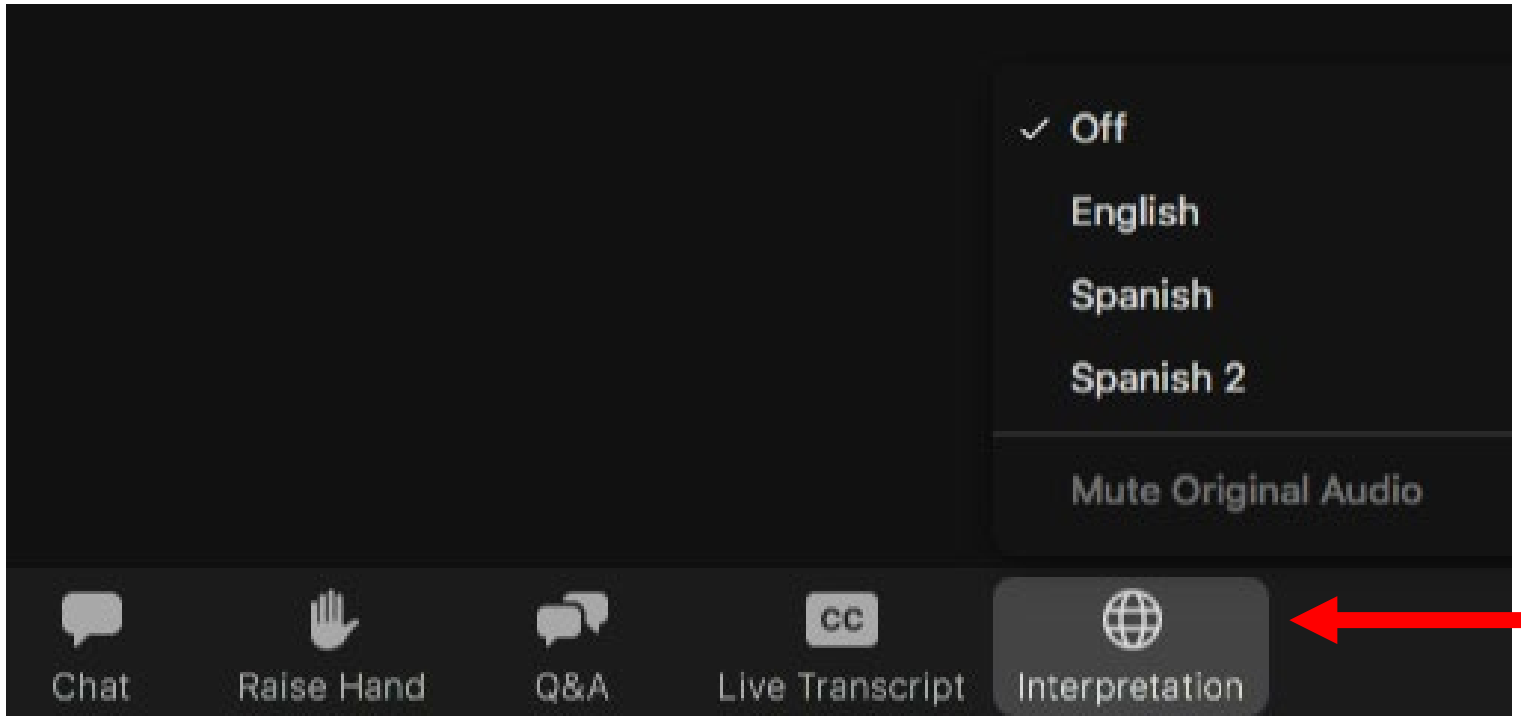
Notes:

MOUNT AUBURN HOSPITAL COMMUNITY LISTENING SESSION

January 20, 2022
January 25, 2022

Beth Israel Lahey Health

中文解释 // Interpretação Portuguesa



选择您的音频频道

Escolha seu canal de áudio

Mount Auburn Hospital Community Listening Session

Agenda

Time	Activity	Speaker/Facilitator
6:00-6:05	Opening remarks	JSI
6:05-6:15	Overview of assessment purpose, process, and guiding principles	Mary DeCourcey, Director of Community Benefits, Mount Auburn Hospital
6:15-6:25	Presentation of preliminary themes and data findings	JSI
6:25-7:25	Breakout Groups	Community Facilitators
7:25-7:30	Wrap up: Closing statements and next steps	Mary DeCourcey

Assessment Purpose and Process

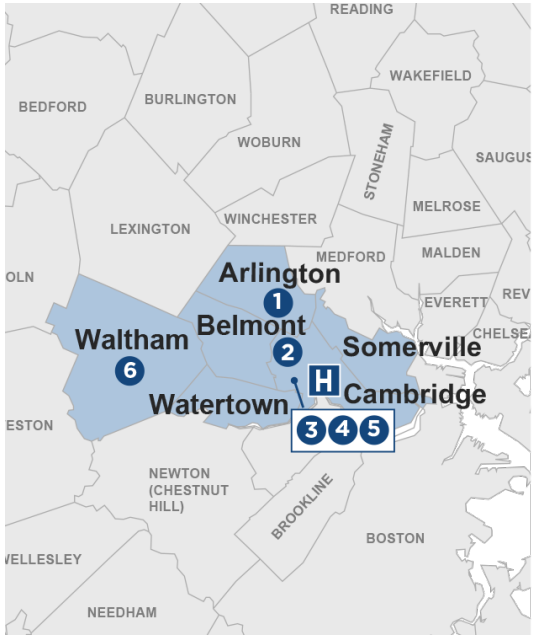
Assessment Purpose and Process

Purpose

Identify and prioritize the health-related and social needs of those living in the service area with an emphasis on diverse populations and those experiencing inequities.

- A **Community Health Needs Assessment** identifies key health needs and issues through data collection and analysis.
- An **Implementation Strategy** is a plan to address public health problems collaboratively with municipalities, organizations, and residents.

All non-profit hospitals are required to conduct a Community Health Needs Assessment (CHNA) and develop an Implementation Strategy (IS) every 3 years



Beth Israel Lahey Health
Mount Auburn Hospital

Community Benefits Service Area

- H Mount Auburn Hospital
- 1 Mount Auburn Hospital Radiology at Arlington
- 2 Mount Auburn Hospital MRI Center
- 3 Mount Auburn Hospital Rehabilitation Services; Outpatient Physical & Occupational Therapy
- 4 Mount Auburn Hospital Mobile PET Unit
- 5 Mount Auburn Hospital Employee Assistance Program, Occupational Health & Rehabilitation Services
- 6 Mount Auburn Hospital Imaging and Specimen Collection

Assessment Purpose and Process

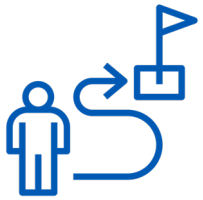
FY22 CHNA and Implementation Strategy Guiding Principles

Equity: Work toward the systemic, fair and just treatment of all people; engage cohorts most impacted by COVID-19

Collaboration: Leverage resources to achieve greater impact by working with community residents and organizations

Engagement: Intentionally outreach to and interact with hardly reached populations; including but not limited to people impacted by trauma, people with disabilities, communities most impacted by inequities, and others

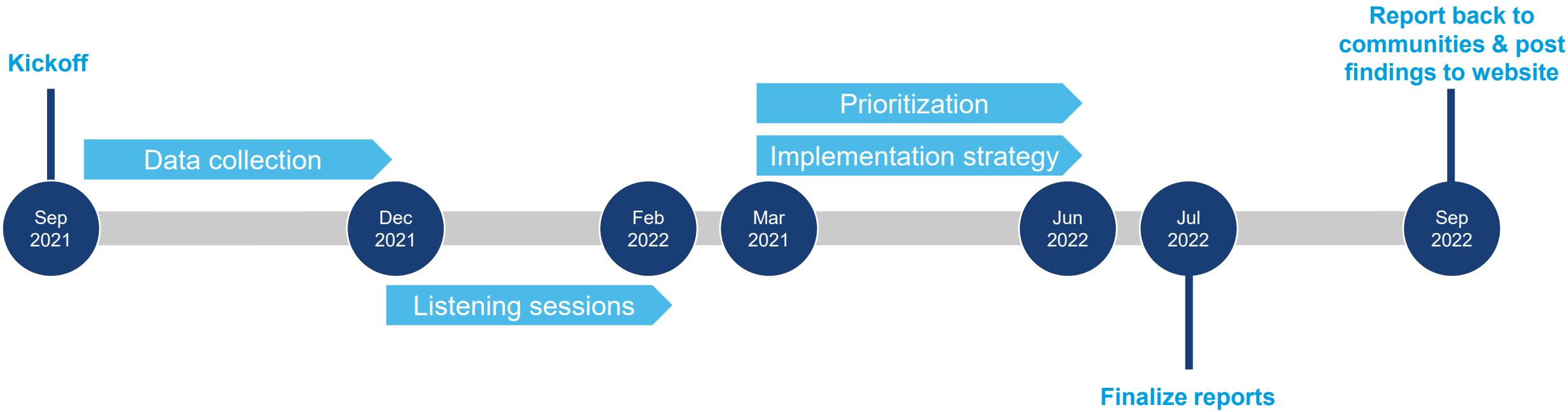
Capacity Building: Build community cohesion and capacity by co-leading Community Listening sessions and training community residents on facilitation



Intentionality: Be deliberate in our engagement and our request and use of data and information; be purposeful and work collaboratively to identify and leverage resources for maximum benefit

Assessment Purpose and Process

FY22 CHNA and Implementation Strategy Process

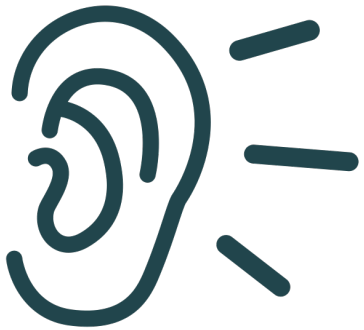


Assessment Purpose and Process

Meeting goals

Goals:

- Conduct listening sessions that are ***interactive, inclusive, participatory and reflective of the populations*** served by MAH
- Present data for prioritization
- Identify opportunities for ***community-driven/led solutions and collaboration***



We want to hear from you.
Please speak up, raise your hand, or use the chat when we get to Breakout Sessions

Key Themes & Data Findings

CHNA Progress
Activities to date

Gathered Publicly Available Data, e.g.:

- ✔ Massachusetts Department of Public Health
- ✔ Center for Health Information and Analytics (CHIA)
- ✔ County Health Rankings
- ✔ Behavioral Risk Factor Surveillance Survey
- ✔ Youth Risk Behavior Survey
- ✔ US Census Bureau

18 **Interviews with Community Leaders**

267 **Survey Respondents**

3 **Small Group Discussions**

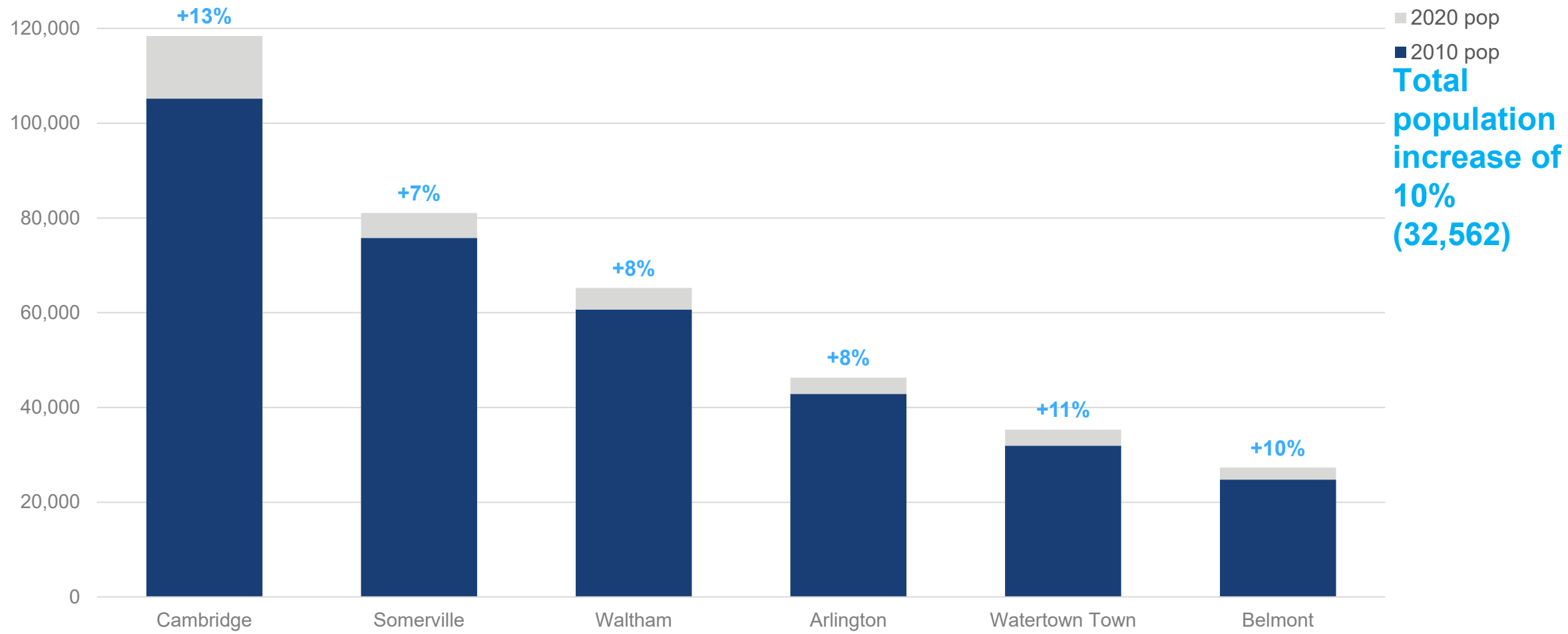
-LGBTQIA+

-English language learners

-Residents who identify as BIPOC

CHNA Progress

Population Change in Community Benefits Service Area 2010-2020

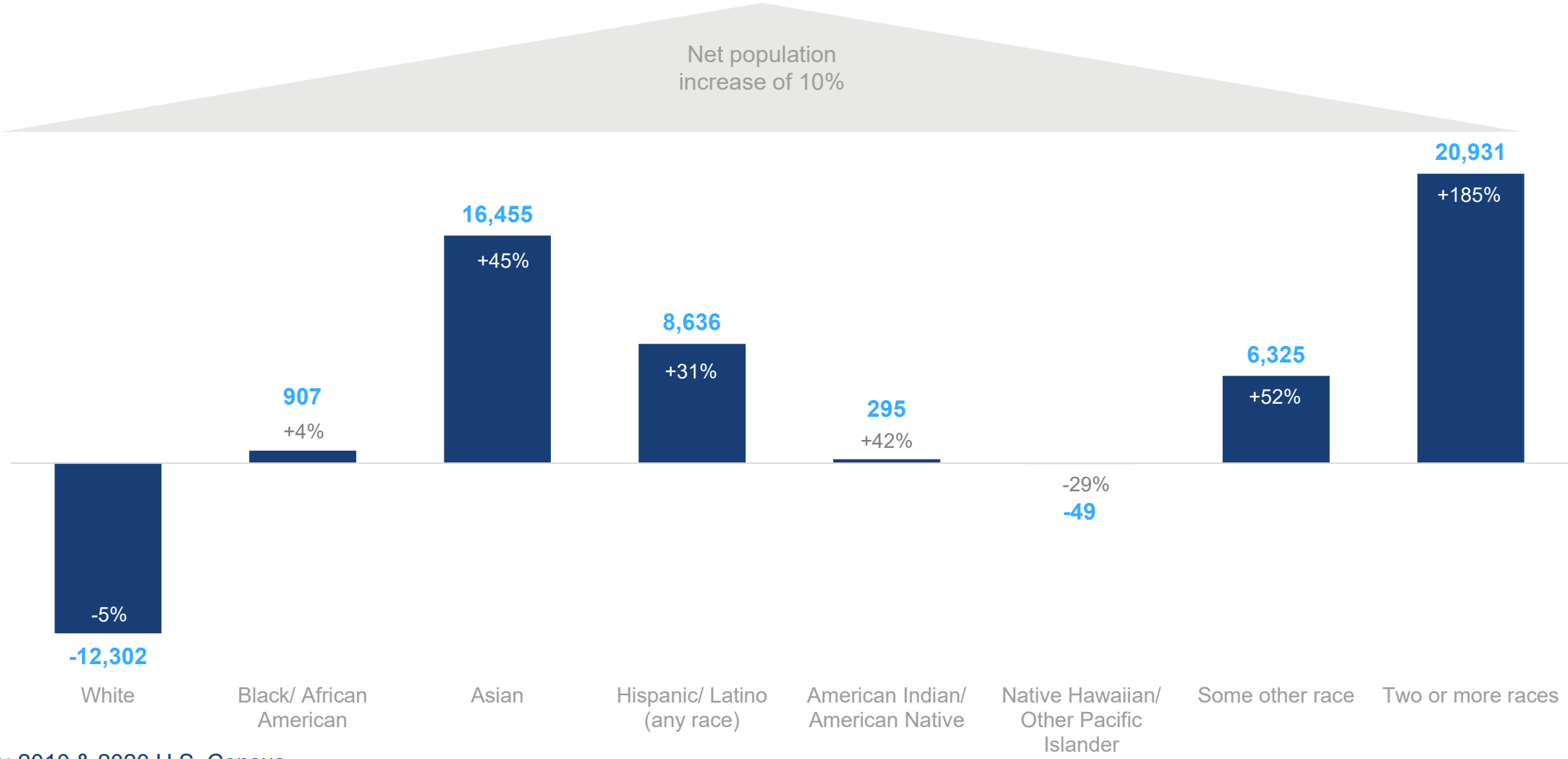


Total population increase of 10% (32,562)

Source: 2010 & 2020 U.S. Census

CHNA Progress

Race/Ethnicity Population Change in Community Benefits Service Area, 2010-2020



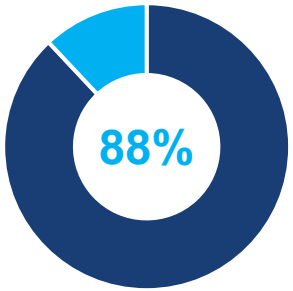
Source: 2010 & 2020 U.S. Census

CHNA Progress
Service Area Strengths

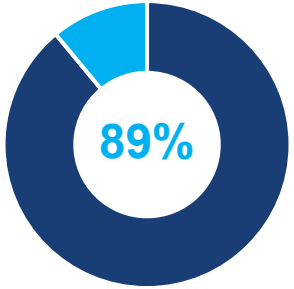
FROM INTERVIEWS & FOCUS GROUPS:

- Increasing racial, ethnic, and cultural diversity
- Culture of community/neighborhood collaboration and sharing
- Urban communities are resource-rich

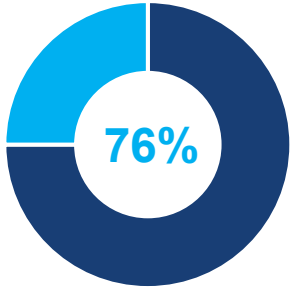
FROM MAH COMMUNITY HEALTH SURVEY:



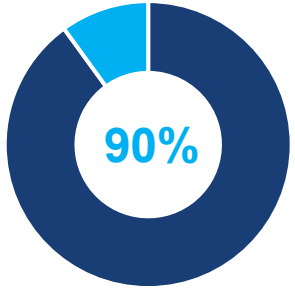
said they were **satisfied with the quality of life** in their community



said the community has **good access to resources**



said the community is a **good place to grow old**



said the community is a **good place to raise kids**

CHNA Progress
Key Themes

- Mental health
- Social determinants of health
- Diversity, equity, inclusion
- Access to care
- Community connections and information sharing

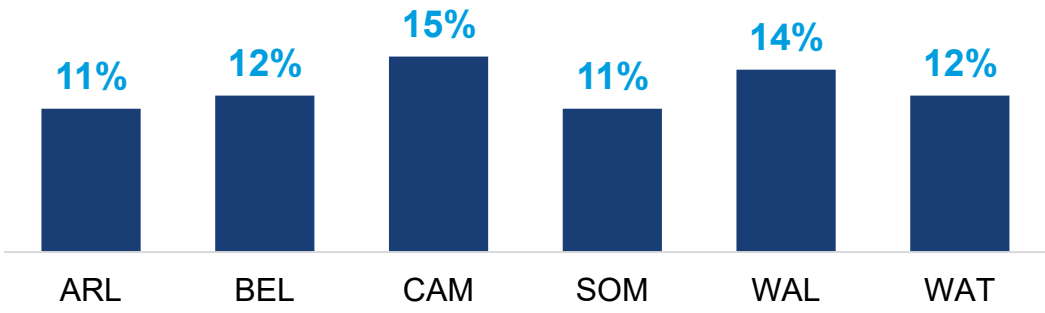
CHNA Progress
Key Themes: Mental Health (Youth)

- Significant prevalence of stress, anxiety, depression, behavioral issues
  - Exacerbated by Covid
- Gaps in workforce – need more providers trained to treat youth specifically

"We now have waitlists of over 100 families seeking mental health services. The wait times for people to access these services are significant, especially for children and teens."

– Key informant

Percentage High Schoolers Reporting Suicidal Ideation, 2021



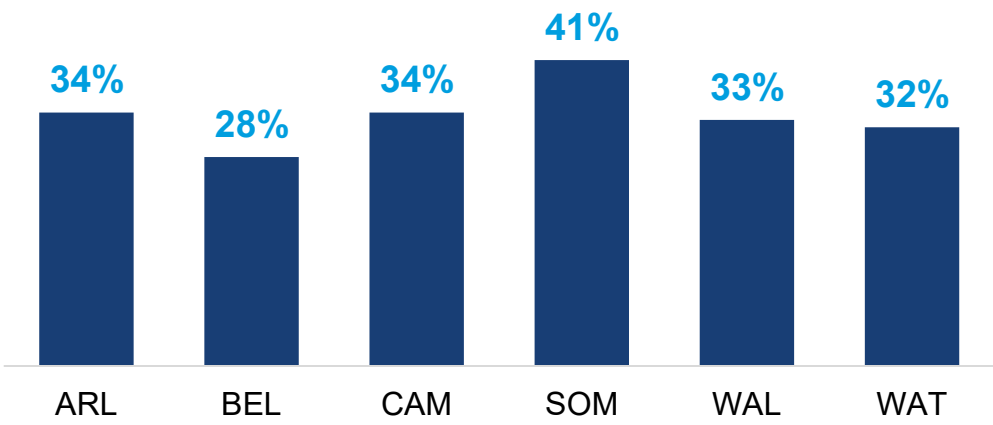
Data Source: Youth Behavior Survey

CHNA Progress
Key Themes: Mental Health (Adult)

- Mental health issues exacerbated by COVID – anxiety, stress, depression, isolation
- Societal and cultural stigmas prevent people from seeking treatment
- Need more providers who reflect diversity of patients

13% of MAH Community Health Survey respondents reported that, within the past year, they needed mental health care but were not able to access it. Many cited lack of providers taking new patients, long wait times, and lack of insurance coverage as barriers

Percentage* with 15 or more poor mental health days in the past month (Fall 2020)



Data source: COVID-19 Community Impact Survey, MDPH

**Unweighted percentages displayed*

CHNA Progress
Key Themes: Social Determinants of Health

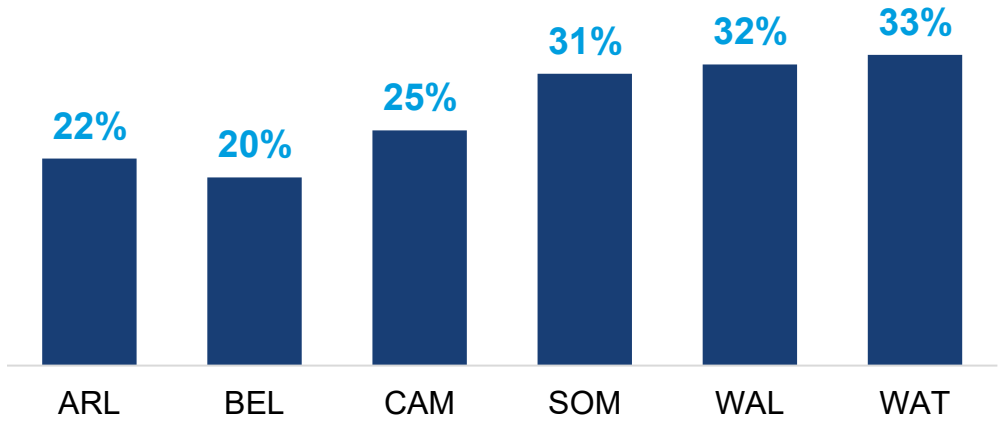
Primary concerns:

- Housing affordability and displacement
- Economic insecurity, loss of employment
- Transportation and mobility
- Food insecurity
- Availability/affordability of childcare

When asked what they'd like to improve in their community, **56%** of MAH Community Health Survey respondents reported

"more affordable housing"
(#1 response)

Percentage* worried about paying for one or more type of expense/bills in the coming weeks (Fall 2020)



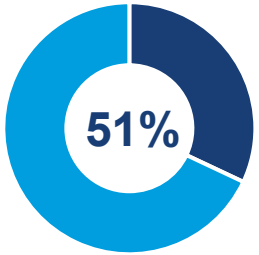
Data source: COVID-19 Community Impact Survey, MDPH

**Unweighted percentages displayed*

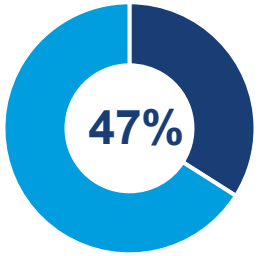
CHNA Progress
Key Themes: Diversity, Equity, and Inclusion

- Distrust of some healthcare and community organizations, especially among undocumented populations who fear sharing their personal information
- Impacts of systemic racism, police brutality, racial/ethnic disparities in incarceration rates
- Need for social services that are culturally appropriate (e.g., culturally appropriate food offered at food banks)

AMONG MAH COMMUNITY HEALTH SURVEY RESPONDENTS:



51% agreed that the built, economic, and educational environments in the community are impacted by systemic racism



47% agreed that the community is impacted by individual racism

"We need to have better understanding and more embracing of the massive diversity in this town. I hope we can do a better job of being aware of one another."

-Key informant

CHNA Progress
Key Themes: Access to Care

- Long wait times, especially for mental health services
- Providers not accepting new patients
- Cost/insurance barriers
- Providers/staff need education on how to best serve specific populations, including LGBTQ+ populations, non-English speakers, undocumented

"Patients are not coming out to their providers or being offered a welcome spacing to do so, which creates a cycle where providers don't think they need to get trained or become knowledgeable about LGBT communities."

-Focus Group participant

CHNA Progress

Key Themes: Community Connections and Information Sharing

- Referrals between organizations with little follow up or understanding of each others' programs/capacities
- Resources may be plentiful, but some residents need targeted outreach and navigation support
  - Homeless or unstably housed
  - Individuals who best communicate in a language other than English
  - Undocumented

Breakout Sessions

Reconvene

Wrap-up
MAH Community Benefits

Mary DeCourcey
Director, Community Benefits
617-499-5625
mdecourc@mah.harvard.edu

Community Benefits Information on website:
https://www.mountauburnhospital.org/about-us/community-health/

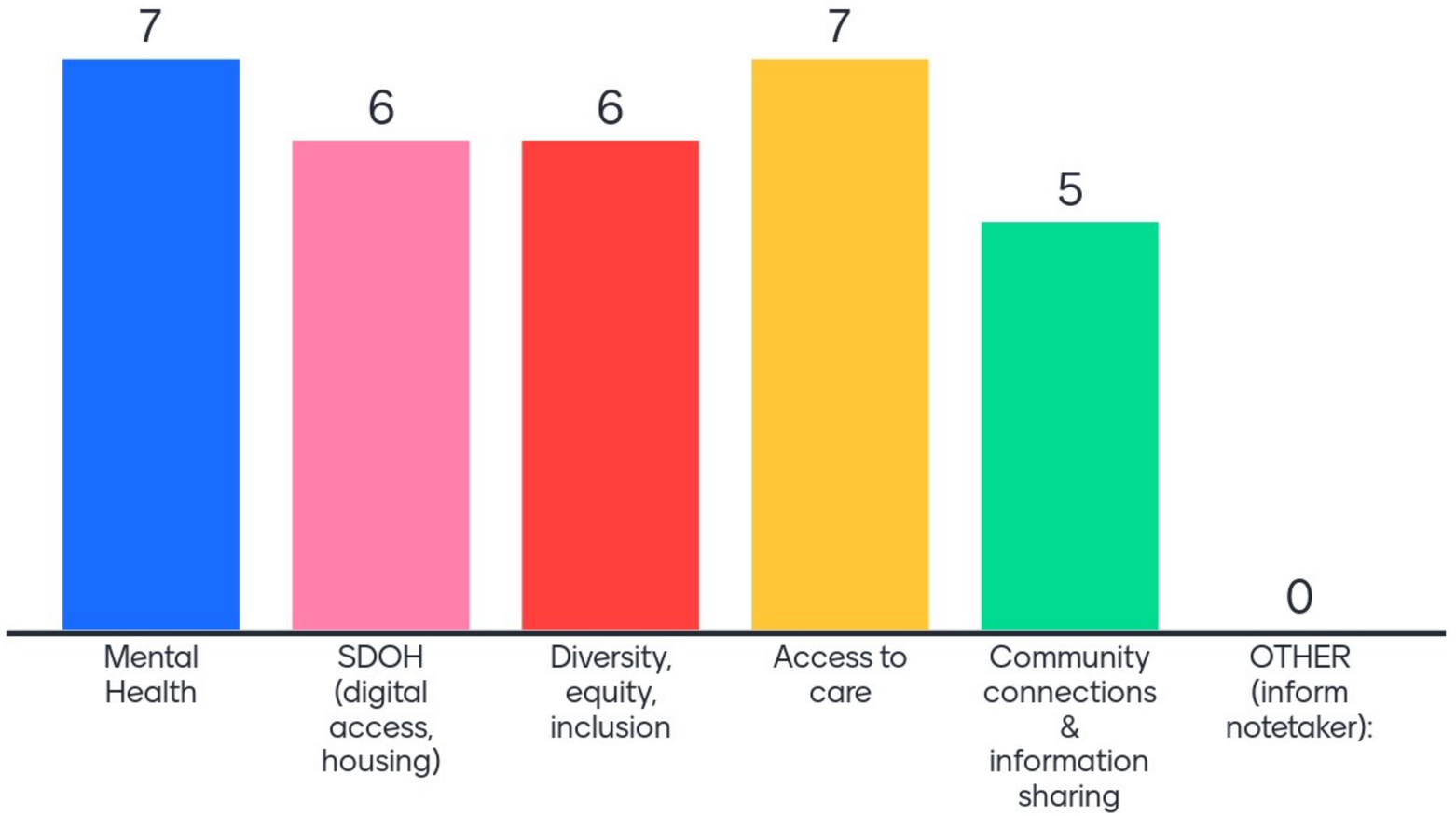
Community Benefits Annual Meeting in June (More info TBD)

Thank you!

Choose your top 4 priority areas.

January 20, 2022 Listening Session: Priority Vote Results

Mentimeter



Priority Area 1: SDOH

January 20 Listening Session Notes

Resources/Assets

Greater Boston Food Bank put out info last year to get info into the public to help dispel myths to help increase their comfort level

Council on Aging--food, activity, fitness, wellness, counseling, etc.

NWH/Mt Auburn provided a wrap around program to help with housing and other SDOH community wide to help prevent teen drop outs.

Need to provide incentives to help recruit community members to complete surveys etc. in a variety of different formats.

Gaps/Barriers

services to address housing and other SDOH need to be more accessible including interpretation and cultural biases in criteria for eligibility

Arlington did a community survey only in English last fall and after push back they got it translated. Need to make sure it is a first thought, not an afterthought.

Need to fund more programs that help to implement programming and services directly to people who need it most.

You may not know of the resources that ARE available in the community. That's why knowledge hubs, like Council on Aging, are so important.

Seniors are challenged in making effective Health Care Powers of Attorney, and Advanced Directives, because they don't have anyone to serve in the agent roles.

Surveys can be put in multiple languages but the FORMAT for access is important like: What's App, text etc.

Need more interpreters available and more info available in more languages.

only 10% of African community will go to apply for food in Arlington because they are private and do not want to show problems/needs

Priority Area 2: Mental Health

Resources/Assets

For older adults in Cambridge area: CONNECT is a resource (via EMHOT grant); though there are few of these in the state

Community liaisons are needed to help groups to reach their community

Providers more in tune with needs of older adults; screening better for senior issues; more needs to be done

MH - have large groups to spread out resources

Arlington established a way to get info to people through tech - William James Referral Network

Service provider in community holds an EDUCATION DAY - to support the community members to take advantage of services and help

People trust their providers in their community that match their culture

Gaps/Barriers

MH Need more support, maybe need to forego individual support for group support

MH - huge challenge left to schools K-12, don't have tools to address needs

Providers sometimes don't know where to send seniors for speciality care

MH - Need more partnerships

Need speciality care to come to the seniors.

Need a lot more geriatric psychiatrists

MH - demystifying and destigmatizing resources is important

Seniors have outlived their PCP's.

Priority Area 3: Diversity, Equity, Inclusion

Resources/Assets

Health care staff training is happening with some community networks a

safe spaces are being created for people to report micro-agressions in health care

Gaps/Barriers

EDI needs to be more clearly defined and not lumped together. More specificity needed in order to respond.

Need providers that represent community, especially in Mental Health--language, race/ethnicity, culture, age

Providers' need to understand that people's attitudes towards death and dying are mightily influenced by culture.

Having materials in plain language is so important

Priority Area 4: Access to Care

Resources/Assets

Belmont Housing bookclub, helps with isolation; need more and different kinds of these opportunities

Cambridge Council on Aging; stayed open during COVID, continued providing programing

Gaps/Barriers

Transportation programs have been hampered by social distancing required by COVID

Sometimes transportation is there, but not the medical escorts, especially escorts that can act as medical advocates. Important to have a second set of ears.

Transportation programs end a 4pm

As population changes, need to adjust to what their needs are.

Many older people have difficulty getting to their medical appointments

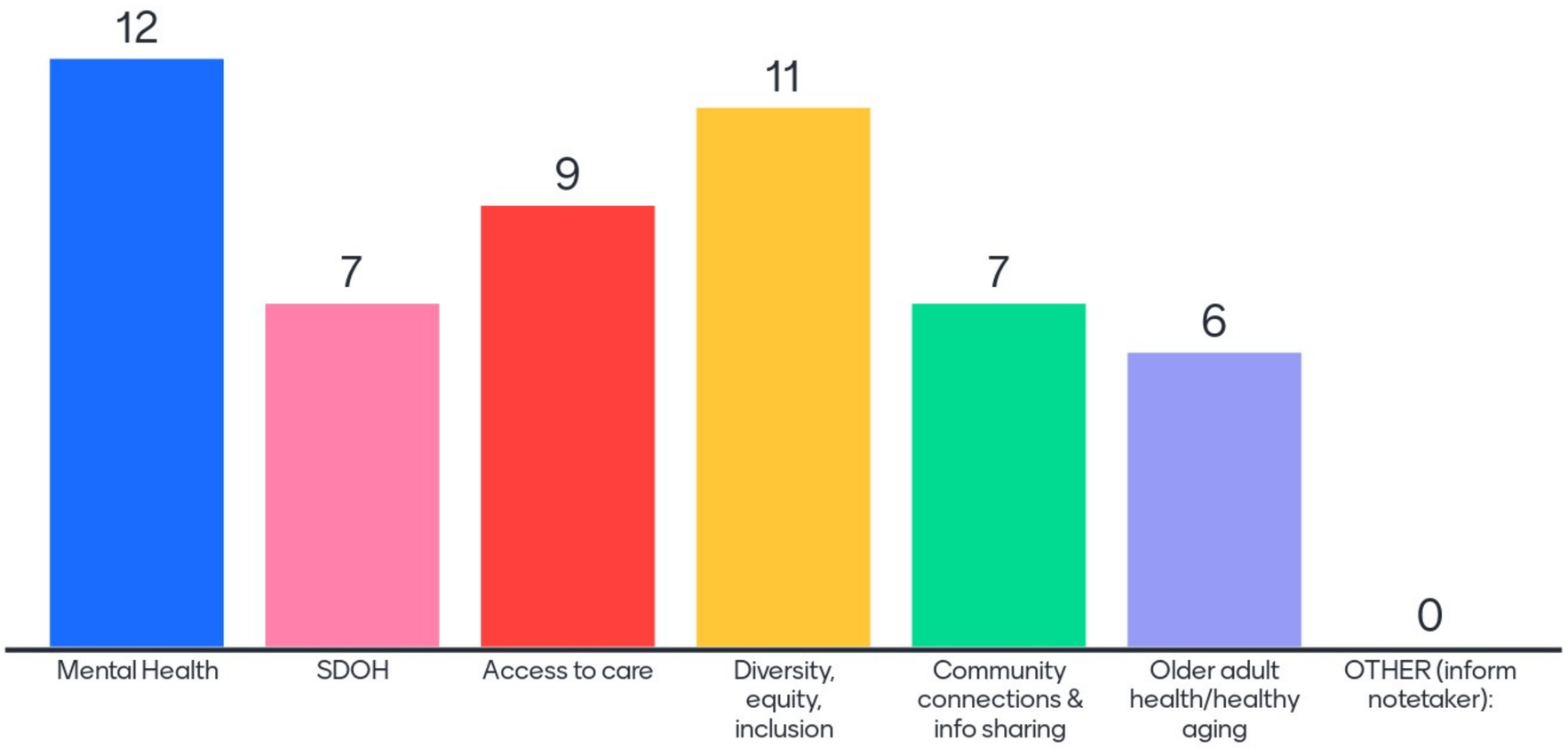
Need to extend ourselves more to be helpful to address cultural nuances needed to increase access to services

African community is not used to the way services are being provided and don't understand

Choose your top 4 priority areas.

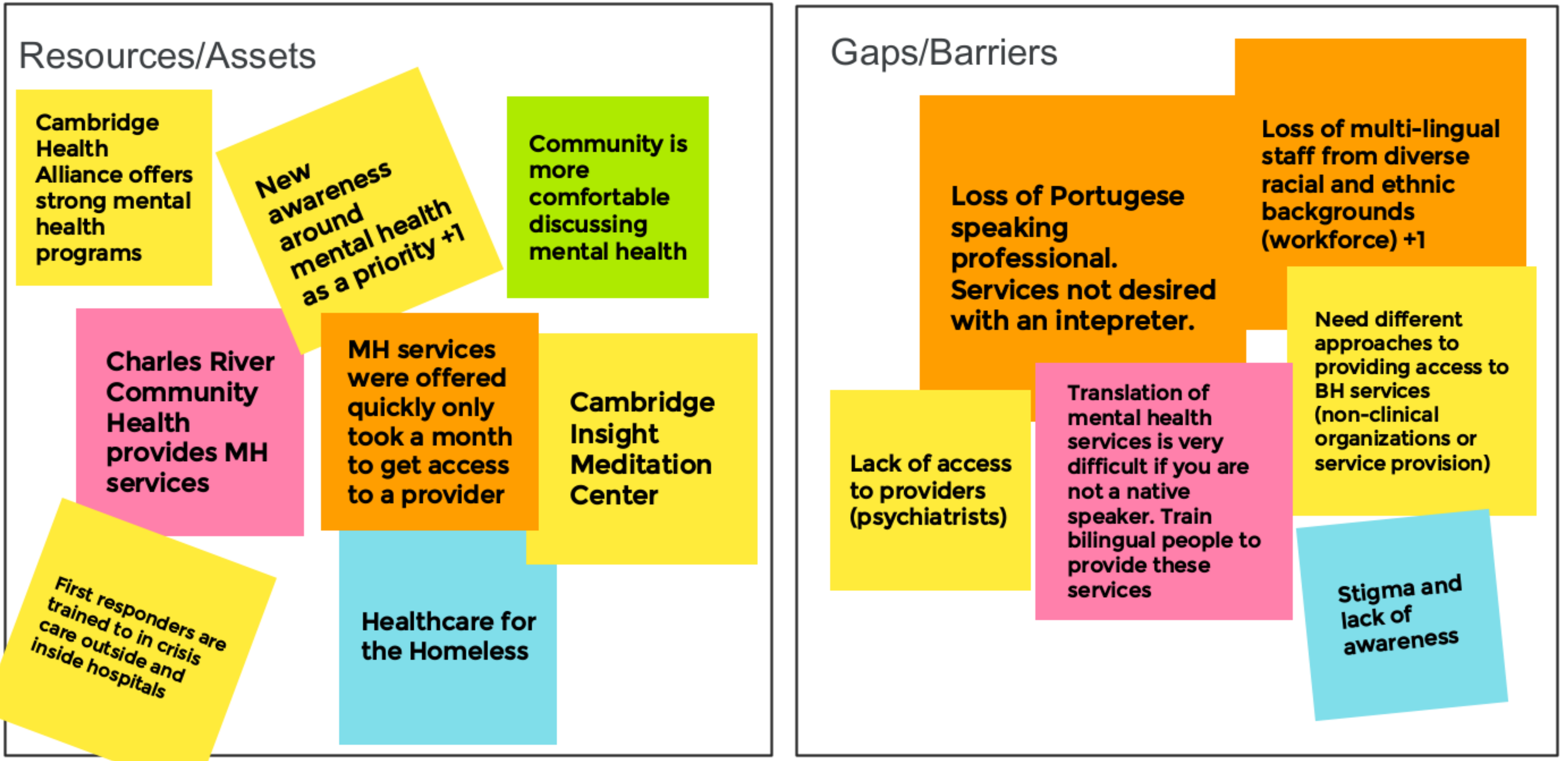
Mentimeter

January 25, 2022 Listening Session: Priority Vote Results



Priority Area 1: Mental Health

January 25 Listening Session Notes



Priority Area 2: Social Determinants of Health

Resources/Assets

Charles River CHC helps to provide access to programs/food for those with food insecurity. There is a food truck that gives people $20 cards to get vegetables and fruit. They are encouraging people to eat better.

Food pantries in Cambridge and Arlington

Gaps/Barriers

Affordable Housing - is lacking. Housing costs are expensive and every month is a struggle to get by.

Priority Area 3: Access to Care

Resources/Assets

- Using libraries as an access point - services are for everyone
- Everett City Hall assists with getting access to care
- Charles River is easily accessible in my community (+1)
- Personal Care Program (in-home care)
- Everett city hall helps with applying for insurance
- Healthcare for the Homeless
- MAPS cares for elderly and undocumented people

Gaps/Barriers

- If you don't have a social security number it is hard to get services
- A lot of Brazilians without documentation who need a lot of help

Priority Area 4: Diversity, Equity, Inclusion

Resources/Assets

- Cambridge Community Learning Center
- SCALE in Somerville
- CHNA 17
- Massachusetts Alliance of Portuguese Speakers (MAPS)

Gaps/Barriers

- Continued efforts to appreciate impacts of systemic racism
- Adequate language services
- People without documentation have great difficulties getting services

Priority Area 5: Community Connections & Info Sharing

Resources/Assets

Eye doctors and dentists are available

Representing the Brazilian Women's Group - look forward to further opportunities to participate

Community access is good

Thank you for this opportunity

Very happy to see that there are concerned people who are interested in what we have to say and for giving us the opportunity for a voice

Appendix B:
Data Book

Secondary data

Key

Significantly low compared to the Commonwealth based on margin of error

Significantly high compared to the Commonwealth overall based on margin of error

			Community Benefits Service Area						
	MA	Middlesex County	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Source
Demographics									
Population									US Census Bureau, American Community Survey 2016-2020
Total Population	6,873,003	1,605,899	45,379	26,158	117,822	81,175	62,597	35,749	
Male	48.5%	49.0%	46.8%	46.5%	50.2%	49.8%	48.3%	46.4%	
Female	51.5%	51.0%	53.2%	53.5%	49.8%	50.2%	51.7%	53.6%	
Age Distribution									US Census Bureau, American Community Survey 2016-2020
Under 5 years (%)	5.2%	5.3%	6.5%	6.5%	4.4%	4.1%	5.0%	6.0%	
5 to 9 years	5.3%	5.4%	5.4%	7.7%	3.3%	3.2%	3.5%	3.4%	
10 to 14 years	5.7%	5.6%	5.9%	6.2%	2.9%	2.2%	3.2%	3.2%	
15 to 19 years	6.6%	6.3%	5.0%	6.5%	8.0%	4.5%	8.5%	3.4%	
20 to 24 years	7.1%	7.0%	3.9%	4.1%	13.3%	11.4%	13.5%	4.4%	
25 to 34 years	14.3%	15.5%	15.7%	9.0%	28.3%	32.9%	17.7%	21.5%	
35 to 44 years	12.2%	13.2%	15.0%	15.0%	12.9%	15.0%	12.9%	16.0%	
45 to 54 years	13.3%	13.4%	13.5%	15.2%	8.1%	9.2%	9.9%	11.2%	
55 to 59 years	7.1%	7.0%	6.3%	6.9%	3.5%	4.4%	6.3%	6.4%	
60 to 64 years	6.5%	6.0%	6.6%	5.8%	3.7%	4.2%	4.9%	7.7%	
65 to 74 years	9.5%	8.7%	9.1%	9.1%	7.0%	4.9%	8.4%	9.9%	
75 to 84 years	4.6%	4.4%	4.9%	5.4%	3.2%	2.6%	4.4%	4.5%	
85 years and over	2.4%	2.3%	2.1%	2.7%	1.4%	1.2%	1.8%	2.4%	
Under 18 years of age	19.8%	19.8%	21.3%	25.5%	12.4%	11.0%	13.7%	14.4%	
Over 65 years of age	16.5%	15.3%	16.1%	17.2%	11.6%	8.8%	14.5%	16.9%	
Race/Ethnicity									US Census Bureau, American Community Survey 2016-2020
White alone (%)	76.6%	75.2%	78.5%	76.80%	64.3%	76.1%	70.5%	78.3%	
Black or African American alone (%)	7.5%	5.3%	3.0%	1.10%	10.4%	5.6%	7.6%	3.0%	
Asian alone (%)	6.8%	12.4%	12.9%	17.10%	17.5%	9.9%	11.8%	12.2%	
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.1%	0.0%	0.00%	0.1%	0.0%	0.0%	0.0%	

			Community Benefits Service Area						
	MA	Middlesex County	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Source
American Indian and Alaska Native (%) alone	0.2%	0.2%	0.0%	0.30%	0.3%	0.2%	0.5%	0.2%	
Some Other Race alone (%)	4.2%	2.9%	1.0%	0.60%	1.8%	3.3%	5.3%	2.0%	
Two or More Races (%)	4.8%	4.0%	4.5%	4.00%	5.6%	5.0%	4.3%	4.3%	
Hispanic or Latino of Any Race (%)	12.0%	8.1%	5.2%	4.20%	9.3%	11.4%	14.3%	7.2%	
Race/Ethnicity of Students in Public Schools									School and District Profiles, Massachusetts Department of Elementary and Secondary Education, 2020-2021
African American (%)	9.3		3.4	3.2	22.8	8.6	9.2	4.3	
Asian (%)	7.2		13.1	21.4	12.3	6.1	5.3	7.2	
Hispanic (%)	22.3		6.2	3.8	13.8	40.8	42.6	19.1	
White (%)	56.7		69.9	63.1	40.9	39.7	40.4	63.6	
Native American (%)	0.2		0.1	0.1	0.2	0.1	0.1	0.4	
Native Hawaiian, Pacific Islander (%)	0.1		0.1	0.1	0.1	0.1	-	-	
Multi-Race, Non-Hispanic (%)	4.10		7.3	8.3	9.8	4.6	2.5	5.3	
Foreign-born	17.0%	21.3%	18.6%	25.7%	29.2%	23.9%	26.6%	23.2%	US Census Bureau, American Community Survey 2016-2020
Naturalized U.S. Citizen	54.2%	50.2%	46.2%	52.5%	37.9%	38.9%	41.9%	50.7%	
Not a U.S. Citizen	45.8%	49.8%	53.8%	47.5%	62.1%	61.1%	58.1%	49.3%	
Region of birth: Europe	20.0%	18.8%	24.5%	25.5%	22.8%	24.2%	11.9%	19.2%	
Region of birth: Asia	31.1%	43.8%	56.9%	59.4%	45.6%	29.2%	41.5%	51.1%	
Region of birth: Africa	9.3%	7.2%	3.0%	4.0%	7.8%	5.5%	9.7%	7.5%	
Region of birth: Oceania	0.3%	0.5%	0.5%	0.4%	1.1%	1.0%	0.1%	0.4%	
Region of birth: Latin America	36.7%	26.9%	9.5%	8.1%	18.9%	34.9%	32.7%	19.6%	
Region of birth: Northern America	2.5%	2.8%	5.5%	2.6%	3.7%	5.1%	4.1%	2.2%	
Language									US Census Bureau, American Community Survey 2016-2020
English only	76.1%	73.4%	78.9%	69.7%	65.9%	71.0%	67.3%	68.1%	
Language other than English	23.9%	26.6%	21.1%	30.3%	34.1%	29.0%	32.7%	31.9%	
Speak English less than "very well"	9.2%	9.0%	6.0%	8.5%	8.3%	10.3%	11.2%	9.6%	
Spanish	9.1%	5.8%	3.1%	2.8%	7.1%	9.0%	11.5%	4.3%	
Speak English less than "very well"	3.8%	2.1%	0.6%	0.8%	1.5%	3.9%	4.6%	0.9%	
Other Indo-European languages	9.0%	11.7%	9.5%	13.1%	13.1%	14.1%	11.2%	17.7%	
Speak English less than "very well"	3.0%	3.6%	2.1%	2.8%	2.6%	4.7%	3.2%	5.0%	
Asian and Pacific Islander languages	4.4%	7.4%	7.6%	13.1%	10.6%	4.7%	7.3%	6.9%	

			Community Benefits Service Area						
	MA	Middlesex County	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Source
Speak English less than "very well"	2.0%	2.9%	3.1%	4.8%	3.2%	1.5%	2.9%	2.5%	
Other languages	1.4%	1.7%	1.0%	1.3%	3.3%	1.2%	2.6%	3.0%	
Speak English less than "very well"	0.4%	0.5%	0.2%	0.1%	1.0%	0.2%	0.5%	1.2%	
Percent of public school student population that are English language learners (%)	10.5		4.1	7.9	5.9	18.3	22.6	14.2	Massachusetts Department of Elementary and Secondary Education, 2021-2022 (Selected populations)
Employment									US Census Bureau, American Community Survey 2016-2020
Unemployment rate	5.1%	4.2%	3.4%	4.4%	4.0%	3.0%	2.6%	5.2%	
Unemployment rate by race/ethnicity									
White alone	4.5%	3.9%	3.4%	4.1%	2.9%	2.7%	2.2%	4.3%	
Black or African American alone	8.3%	7.0%	1.7%	8.7%	10.1%	6.8%	3.5%	12.4%	
American Indian and Alaska Native alone	10.7%	12.1%	-	14.3%	21.1%	0.0%	29.7%	34.9%	
Asian alone	4.2%	4.1%	4.2%	4.1%	3.8%	3.6%	2.2%	8.3%	
Native Hawaiian and Other Pacific Islander alone	5.4%	14.6%	-	-	24.7%	0.0%	0.0%	-	
Some other race alone	8.3%	5.7%	0.0%	0.0%	2.0%	4.3%	4.8%	6.0%	
Two or more races	9.1%	5.6%	1.9%	13.8%	7.3%	3.2%	2.7%	1.6%	
Hispanic or Latino origin (of any race)	8.3%	6.0%	3.5%	1.4%	7.2%	3.1%	4.1%	5.4%	
Unemployment rate by educational attainment									
Less than high school graduate	9.7%	7.8%	0.0%	0.0%	18.9%	4.9%	5.5%	4.4%	
High school graduate (includes equivalency)	5.9%	5.1%	7.5%	5.9%	6.4%	6.0%	3.4%	8.7%	
Some college or associate's degree	4.5%	4.0%	5.4%	3.1%	6.7%	2.7%	1.7%	4.6%	
Bachelor's degree or higher	2.8%	2.7%	2.1%	3.2%	2.7%	1.7%	1.3%	3.7%	
Income and Poverty									US Census Bureau, American Community Survey 2016-2020
Median household income (dollars)	84,385	106,202	114,576	140,500	107,490	102,311	95,851	100,434	
Population living below the federal poverty line in the last 12 months									
Individuals	9.8%	7.2%	5.5%	5.4%	12.0%	11.3%	9.2%	6.4%	
Families	6.6%	4.5%	3.9%	3.3%	6.4%	8.2%	5.0%	3.1%	
Individuals under 18 years of age	12.2%	7.6%	4.2%	5.6%	12.2%	19.7%	11.7%	5.7%	
Individuals over 65 years of age	8.9%	7.5%	11.0%	6.5%	9.8%	12.3%	8.5%	8.2%	

			Community Benefits Service Area						
	MA	Middlesex County	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Source
Female head of household, no spouse present	20.5%	16.2%	10.0%	14.6%	23.5%	32.2%	6.8%	14.2%	
White alone	7.9%	6.0%	4.4%	3.7%	8.9%	8.8%	6.6%	5.7%	
Black or African American alone	17.6%	14.6%	10.4%	11.9%	24.1%	35.0%	8.4%	6.4%	
American Indian and Alaska Native alone	23.3%	26.9%	0.0%	60.0%	36.5%	0.0%	7.7%	0.0%	
Asian alone	11.8%	9.4%	10.7%	9.1%	15.4%	17.8%	14.8%	8.5%	
Native Hawaiian and Other Pacific Islander alone	11.9%	14.6%	-	-	0.0%	0.0%		-	
Some other race alone	22.2%	14.7%	8.6%	27.2%	24.7%	13.4%	25.3%	7.3%	
Two or more races	15.5%	8.7%	6.6%	12.6%	8.5%	9.8%	17.2%	12.3%	
Hispanic or Latino origin (of any race)	23.0%	17.3%	10.1%	16.0%	23.0%	19.1%	17.3%	15.9%	
Less than high school graduate	23.2%	18.4%	20.2%	6.6%	26.5%	21.6%	21.6%	20.5%	
High school graduate (includes equivalency)	11.7%	10.6%	13.5%	12.9%	25.9%	14.1%	9.6%	5.6%	
Some college, associate's degree	8.4%	7.1%	10.4%	11.3%	15.8%	9.6%	8.4%	11.6%	
Bachelor's degree or higher	3.9%	3.5%	2.6%	3.0%	7.1%	5.7%	3.7%	3.7%	
With Social Security	30.2%	26.3%	23.6%	26.5%	19.4%	15.2%	26.5%	25.7%	
With retirement income	19.3%	17.4%	18.4%	17.3%	11.9%	9.8%	15.9%	16.0%	
With Supplemental Security Income	5.9%	4.0%	2.3%	1.6%	3.0%	4.2%	5.0%	2.4%	
With cash public assistance income	2.8%	2.0%	2.7%	1.3%	1.7%	1.5%	1.6%	1.7%	
With Food Stamp/SNAP benefits in the past 12 months	11.6%	6.7%	4.8%	2.8%	7.0%	8.0%	5.7%	4.2%	
Public School Distric Students Who are Low Income (%)	36.6		9.1	8.3	31.5	44.7	40.7	32.6	Massachusetts Department of Elementary and Secondary Education, 2021-2022 (Selected populations)
Housing									US Census Bureau, American Community Survey 2016-2020
Occupied housing units									
Owner-occupied	62.5%	62.1%	57.9%	64.2%	34.9%	33.5%	50.0%	51.1%	
Renter-occupied	37.5%	37.9%	42.1%	35.8%	65.1%	66.5%	50.0%	48.9%	
Lacking complete plumbing facilities	0.3%	0.3%	0.1%	0.2%	0.6%	0.4%	0.1%	0.4%	
Lacking complete kitchen facilities	0.8%	0.8%	0.9%	0.1%	1.3%	0.4%	1.1%	1.3%	

			Community Benefits Service Area						
	MA	Middlesex County	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Source
No telephone service available	1.2%	1.0%	1.4%	1.5%	1.9%	1.9%	1.8%	1.3%	
Monthly housing costs <35% of total household income									
Among owner-occupied housing units with a mortgage	22.0%	20.5%	13.7%	22.2%	21.6%	20.3%	23.8%	24.0%	
Among owner-occupied units without a mortgage	15.2%	15.4%	15.9%	24.0%	9.1%	18.6%	17.2%	12.0%	
Among occupied units paying rent	39.1%	35.1%	28.3%	28.3%	34.5%	27.0%	34.4%	35.8%	
Eviction filings, 2018	34,200	5,400	47	31	471	241	218	64	Eviction Lab, 2018 Evictions
Access to Technology									US Census Bureau, American Community Survey 2016-2020
Among households									
Has smartphone	83.3%	85.9%	83.9%	86.7%	88.9%	89.3%	87.0%	86.0%	
Has desktop or laptop	82.2%	87.6%	89.9%	91.8%	91.1%	87.2%	85.4%	86.8%	
Has tablet or other portable wireless computer	64.8%	69.5%	69.0%	76.4%	67.6%	64.4%	66.7%	67.2%	
No computer	7.4%	5.8%	5.1%	4.5%	4.5%	6.3%	5.5%	5.6%	
With broadband internet	88.2%	91.3%	92.5%	93.9%	90.0%	91.1%	90.5%	92.8%	
Transportation									US Census Bureau, American Community Survey 2016-2020
Mode of transportation to work for workers aged 16+									
Car, truck, or van -- drove alone	68.0%	64.1%	54.7%	59.1%	24.3%	34.1%	66.3%	60.8%	
Car, truck, or van -- carpooled	7.3%	6.7%	5.1%	7.1%	3.3%	4.9%	10.9%	6.9%	
Public transportation (excluding taxicab)	9.5%	11.4%	18.0%	16.1%	26.3%	29.5%	6.1%	13.0%	
Walked	4.8%	4.9%	2.6%	2.3%	23.9%	10.7%	7.2%	2.9%	
Other means	2.1%	2.7%	4.6%	2.9%	8.7%	8.1%	2.1%	4.9%	
Worked from home	8.3%	10.2%	15.0%	12.4%	13.5%	12.7%	7.4%	11.5%	
Mean travel time to work (minutes)	30	31.1	33.8	31	26.5	32.3	25.4	28	
Vehicles available among occupied housing units									
No vehicles available	12.2%	10.5%	10.8%	6.1%	32.7%	24.1%	6.8%	10.2%	
1 vehicle available	35.1%	35.1%	46.7%	36.9%	48.1%	46.8%	41.6%	49.4%	
2 vehicles available	36.1%	38.6%	34.6%	47.9%	16.3%	22.9%	39.5%	32.0%	
3 or more vehicles available	16.5%	15.8%	7.9%	9.2%	2.9%	6.2%	12.1%	8.3%	
Education									US Census Bureau, American Community Survey 2016-2020
Educational attainment of adults 25 years and older									

			Community Benefits Service Area						
	MA	Middlesex County	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Source
Less than 9th grade (%)	4.2%	3.2%	1.4%	1.7%	2.5%	4.6%	4.4%	2.4%	
9th to 12th grade, no diploma (%)	4.7%	3.2%	1.6%	1.5%	2.0%	4.0%	4.2%	1.8%	
High school graduate (includes equivalency) (%)	23.5%	18.5%	11.6%	8.6%	6.8%	13.7%	19.6%	15.1%	
Some college, no degree (%)	15.3%	12.2%	8.9%	7.4%	7.7%	9.1%	12.1%	9.0%	
Associate's degree (%)	7.7%	5.9%	4.0%	4.3%	2.0%	2.8%	7.1%	5.7%	
Bachelor's degree (%)	24.5%	28.1%	30.4%	26.5%	29.5%	34.3%	28.2%	31.3%	
Graduate or professional degree (%)	20.0%	28.9%	42.1%	50.0%	49.6%	31.4%	24.3%	34.7%	
High school graduate or higher (%)	91.1%	93.7%	97.0%	96.8%	95.5%	91.4%	91.4%	95.8%	
Bachelor's degree or higher (%)	44.5%	57.1%	72.5%	76.4%	79.1%	65.7%	52.5%	66.0%	
Educational attainment by race/ethnicity									
White alone									
High school graduate or higher	93.3%	95.3%	97.3%	96.9%	96.8%	93.5%	93.7%	96.0%	
Bachelor's degree or higher	46.3%	57.7%	73.0%	76.2%	83.1%	68.6%	54.6%	63.7%	
Black alone									
High school graduate or higher	86.2%	89.9%	98.9%	100.0%	86.1%	85.9%	90.6%	91.9%	
Bachelor's degree or higher	27.6%	36.1%	41.4%	58.8%	38.0%	38.1%	35.8%	63.7%	
American Indian or Alaska Native alone									
High school graduate or higher	81.0%	83.0%	100.0%	100.0%	94.4%	67.4%	55.6%	100.0%	
Bachelor's degree or higher	21.9%	18.5%	0.0%	100.0%	16.1%	8.9%	15.3%	100.0%	
Asian alone									
High school graduate or higher	85.7%	90.0%	95.8%	95.9%	97.0%	89.9%	93.5%	96.9%	
Bachelor's degree or higher	61.8%	70.4%	81.4%	80.0%	91.7%	74.8%	71.3%	85.6%	
Native Hawaiian and Other Pacific Islander alone									
High school graduate or higher	89.1%	95.3%	-	-	100.0%	0.0%	-	-	
Bachelor's degree or higher	36.4%	25.5%	-	-	32.6%	0.0%	-	-	
Some other race alone									
High school graduate or higher	69.9%	72.1%	81.0%	100.0%	87.9%	64.9%	58.5%	82.2%	
Bachelor's degree or higher	15.7%	20.2%	13.9%	50.4%	57.9%	18.9%	9.5%	44.9%	
Two or more races									
High school graduate or higher	81.3%	89.7%	100.0%	94.8%	93.6%	83.7%	81.9%	96.8%	
Bachelor's degree or higher	34.9%	52.7%	72.2%	73.4%	68.6%	60.5%	35.2%	56.9%	

			Community Benefits Service Area						
	MA	Middlesex County	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Source
Hispanic or Latino Origin									
High school graduate or higher	72.4%	77.8%	94.8%	91.2%	84.1%	69.3%	64.0%	92.5%	
Bachelor's degree or higher	20.9%	32.1%	48.4%	68.2%	59.6%	35.7%	22.5%	55.9%	
4-Year Graduation Rate Among Public High School Students (%)	89.0		94.9	96.2	89.2	88.0	80.7	83.5	Massachusetts Department of Elementary and Secondary Education, 2020
Safety/Crime									Massachusetts Crime Statistics, 2021
Property Crimes Offenses (#)									
Burglary	9,592.0		32	57	207	120	40	26	
Larceny-theft	55,672.0		102	112	2154	756	254	221	
Motor vehicle theft	7,045.0		6	6	120	84	19	22	
Arson	312.0		0	1	5	4	2	1	
Crimes Against Persons Offenses (#)									
Murder/non-negligent manslaughter	151		0	1	1	3	0	0	
Sex offenses	4,171		6	2	37	40	10	12	
Assaults	67,690		97	54	1,228	389	249	185	
Access to Care									
Ratio of population to primary care physicians	960 to 1	780 to 1							County Health Rankings, 2019
Ratio of population to mental health providers	140 to 1	160 to 1							County Health Rankings, 2021
Ratio of population to dentists	930 to 1	980 to 1							County Health Rankings, 2020
Health insurance coverage among civilian noninstitutionalized population (%)									American Community Survey (U.S. Census Bureau), 2016-2020
With health insurance coverage	97.3%	97.4%	98.8%	98.4%	97.7%	97.3%	96.3%	97.7%	
With private health insurance	74.5%	81.0%	87.7%	87.9%	85.3%	79.4%	78.1%	80.9%	
With public coverage	36.1%	28.5%	22.6%	23.0%	20.6%	24.0%	29.8%	29.8%	
No health insurance coverage	2.7%	2.6%	1.2%	1.6%	2.3%	2.7%	3.7%	2.3%	

Key

Significantly low compared to the Commonwealth based on margin of error

Significantly high compared to the Commonwealth overall based on margin of error

			Community Benefits Service Area						
	Massachusetts	Middlesex County	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Source
Overall Health									
Mortality rate (age-adjusted per 100,000)	654	671	574.2	451	536	645.3	599.6	664.9	Massachusetts Death Report, 2019
Premature mortality rate (per 100,000)	272.8	271.3	210.4	119.9	193.8	217.3	214.4	199.8	
Leading causes of death (counts)									
Cancer	12,584		84	35	126	93	95	66	
Heart Disease	11,779		76	37	95	100	91	63	
Chronic Lower Respiratory Disease	2,842		18	6	18	16	11	11	
Stroke	2,463		17	8	25	15	15	9	
Disability									US Census Bureau, American Community Survey 2016-2020
Percent of population with a disability	11.7%	9.5%	8.6%	7.4%	6.9%	8.0%	9.7%	12.4%	
Under 18	4.7%	3.8%	1.6%	2.6%	2.6%	4.1%	3.0%	5.5%	
18-64	8.9%	6.6%	5.5%	4.5%	5.0%	5.5%	6.8%	8.2%	
65+	31.3%	29.3%	30.0%	24.5%	23.9%	36.2%	30.8%	35.1%	
Healthy Living									
Adults over 18 with no leisure-time physical activity (age-adjusted) (%)	26	22							Behavioral Risk Factor Surveillance System, 2019
Adults who participated in enough aerobic and muscle strengthening exercises to meet guidelines (%)	22.2								Behavioral Risk Factor Surveillance System, 2019
Population with adequate access to locations for physical activity (%)	89	95							County Health Rankings, 2021
Adults who consumed fruit less than one time per day (%)	32.7								Behavioral Risk Factor Surveillance System, 2019
Adults who consumed vegetables less than one time per day (%)	15.5								Behavioral Risk Factor Surveillance System, 2019
Population with limited access to healthy foods (%)	4	3							USDA Food Environment Atlas, 2019
Total Population that Did Not Have Access to a Reliable Source of Food During Past Year (food insecurity rate) (%)	8.2								Feeding America, Map the Meal Gap, 2019
Percentage of adults who report fewer than 7 hours of sleep on average (age-adjusted) (%)	34	33							Behavioral Risk Factor Surveillance System, 2018
Mental Health									
Average number of mentally unhealthy days in past 30 days (adults)	4.2	4							County Health Rankings, 2019
Youth Risk Behavior Survey (YRBS)									Youth Risk Behavior Survey - Report years indicated
	2019		2021	2021	2021	2021	2021	2021	
% of students (grades 6-8) bullied on school property (%)	35.3		21.8 (ever)	21.0 (ever)	--	--	--	26.2 (ever)	
% of students (grades 6-8) bullied electronically (%)	15.2		11.6 (ever)	13.6 (ever)	12.8	15.3	23.6	23.7 (ever)	
% of students (grades 9-12) bullied on school property (%)	16.3		4.2	3.2	--	--	--	5.7	
% of students (grades 9-12) bullied electronically (%)	13.9		9.1	9.7	7.1	5.6	6.3	8.3	
% of students (grades 6-8) reporting self harm (%)	21		15.9	--	10.3	16.8	--	19.3	
% of students (grades 6-8) reporting suicide ideation (%)	11.3		15.4 (ever)	17.8 (ever)	11.1	12.4	26.0	14.1	
% of students (grades 6-8) reporting suicide attempt (%)	5		2.2 (ever)	1.9	1.3	3.8	--	4.6	
% of students (grades 9-12) reporting self harm (%)	16.4		17.0	12.4	11.9	11.2	14.2	14.0	
% of students (grades 9-12) reporting suicide ideation (%)	17.5		11.0	12.0	15.1	11.3	14.2	11.9	
% of students (grades 9-12) reporting suicide attempt (%)	7.3		2.0	--	1.6	2.5	6.2	3.6	
Substance Use									
Admissions to DPH-funded treatment programs (count)	98944		202	0-100	553	574	431	153	MA DPH, Bureau of Substance Abuse Services, 2017

			Community Benefits Service Area						
	Massachusetts	**Middlesex County**	**Arlington**	**Belmont**	**Cambridge**	**Somerville**	**Waltham**	**Watertown**	Source
Rate of injection drug user admissions to DPH-funded treatment program (%)	52.4		49	42.2	48.6	44.5	36.9	39.9	MA DPH, Bureau of Substance Abuse Services, 2017
Primary substance of use when entering treatment									MA DPH, Bureau of Substance Abuse Services, 2017
Alcohol (%)	32.8		34.2	37.3	35.3	36.4	48.5	43.8	
Crack/Cocaine (%)	4.1		3.5	-	4	2.4	1.6	-	
Heroin (%)	52.8		44.6	50.8	50.3	51	39.9	35.9	
Marijuana (%)	3.5			-	2.7	1.4	3.2	-	
Other Opioids (%)	4.6		3.5	-	4.7	5.6	5.8	6.5	
Other Sedatives/Hypnotics (%)	1.5		5	-	2.2	1.6	-	-	
Other Stimulants (%)	0.5		-	-	-	1	-	-	
Other (%)	0.3		-	-	-	-	-	-	
Adults who are current smokers (age-adjusted) (%)	12	12							Behavioral Risk Factor Surveillance System, 2019
Adults who report excessive drinking (binge or heavy drinking) (%)	22	23							Behavioral Risk Factor Surveillance System, 2019
Youth Risk Behavior Survey (YRBS)									Youth Risk Behavior Survey - Report years indicated
	2019		**2021**	**2021**	**2021**	**2021**	**2021**	**2021**	
Students (grades 6-8) reporting lifetime alcohol use (%)	13.6		9.1	11.5	--	13.7	17.8	13.1	
Students (grades 6-8) reporting current alcohol use (%)	4.4		1.1	3.1	16.1	2.6	3.0	3.5	
Students (grades 9-12) reporting lifetime alcohol use (%)	--		39.0	41.7	--	29.5	--	43.6	
Students (grades 9-12) reporting current alcohol use (%)	29.8		17.4	17.1	1.4	8.7	16.0	22.8	
Students (grades 6-8) reporting current binge alcohol use (%)	0.9		--	--	--	0.6	--	--	
Students (grades 9-12) reporting current binge alcohol use (%)	15.0		5.5	7.1	--	2.3	5.9	13.6	
Students (grades 6-8) reporting lifetime cigarette use (%)	5.2		1.1	1.4	--	6.2	--	4.0	
Students (grades 6-8) reporting current cigarette use (%)	--		0.0	0.2	0.2	1.7	1.4	0.6	
Students (grades 9-12) reporting lifetime cigarette use (%)	17.7		8.5	--	--	8.5	--	14.2	
Students (grades 9-12) reporting current cigarette use (%)	5.0		2.9	--	3.8	1.2	2.3	5.1	
Students (grades 6-8) reporting lifetime marijuana use (%)	7.0		0.7	1.1	--	3.9	--	3.2	
Students (grades 6-8) reporting current marijuana use (%)	3.0		0.1	0.5	0.6	2.2	1.2	3.1	
Students (grades 9-12) reporting lifetime marijuana use (%)	41.9		18.7	16.6	--	21.6	--	23.6	
Students (grades 9-12) reporting current marijuana use (%)	26.0		7.6	6.3	14.6	8.7	8.7	12.2	
Students (grades 6-8) reporting lifetime electronic tobacco use (%)	14.7		1.4	2.5	--	8.1	--	6.4	
Students (grades 6-8) reporting current electronic tobacco use (%)	--		0.4	0.9	1.2	3.3	4.4	2.1	
Students (grades 9-12) reporting lifetime electronic tobacco use (%)	50.7		19.6	14.8	--	22.2	--	30.2	
Students (grades 9-12) reporting current electronic tobacco use (%)	32.2		6.0	5.1	8.9	7.8	10.1	14.5	
Chronic Disease (more data on CHIA data tabs)									

			Community Benefits Service Area						
	Massachusetts	**Middlesex County**	**Arlington**	**Belmont**	**Cambridge**	**Somerville**	**Waltham**	**Watertown**	Source
Cancer mortality (all types, age-adjusted rate per 100,000)	149.92	140.37							Massachusetts Cancer Registry, 2014-2018
Cancer incidence (age-adjusted per 100,000)									
All sites	498.16	483.79							
Breast Cancer	176.35	189.2							
Cervical Cancer	5.5	4.66							
Coloretal Cancer	35.96	35.38							
Lung and Bronchus Cancer	61.41	54.88							
Prostate Cancer	108.84	106.55							
Risk factors									
Percent of Adults who are Obese (%)	24		19.6	19.2	21.4	22.2	22.4	20.6	Behavioral Risk Factor Surveillance System, 2018
Diagnosed diabetes among adults aged >=18 years (%)	8.6		5.8	5.9	7.1	7.4	7.3	6.2	Behavioral Risk Factor Surveillance System, 2018
Age-adjusted mortality due to heart disease per 100,000 population (%)	138.7								Massachusetts Department of Public Health, Population Health Information Tool, 2015
Adults ever told by doctor that they had angina or coronary heart disease (age-adjusted) (%)	4.7		4.1	4.1	4.5	4.9	4.9	4.4	Behavioral Risk Factor Surveillance System, 2017
Adults ever told by doctor that they had high blood pressure (age adjusted) (%)	26.8		22.8	22.7	25.3	25.6	25.5	23.7	Behavioral Risk Factor Surveillance System, 2017
Adults ever told by doctor that they had high cholesterol (age-adjusted) (%)	33.1		25.8	25.8	26.5	26.8	27	26.3	Behavioral Risk Factor Surveillance System, 2017
Reproductive Health									
Infant Mortality Rate (per 1,000 live births)	3.7	2.8							March of Dimes, 2019
Low birth weight (%)	7.4	7							March of Dimes, 2020
Mothers with late or no prenatal care (%)	3.9%	3.4							March of Dimes, 2020
Births to adolescent mothers (per 1,000 females ages 15-19)	8	4							National Center for Health Statistics, 2014-2020
Percent of mothers receiving publicly funded prenatal care 2016	38.60%								Massachusetts Births 2016
Women screened for postpartum depression within 6 months after delivery (%)									MDPH January 2016-December 2016
White (non-Hispanic)	13.60%								
Black (non-Hispanic)	9.70%								
Asian or Pacific Islander (non-Hispanic)	14.60%								
American Indian/Alaska Native (non-Hispanic)	10.30%								
Other race (non-Hispanic)	13.30%								
Unknown race	12.40%								
Less than a high school diploma	8.00%								
With a high school diploma or GED	9.30%								
Some College/Associate Degree	11.40%								
Bachelor Degree	14.10%								
Graduate Degrees	15.20%								
Among individuals who had a full-term birth	12.10%								
Among individuals who had a pre-term birth	11.50%								
Among individuals who are not married	9.70%								
Among individuals who are married	13.70%								
Frequency of self-reported postpartum depressive symptoms 2017									MDPH 2019. CY18 Summary of Activities Related to Screening for Postpartum Depression
Rarely/Never	61.4%								
Often/Always	10.7%								
Sometimes	27.9%								
Communicable and Infectious Disease									
HIV prevalence (per 100,000 population 13 years and older)	355	288							National Center for HIV/AIDS, Viral Hepatitis, STD, TB Prevention, 2019
STI infection cases (per 100,000)									Massachusetts Population Health Information Tool, 2018
Syphillis (case count)	1,164		7	0	23	29	15	7	
Gonorrhea (case count)	7,629		34	7	186	175	60	35	
Chlamydia	30,297		96	40	524	401	262	90	

			Community Benefits Service Area						
	Massachusetts	**Middlesex County**	**Arlington**	**Belmont**	**Cambridge**	**Somerville**	**Waltham**	**Watertown**	Source
Confirmed and probable Hepatitis B cases (per 100,000 population)	25.1								Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences. Hepatitis B Virus Infection 2020 Surveillance Report. https://www.mass.gov/lists/infectious-disease- data-reports-and-requests. Published February 2021
Rate of Hepatitis C (per 100,000)	97.9		26.4	37	48.3	44.5	44	45.4	Massachusetts Population Health Information Tool, 2018
Tuberculosis (case count)	204		Less than 5	0	6	1	3	Less than 5	Massachusetts Population Health Information Tool, 2018
Medicare enrollees that had annual flu vaccination (%)	56%	59%							Mapping Medicare Disparities, 2019

*Suppressed

	Massachusetts	Middlesex County	Community Benefits Service Area: Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown	Source
COVID-19 Community Impact Survey									MDPH COVID-19 Community Impact Survey, updated November 2021. Note that these unweighted percentages represent rates of response of individuals that completed the survey in those geographies, and may not be represenative of those geographies as a whole.
% very worried about getting infected with COVID-19		28%	27%	31%	26%	26%	27%	29%	
% ever been tested for COVID		48%	43%	46%	58%	63%	44%	44%	
% who have not gotten the medical care they needed since July 2020		19%	20%	16%	25%	25%	16%	21%	
% with 15 or more of poor mental health days in the past 30 days		32%	34%	28%	34%	41%	33%	32%	
% of substance users who said they are now using more substances than before the pandemic		42%	45%	44%	38%	51%	34%	39%	
% Worried about paying for 1 or more types of expense or bills in the coming few weeks		31%	22%	20%	25%	31%	32%	33%	
% Worried about getting food or groceries in the coming weeks		18%	11%	14%	12%	12%	17%	19%	
% Worried about getting face masks in the coming weeks		11%	6%	13%	10%	9%	13%	7%	
% Worried about getting medication in the coming weeks		10%	7%	9%	7%	12%	9%	9%	
% Worried about getting broadband in the coming weeks		10%	4%	4%	8%	8%	9%	8%	
% of Employed residents who experienced job loss		8%	7%	5%	7%	7%	5%	12%	
% of employed residents who experienced reduced work hours		12%	15%	8%	12%	11%	11%	6%	
% Worried about paying mortgage, rent, or utilities related expenses		21%	14%	16%	16%	20%	22%	19%	
% Worried they may have to move out of where they live in the next few months		17%	10%	*	18%	23%	11%	21%	
Boston Indicators: COVID Community Data Lab									Boston Indicators
Unemployment claims (#) reported on 10/30/21	5,901								
Unemplyment rate as of 10/21/21	5.3%								
COVID-19 Layoff									Metropolitian Area Planning Council, The COVID-19 Layoff Housing Gap (October 2020)
Estimated number of households in need of assistance with no government aid (without any unmployment benefits)			285	150	808	854	524	332	
Unemployment claims (#)			1,469	777	3,382	3,556	2,579	1,691	

Community Health Needs Assessment - Mount Auburn Hospital

Source: Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume
Patients aged 0-17, Mount Auburn Hospital Community Benefits Service Area defined by BILH Community Benefits

		Mount Auburn Hospital Community Benefits Service Area					
	MA	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
All Cause							
FY19 Inpatient Discharges (all cause) rate per 100,000	1,735	1,503	1,179	1,376	1,694	1,916	1,708
Change in Inpatient Discharge Rate FY17 to FY19	-7%	-14%	-18%	-10%	16%	-1%	23%
FY19 ED Volume (all cause) rate per 100,000	19,530	11,809	9,553	16,092	20,800	16,483	11,796
Change in ED Volume Rate FY17 to FY19	-1%	-18%	-14%	3%	-8%	12%	-8%
Chronic Disease							
Asthma							
FY19 Inpatient Discharges rate per 100,000	333	154	121	271	367	360	399
Change in Inpatient Discharge Rate FY17 to FY19	-12%	-67%	-50%	0%	14%	12%	92%
FY19 ED Volume rate per 100,000	2,481	1,328	988	2,649	3,807	2,030	1,325
Change in ED Volume Rate FY17 to FY19	2%	0%	-22%	5%	-2%	8%	-16%
Diabetes Mellitus							
FY19 Inpatient Discharges rate per 100,000	53	51	17	45	26	76	16
Change in Inpatient Discharge Rate FY17 to FY19	7%	-38%	-67%	40%	-57%	14%	0%
FY19 ED Volume rate per 100,000	117	31	0	78	87	57	0
Change in ED Volume Rate FY17 to FY19	-2%	-85%	-100%	200%	-64%	-14%	-100%
Obesity							
FY19 Inpatient Discharges rate per 100,000	61	72	35	52	17	47	144
Change in Inpatient Discharge Rate FY17 to FY19	6%	133%	-50%	14%	-78%	-38%	350%
FY19 ED Volume rate per 100,000	81	31	35	284	821	85	48
Change in ED Volume Rate FY17 to FY19	0%	200%	0%	47%	-10%	0%	-25%
Injuries and Infections							
Allergy							
FY19 Inpatient Discharges rate per 100,000	125	103	69	78	96	114	144
Change in Inpatient Discharge Rate FY17 to FY19	2%	11%	0%	-33%	120%	50%	80%
FY19 ED Volume rate per 100,000	1,874	1,987	1,196	2,332	3,755	2,276	1,341
Change in ED Volume Rate FY17 to FY19	-1%	38%	-45%	-24%	-20%	21%	-42%
HIV Infection							
FY19 Inpatient Discharges rate per 100,000	1	10	0	0	0	9	0
Change in Inpatient Discharge Rate FY17 to FY19	18%	0%	0%	0%	0%	0%	0%
FY19 ED Volume rate per 100,000	1	0	0	0	0	0	0
Change in ED Volume Rate FY17 to FY19	-23%	0%	0%	0%	0%	0%	0%
Infections							
FY19 Inpatient Discharges rate per 100,000	767	659	451	549	795	835	654
Change in Inpatient Discharge Rate FY17 to FY19	-2%	10%	-35%	16%	47%	-1%	0%
FY19 ED Volume rate per 100,000	7,457	2,780	2,254	5,807	9,789	7,189	4,342
Change in ED Volume Rate FY17 to FY19	4%	-18%	1%	-3%	-7%	40%	-12%
Injuries							
FY19 Inpatient Discharges rate per 100,000	345	278	312	297	279	303	271
Change in Inpatient Discharge Rate FY17 to FY19	-4%	59%	125%	53%	28%	-3%	113%
FY19 ED Volume rate per 100,000	7,024	5,477	5,374	6,202	6,235	4,884	4,326
Change in ED Volume Rate FY17 to FY19	-8%	-9%	-10%	6%	-11%	-5%	-5%
Poisonings							
FY19 Inpatient Discharges rate per 100,000	85	31	35	26	61	57	32
Change in Inpatient Discharge Rate FY17 to FY19	-30%	-25%	100%	-20%	-13%	-14%	0%
FY19 ED Volume rate per 100,000	501	319	191	736	1,677	237	128
Change in ED Volume Rate FY17 to FY19	32%	-38%	83%	41%	49%	-39%	-47%
Pneumonia/Influenza							
FY19 Inpatient Discharges rate per 100,000	213	124	87	149	166	389	208
Change in Inpatient Discharge Rate FY17 to FY19	3%	-50%	-44%	53%	-17%	128%	8%
FY19 ED Volume rate per 100,000	1,098	288	347	620	777	1,546	878
Change in ED Volume Rate FY17 to FY19	38%	17%	5%	43%	20%	65%	90%
Sexually Transmitted Diseases							
FY19 Inpatient Discharges rate per 100,000	4	0	0	0	0	19	0
Change in Inpatient Discharge Rate FY17 to FY19	7%	0%	0%	0%	-100%	0%	0%
FY19 ED Volume rate per 100,000	35	10	0	13	17	0	0
Change in ED Volume Rate FY17 to FY19	15%	-50%	0%	0%	0%	-100%	0%
Other							
Attention Deficit Hyperactivity Disorder							
FY19 Inpatient Discharges rate per 100,000	141	113	87	136	148	95	239
Change in Inpatient Discharge Rate FY17 to FY19	-3%	-31%	-58%	-16%	42%	-29%	50%
FY19 ED Volume rate per 100,000	588	618	173	187	183	275	208
Change in ED Volume Rate FY17 to FY19	17%	94%	-50%	314%	91%	-33%	-32%
Learning Disorders							
FY19 Inpatient Discharges rate per 100,000	135	165	104	97	105	133	223
Change in Inpatient Discharge Rate FY17 to FY19	12%	129%	-25%	-6%	33%	17%	8%
FY19 ED Volume rate per 100,000	103	62	69	123	131	152	208
Change in ED Volume Rate FY17 to FY19	84%	200%	100%	111%	400%	700%	333%
Mental Health							
FY19 Inpatient Discharges rate per 100,000	772	1,040	572	930	987	351	878
Change in Inpatient Discharge Rate FY17 to FY19	-5%	-28%	0%	-9%	9%	-54%	15%
FY19 ED Volume rate per 100,000	2,592	2,244	1,127	1,305	1,284	1,679	910
Change in ED Volume Rate FY17 to FY19	5%	-52%	-4%	0%	-5%	-9%	-20%

Substance Use Disorders							
FY19 Inpatient Discharges rate per 100,000	53	72	17	45	35	38	16
Change in Inpatient Discharge Rate FY17 to FY19	-8%	-36%	0%	75%	-60%	100%	-67%
FY19 ED Volume rate per 100,000	343	443	52	174	175	351	144
Change in ED Volume Rate FY17 to FY19	-5%	-54%	-63%	29%	-38%	85%	-10%
Complication of Medical Care							
FY19 Inpatient Discharges rate per 100,000	229	93	121	142	175	209	271
Change in Inpatient Discharge Rate FY17 to FY19	-4%	-18%	133%	-29%	-5%	-27%	89%
FY19 ED Volume rate per 100,000	208	113	35	149	131	180	144
Change in ED Volume Rate FY17 to FY19	3%	-21%	-33%	-28%	-46%	-21%	29%

Community Health Needs Assessment - Mount Auburn Hospital

Source: Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume
Patients aged 18-44, Mount Auburn Hospital Community Benefits Service Area defined by BILH Community Benefits

		Mount Auburn Hospital Community Benefits Service Area					
	MA	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
All Cause							
FY19 Inpatient Discharges (all cause) rate per 100,000	6,072	5,362	4,091	2,995	3,501	4,989	4,954
Change in Inpatient Discharge Rate FY17 to FY19	0%	3%	4%	11%	2%	15%	7%
FY19 ED Volume (all cause) rate per 100,000	25,053	10,930	7,989	10,954	16,173	14,147	11,422
Change in ED Volume Rate FY17 to FY19	-1%	-15%	-24%	-11%	-11%	3%	-21%
Cancer							
Breast Cancer							
FY19 Inpatient Discharges rate per 100,000	32	43	36	24	9	14	14
Change in Inpatient Discharge Rate FY17 to FY19	-10%	-33%	-40%	33%	-56%	-33%	-33%
FY19 ED Volume rate per 100,000	27	43	0	6	0	7	7
Change in ED Volume Rate FY17 to FY19	25%	500%	-100%	300%	-100%	-50%	0%
Colorectal Cancer							
FY19 Inpatient Discharges rate per 100,000	15	0	0	9	14	24	14
Change in Inpatient Discharge Rate FY17 to FY19	17%	-100%	0%	20%	50%	600%	100%
FY19 ED Volume rate per 100,000	4	0	0	0	5	0	14
Change in ED Volume Rate FY17 to FY19	21%	0%	0%	0%	0%	0%	0%
GYN Cancer							
FY19 Inpatient Discharges rate per 100,000	41	7	0	11	2	14	21
Change in Inpatient Discharge Rate FY17 to FY19	11%	0%	0%	-42%	-92%	33%	50%
FY19 ED Volume rate per 100,000	30	7	12	0	2	17	0
Change in ED Volume Rate FY17 to FY19	23%	0%	0%	-100%	-75%	150%	-100%
Lung Cancer							
FY19 Inpatient Discharges rate per 100,000	26	14	24	26	21	17	21
Change in Inpatient Discharge Rate FY17 to FY19	3%	-33%	0%	143%	125%	150%	0%
FY19 ED Volume rate per 100,000	7	0	0	3	2	0	7
Change in ED Volume Rate FY17 to FY19	47%	0%	0%	-50%	0%	-100%	-67%
Prostate Cancer							
FY19 Inpatient Discharges rate per 100,000	1	0	0	0	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19	-15%	-100%	0%	0%	0%	0%	0%
FY19 ED Volume rate per 100,000	0	0	0	0	0	0	0
Change in ED Volume Rate FY17 to FY19	150%	-100%	0%	0%	0%	0%	0%
Other Cancer							
FY19 Inpatient Discharges rate per 100,000	304	136	289	176	265	281	213
Change in Inpatient Discharge Rate FY17 to FY19	2%	-44%	71%	1%	138%	93%	-12%
FY19 ED Volume rate per 100,000	142	36	24	38	59	101	107
Change in ED Volume Rate FY17 to FY19	29%	25%	-50%	-7%	47%	15%	25%
Chronic Disease							
Asthma							
FY19 Inpatient Discharges rate per 100,000	745	450	349	303	332	534	419
Change in Inpatient Discharge Rate FY17 to FY19	-5%	3%	16%	11%	4%	22%	9%
FY19 ED Volume rate per 100,000	2,649	1,221	698	1,346	2,108	1,823	1,166
Change in ED Volume Rate FY17 to FY19	3%	14%	-32%	-18%	-16%	19%	-29%
Congestive Heart Failure							
FY19 Inpatient Discharges rate per 100,000	124	64	12	49	26	51	14
Change in Inpatient Discharge Rate FY17 to FY19	14%	29%	-50%	7%	38%	25%	0%
FY19 ED Volume rate per 100,000	56	7	0	11	14	10	21
Change in ED Volume Rate FY17 to FY19	42%	0%	0%	-36%	0%	50%	-57%
COPD and Lung Disease							
FY19 Inpatient Discharges rate per 100,000	136	50	48	66	54	57	57
Change in Inpatient Discharge Rate FY17 to FY19	-5%	250%	-50%	65%	109%	-19%	-11%
FY19 ED Volume rate per 100,000	127	21	36	35	14	68	64
Change in ED Volume Rate FY17 to FY19	16%	-40%	50%	15%	-67%	43%	50%
Diabetes Mellitus							
FY19 Inpatient Discharges rate per 100,000	478	286	72	148	201	382	242
Change in Inpatient Discharge Rate FY17 to FY19	5%	21%	20%	-8%	18%	53%	10%
FY19 ED Volume rate per 100,000	1,167	493	156	353	668	788	448
Change in ED Volume Rate FY17 to FY19	7%	30%	-38%	-27%	-7%	16%	-2%
Heart Disease							
FY19 Inpatient Discharges rate per 100,000	445	286	132	185	185	247	149
Change in Inpatient Discharge Rate FY17 to FY19	6%	33%	-39%	46%	-1%	-3%	24%
FY19 ED Volume rate per 100,000	375	121	84	144	185	365	199
Change in ED Volume Rate FY17 to FY19	31%	-29%	40%	0%	4%	64%	-10%
Hypertension							
FY19 Inpatient Discharges rate per 100,000	606	314	205	205	265	484	362
Change in Inpatient Discharge Rate FY17 to FY19	1%	38%	55%	24%	11%	40%	28%
FY19 ED Volume rate per 100,000	1,838	693	385	599	917	1,282	888
Change in ED Volume Rate FY17 to FY19	8%	-24%	-36%	-5%	-14%	20%	7%
Liver Disease							
FY19 Inpatient Discharges rate per 100,000	427	143	168	147	187	382	235
Change in Inpatient Discharge Rate FY17 to FY19	15%	-41%	100%	3%	16%	19%	120%
FY19 ED Volume rate per 100,000	185	79	24	24	50	210	57
Change in ED Volume Rate FY17 to FY19	25%	22%	-33%	-11%	-38%	55%	33%

Obesity							
FY19 Inpatient Discharges rate per 100,000	919	386	349	248	296	585	498
Change in Inpatient Discharge Rate FY17 to FY19	6%	2%	53%	32%	-12%	26%	-5%
FY19 ED Volume rate per 100,000	530	150	60	409	748	531	163
Change in ED Volume Rate FY17 to FY19	11%	-46%	67%	7%	-26%	145%	-12%
Stroke and Other Neurovascular Diseases							
FY19 Inpatient Discharges rate per 100,000	71	21	36	34	43	51	57
Change in Inpatient Discharge Rate FY17 to FY19	9%	-50%	200%	57%	-10%	67%	-20%
FY19 ED Volume rate per 100,000	28	21	0	9	9	14	28
Change in ED Volume Rate FY17 to FY19	11%	0%	-100%	-40%	-60%	300%	33%
Injuries and Infections							
Allergy							
FY19 Inpatient Discharges rate per 100,000	553	471	253	159	187	369	291
Change in Inpatient Discharge Rate FY17 to FY19	13%	74%	-30%	-5%	4%	60%	21%
FY19 ED Volume rate per 100,000	3,482	3,027	2,503	2,501	4,406	2,810	2,289
Change in ED Volume Rate FY17 to FY19	44%	9%	-6%	-22%	-18%	61%	-23%
Hepatitis							
FY19 Inpatient Discharges rate per 100,000	344	228	205	102	137	244	107
Change in Inpatient Discharge Rate FY17 to FY19	-4%	33%	750%	-21%	-27%	4%	-25%
FY19 ED Volume rate per 100,000	195	129	24	40	31	74	64
Change in ED Volume Rate FY17 to FY19	1%	6%	100%	-28%	-43%	-56%	-31%
HIV Infection							
FY19 Inpatient Discharges rate per 100,000	44	57	24	9	14	27	57
Change in Inpatient Discharge Rate FY17 to FY19	2%	300%	0%	-45%	-25%	300%	700%
FY19 ED Volume rate per 100,000	102	43	12	29	9	24	28
Change in ED Volume Rate FY17 to FY19	11%	500%	-50%	-47%	-69%	-30%	-20%
Infections							
FY19 Inpatient Discharges rate per 100,000	1,534	693	686	573	711	1,082	739
Change in Inpatient Discharge Rate FY17 to FY19	2%	-12%	-21%	31%	11%	30%	2%
FY19 ED Volume rate per 100,000	5,547	2,128	1,709	2,367	3,764	2,895	2,417
Change in ED Volume Rate FY17 to FY19	-6%	-17%	-30%	-15%	-19%	4%	-23%
Injuries							
FY19 Inpatient Discharges rate per 100,000	1,103	714	578	376	450	873	533
Change in Inpatient Discharge Rate FY17 to FY19	5%	18%	30%	13%	4%	50%	44%
FY19 ED Volume rate per 100,000	7,762	3,420	2,900	3,378	5,112	3,927	3,959
Change in ED Volume Rate FY17 to FY19	-4%	-15%	-13%	-7%	-6%	-3%	-4%
Poisonings							
FY19 Inpatient Discharges rate per 100,000	189	114	60	57	69	98	85
Change in Inpatient Discharge Rate FY17 to FY19	-7%	-27%	67%	-21%	-17%	-28%	-43%
FY19 ED Volume rate per 100,000	693	293	96	327	476	254	242
Change in ED Volume Rate FY17 to FY19	-8%	-40%	-62%	-5%	8%	-34%	-26%
Pneumonia/Influenza							
FY19 Inpatient Discharges rate per 100,000	286	164	168	95	133	183	128
Change in Inpatient Discharge Rate FY17 to FY19	8%	21%	40%	-2%	44%	32%	38%
FY19 ED Volume rate per 100,000	588	178	120	183	310	348	213
Change in ED Volume Rate FY17 to FY19	27%	19%	-33%	2%	27%	39%	-9%
Sexually Transmitted Diseases							
FY19 Inpatient Discharges rate per 100,000	80	79	72	41	50	64	57
Change in Inpatient Discharge Rate FY17 to FY19	-9%	-21%	20%	8%	-5%	-5%	14%
FY19 ED Volume rate per 100,000	262	50	24	81	121	115	100
Change in ED Volume Rate FY17 to FY19	15%	-30%	100%	23%	-4%	162%	100%
Tuberculosis							
FY19 Inpatient Discharges rate per 100,000	9	0	12	8	7	7	7
Change in Inpatient Discharge Rate FY17 to FY19	-3%	-100%	0%	150%	50%	100%	0%
FY19 ED Volume rate per 100,000	5	0	0	0	0	0	7
Change in ED Volume Rate FY17 to FY19	0%	0%	0%	-100%	-100%	0%	0%
Other							
Dementia and Cognitive Disorders							
FY19 Inpatient Discharges rate per 100,000	177	86	108	79	64	149	43
Change in Inpatient Discharge Rate FY17 to FY19	9%	-37%	350%	41%	-18%	22%	-25%
FY19 ED Volume rate per 100,000	201	129	72	179	230	149	78
Change in ED Volume Rate FY17 to FY19	-11%	-25%	-40%	-21%	-9%	22%	-21%
Mental Health							
FY19 Inpatient Discharges rate per 100,000	4,382	3,027	2,322	2,004	2,435	3,558	2,573
Change in Inpatient Discharge Rate FY17 to FY19	5%	-7%	38%	25%	13%	21%	-2%
FY19 ED Volume rate per 100,000	7,907	3,120	1,420	2,715	3,214	3,764	2,808
Change in ED Volume Rate FY17 to FY19	16%	-16%	-42%	4%	-1%	-22%	-32%
Parkinsons and Movement Disorders							
FY19 Inpatient Discharges rate per 100,000	41	64	24	12	24	30	7
Change in Inpatient Discharge Rate FY17 to FY19	-2%	80%	0%	-20%	43%	13%	-75%
FY19 ED Volume rate per 100,000	95	43	12	46	59	47	64
Change in ED Volume Rate FY17 to FY19	-4%	-25%	-83%	-30%	-24%	-36%	-44%
Substance Use Disorders							
FY19 Inpatient Discharges rate per 100,000	2,012	964	626	614	685	1,167	917
Change in Inpatient Discharge Rate FY17 to FY19	-2%	4%	24%	4%	-14%	-4%	-7%
FY19 ED Volume rate per 100,000	8,347	2,584	1,781	3,439	4,725	4,217	2,751
Change in ED Volume Rate FY17 to FY19	0%	-31%	-17%	-12%	-15%	-5%	-31%
Complication of Medical Care							
FY19 Inpatient Discharges rate per 100,000	2,698	3,320	2,418	1,665	1,800	2,587	3,092
Change in Inpatient Discharge Rate FY17 to FY19	5%	9%	3%	17%	4%	24%	26%
FY19 ED Volume rate per 100,000	582	350	229	275	528	325	256
Change in ED Volume Rate FY17 to FY19	14%	4%	12%	28%	60%	9%	-42%

Community Health Needs Assessment - Mount Auburn Hospital

Source: Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume
Patients aged 45-64, Mount Auburn Hospital Community Benefits Service Area defined by BILH Community Benefits

		Mount Auburn Hospital Community Benefits Service Area					
	MA	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
All Cause							
FY19 Inpatient Discharges (all cause) rate per 100,000	9,762	5,685	4,869	7,699	6,513	9,133	6,897
Change in Inpatient Discharge Rate FY17 to FY19	0%	0%	5%	11%	1%	4%	1%
FY19 ED Volume (all cause) rate per 100,000	24,003	10,586	8,370	29,284	22,156	18,955	12,805
Change in ED Volume Rate FY17 to FY19	2%	-7%	-22%	4%	-13%	-11%	-17%
Cancer							
Breast Cancer							
FY19 Inpatient Discharges rate per 100,000	258	210	409	261	151	285	206
Change in Inpatient Discharge Rate FY17 to FY19	-5%	-7%	38%	112%	-4%	64%	-27%
FY19 ED Volume rate per 100,000	195	70	113	118	81	167	54
Change in ED Volume Rate FY17 to FY19	18%	13%	0%	79%	0%	-20%	-58%
Colorectal Cancer							
FY19 Inpatient Discharges rate per 100,000	116	78	155	114	64	167	130
Change in Inpatient Discharge Rate FY17 to FY19	0%	-23%	83%	200%	-42%	71%	50%
FY19 ED Volume rate per 100,000	27	0	28	9	0	56	87
Change in ED Volume Rate FY17 to FY19	12%	-100%	0%	-67%	0%	-11%	300%
GYN Cancer							
FY19 Inpatient Discharges rate per 100,000	182	202	240	156	162	125	206
Change in Inpatient Discharge Rate FY17 to FY19	-3%	44%	143%	0%	47%	-33%	-5%
FY19 ED Volume rate per 100,000	82	23	14	71	17	56	11
Change in ED Volume Rate FY17 to FY19	21%	-40%	0%	-12%	50%	-43%	-67%
Lung Cancer							
FY19 Inpatient Discharges rate per 100,000	358	194	240	308	289	341	261
Change in Inpatient Discharge Rate FY17 to FY19	5%	-14%	240%	48%	79%	4%	-37%
FY19 ED Volume rate per 100,000	97	16	14	14	41	21	76
Change in ED Volume Rate FY17 to FY19	21%	100%	-50%	-70%	-22%	-40%	40%
Prostate Cancer							
FY19 Inpatient Discharges rate per 100,000	133	101	85	104	69	76	119
Change in Inpatient Discharge Rate FY17 to FY19	-5%	-7%	-33%	5%	-8%	-65%	83%
FY19 ED Volume rate per 100,000	60	109	14	33	12	21	11
Change in ED Volume Rate FY17 to FY19	30%	1300%	-50%	250%	0%	-75%	0%
Other Cancer							
FY19 Inpatient Discharges rate per 100,000	1,984	1,413	1,990	1,573	1,349	2,391	2,172
Change in Inpatient Discharge Rate FY17 to FY19	3%	-29%	21%	22%	4%	47%	18%
FY19 ED Volume rate per 100,000	597	163	141	294	266	1,050	413
Change in ED Volume Rate FY17 to FY19	27%	-16%	-33%	41%	-8%	110%	15%
Chronic Disease							
Asthma							
FY19 Inpatient Discharges rate per 100,000	1,051	691	438	834	689	987	565
Change in Inpatient Discharge Rate FY17 to FY19	-17%	17%	29%	14%	-6%	-17%	-7%
FY19 ED Volume rate per 100,000	1,944	1,033	550	3,359	2,200	1,995	1,130
Change in ED Volume Rate FY17 to FY19	0%	19%	-59%	16%	-39%	-9%	-11%
Congestive Heart Failure							
FY19 Inpatient Discharges rate per 100,000	1,292	645	536	1,052	903	1,369	825
Change in Inpatient Discharge Rate FY17 to FY19	10%	1%	111%	15%	9%	39%	52%
FY19 ED Volume rate per 100,000	396	78	56	635	266	361	98
Change in ED Volume Rate FY17 to FY19	41%	-17%	100%	24%	-36%	49%	-18%
COPD and Lung Disease							
FY19 Inpatient Discharges rate per 100,000	1,994	753	452	1,573	1,100	1,710	1,010
Change in Inpatient Discharge Rate FY17 to FY19	1%	-13%	-20%	23%	8%	26%	52%
FY19 ED Volume rate per 100,000	1,388	466	71	1,890	938	994	391
Change in ED Volume Rate FY17 to FY19	10%	33%	-58%	7%	-32%	4%	-16%
Diabetes Mellitus							
FY19 Inpatient Discharges rate per 100,000	2,808	1,429	790	2,478	2,020	2,593	1,857
Change in Inpatient Discharge Rate FY17 to FY19	3%	8%	8%	35%	3%	41%	8%
FY19 ED Volume rate per 100,000	4,109	1,173	917	4,989	3,763	3,378	2,020
Change in ED Volume Rate FY17 to FY19	10%	-25%	-41%	19%	-24%	1%	-21%
Heart Disease							
FY19 Inpatient Discharges rate per 100,000	3,609	2,198	1,609	2,791	2,333	3,865	2,346
Change in Inpatient Discharge Rate FY17 to FY19	4%	34%	52%	16%	5%	19%	6%
FY19 ED Volume rate per 100,000	1,448	645	381	1,971	932	2,433	880
Change in ED Volume Rate FY17 to FY19	17%	46%	-31%	51%	4%	13%	-18%
Hypertension							
FY19 Inpatient Discharges rate per 100,000	4,045	2,066	1,948	2,487	2,559	3,663	2,618
Change in Inpatient Discharge Rate FY17 to FY19	-2%	19%	29%	3%	7%	3%	16%
FY19 ED Volume rate per 100,000	7,878	2,874	2,315	9,874	7,271	6,992	4,334
Change in ED Volume Rate FY17 to FY19	10%	-13%	-19%	7%	-18%	-1%	-17%
Liver Disease							
FY19 Inpatient Discharges rate per 100,000	1,562	753	720	1,473	1,100	1,793	1,097
Change in Inpatient Discharge Rate FY17 to FY19	5%	1%	113%	24%	20%	10%	44%
FY19 ED Volume rate per 100,000	404	101	85	303	133	528	152
Change in ED Volume Rate FY17 to FY19	19%	0%	20%	156%	-30%	162%	100%

Obesity							
FY19 Inpatient Discharges rate per 100,000	2,410	1,157	988	1,180	1,297	2,370	1,792
Change in Inpatient Discharge Rate FY17 to FY19	5%	13%	84%	18%	4%	32%	2%
FY19 ED Volume rate per 100,000	675	280	198	1,483	1,789	938	478
Change in ED Volume Rate FY17 to FY19	17%	-20%	-30%	54%	-5%	71%	33%
Stroke and Other Neurovascular Diseases							
FY19 Inpatient Discharges rate per 100,000	443	295	282	313	278	334	467
Change in Inpatient Discharge Rate FY17 to FY19	2%	31%	18%	35%	-24%	-16%	169%
FY19 ED Volume rate per 100,000	119	39	56	57	41	125	54
Change in ED Volume Rate FY17 to FY19	6%	0%	100%	-48%	-46%	13%	0%
Injuries and Infections							
Allergy							
FY19 Inpatient Discharges rate per 100,000	1,314	746	536	867	660	1,133	695
Change in Inpatient Discharge Rate FY17 to FY19	20%	45%	31%	45%	50%	63%	-14%
FY19 ED Volume rate per 100,000	4,000	3,611	2,837	9,006	6,924	4,170	3,302
Change in ED Volume Rate FY17 to FY19	59%	12%	-24%	-5%	-20%	23%	-18%
Hepatitis							
FY19 Inpatient Discharges rate per 100,000	492	93	99	640	313	521	250
Change in Inpatient Discharge Rate FY17 to FY19	-19%	-50%	-22%	-35%	-17%	-13%	-21%
FY19 ED Volume rate per 100,000	211	16	14	194	58	160	33
Change in ED Volume Rate FY17 to FY19	-11%	-60%	-50%	-32%	-29%	77%	-63%
HIV Infection							
FY19 Inpatient Discharges rate per 100,000	157	16	212	341	122	125	119
Change in Inpatient Discharge Rate FY17 to FY19	-7%	-67%	275%	-12%	40%	0%	10%
FY19 ED Volume rate per 100,000	236	23	42	535	110	139	130
Change in ED Volume Rate FY17 to FY19	-3%	0%	50%	-28%	36%	-59%	500%
Infections							
FY19 Inpatient Discharges rate per 100,000	3,824	2,144	1,807	2,378	2,339	3,788	3,063
Change in Inpatient Discharge Rate FY17 to FY19	3%	0%	31%	8%	0%	18%	31%
FY19 ED Volume rate per 100,000	3,618	1,483	1,327	3,151	3,358	2,224	2,303
Change in ED Volume Rate FY17 to FY19	-4%	-14%	-19%	-15%	-22%	-14%	-14%
Injuries							
FY19 Inpatient Discharges rate per 100,000	3,425	2,190	1,609	2,374	2,466	3,322	2,444
Change in Inpatient Discharge Rate FY17 to FY19	6%	17%	25%	24%	44%	5%	12%
FY19 ED Volume rate per 100,000	7,959	3,953	3,472	7,519	6,449	6,179	4,844
Change in ED Volume Rate FY17 to FY19	-2%	1%	-21%	6%	-14%	-6%	0%
Poisonings							
FY19 Inpatient Discharges rate per 100,000	232	116	56	213	145	181	152
Change in Inpatient Discharge Rate FY17 to FY19	-7%	-17%	-20%	-22%	25%	-7%	27%
FY19 ED Volume rate per 100,000	395	148	141	441	232	222	217
Change in ED Volume Rate FY17 to FY19	5%	-27%	-33%	1%	-25%	-18%	43%
Pneumonia/Influenza							
FY19 Inpatient Discharges rate per 100,000	1,135	482	466	962	753	1,029	869
Change in Inpatient Discharge Rate FY17 to FY19	8%	11%	22%	23%	44%	23%	40%
FY19 ED Volume rate per 100,000	555	264	169	469	452	500	239
Change in ED Volume Rate FY17 to FY19	11%	-8%	9%	10%	4%	-12%	-24%
Sexually Transmitted Diseases							
FY19 Inpatient Discharges rate per 100,000	24	23	14	24	17	7	22
Change in Inpatient Discharge Rate FY17 to FY19	-3%	50%	0%	-29%	50%	-75%	0%
FY19 ED Volume rate per 100,000	38	23	0	28	17	7	43
Change in ED Volume Rate FY17 to FY19	5%	200%	0%	-14%	-57%	-88%	0%
Tuberculosis							
FY19 Inpatient Discharges rate per 100,000	18	23	0	19	12	42	43
Change in Inpatient Discharge Rate FY17 to FY19	-3%	0%	0%	33%	0%	200%	0%
FY19 ED Volume rate per 100,000	6	0	0	9	0	0	0
Change in ED Volume Rate FY17 to FY19	7%	0%	0%	0%	-100%	0%	0%
Other							
Dementia and Cognitive Disorders							
FY19 Inpatient Discharges rate per 100,000	868	544	438	715	585	869	641
Change in Inpatient Discharge Rate FY17 to FY19	10%	-4%	63%	14%	31%	36%	31%
FY19 ED Volume rate per 100,000	325	132	99	1,350	556	167	119
Change in ED Volume Rate FY17 to FY19	-5%	-32%	-46%	-19%	-33%	-61%	-45%
Mental Health							
FY19 Inpatient Discharges rate per 100,000	7,268	4,908	3,275	7,315	5,703	6,860	5,789
Change in Inpatient Discharge Rate FY17 to FY19	4%	37%	17%	32%	20%	1%	41%
FY19 ED Volume rate per 100,000	6,209	1,615	1,341	5,889	3,821	3,628	2,009
Change in ED Volume Rate FY17 to FY19	17%	-15%	-31%	15%	15%	-42%	-40%
Parkinsons and Movement Disorders							
FY19 Inpatient Discharges rate per 100,000	252	233	183	242	243	229	228
Change in Inpatient Discharge Rate FY17 to FY19	8%	131%	63%	50%	110%	0%	-19%
FY19 ED Volume rate per 100,000	185	109	56	204	168	70	87
Change in ED Volume Rate FY17 to FY19	5%	0%	-20%	-17%	-26%	-38%	0%
Substance Use Disorders							
FY19 Inpatient Discharges rate per 100,000	3,820	1,608	974	3,388	2,727	3,239	2,064
Change in Inpatient Discharge Rate FY17 to FY19	0%	0%	13%	19%	9%	-10%	24%
FY19 ED Volume rate per 100,000	7,619	2,252	1,002	14,280	8,233	6,318	2,433
Change in ED Volume Rate FY17 to FY19	3%	8%	-45%	3%	-16%	-23%	-31%
Complication of Medical Care							
FY19 Inpatient Discharges rate per 100,000	1,870	1,328	1,087	1,156	1,216	1,877	1,466
Change in Inpatient Discharge Rate FY17 to FY19	7%	12%	31%	15%	18%	27%	-6%
FY19 ED Volume rate per 100,000	472	412	56	540	834	341	282
Change in ED Volume Rate FY17 to FY19	8%	112%	-69%	58%	148%	-17%	-19%

Community Health Needs Assessment - Mount Auburn Hospital

Source: Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume
Patients aged 65+, Mount Auburn Hospital Community Benefits Service Area defined by BILH Community Benefits

		Mount Auburn Hospital Community Benefits Service Area					
	MA	Arlington	Belmont	Cambridge	Somerville	Waltham	Watertown
All Cause							
FY19 Inpatient Discharges (all cause) rate per 100,000	25,473	23,123	20,021	21,241	22,976	25,103	27,408
Change in Inpatient Discharge Rate FY17 to FY19	5%	15%	20%	12%	11%	13%	10%
FY19 ED Volume (all cause) rate per 100,000	26,010	17,351	15,577	24,671	26,511	23,841	21,014
Change in ED Volume Rate FY17 to FY19	10%	-2%	-11%	1%	1%	4%	-11%
Cancer							
Breast Cancer							
FY19 Inpatient Discharges rate per 100,000	1,253	1,664	1,300	1,322	979	1,474	1,421
Change in Inpatient Discharge Rate FY17 to FY19	6%	111%	38%	46%	2%	24%	51%
FY19 ED Volume rate per 100,000	480	192	252	171	45	615	363
Change in ED Volume Rate FY17 to FY19	42%	45%	140%	-12%	-60%	-9%	120%
Colorectal Cancer							
FY19 Inpatient Discharges rate per 100,000	271	263	189	290	203	445	430
Change in Inpatient Discharge Rate FY17 to FY19	2%	47%	80%	56%	-14%	40%	53%
FY19 ED Volume rate per 100,000	42	0	0	22	11	11	66
Change in ED Volume Rate FY17 to FY19	9%	-100%	0%	-40%	0%	-86%	-20%
GYN Cancer							
FY19 Inpatient Discharges rate per 100,000	508	826	377	445	687	689	545
Change in Inpatient Discharge Rate FY17 to FY19	6%	73%	200%	22%	56%	25%	57%
FY19 ED Volume rate per 100,000	145	132	21	52	34	159	132
Change in ED Volume Rate FY17 to FY19	47%	267%	0%	-30%	50%	-40%	-20%
Lung Cancer							
FY19 Inpatient Discharges rate per 100,000	1,347	1,293	1,237	1,084	1,272	1,697	1,569
Change in Inpatient Discharge Rate FY17 to FY19	9%	21%	97%	28%	-7%	22%	40%
FY19 ED Volume rate per 100,000	282	36	84	82	158	414	165
Change in ED Volume Rate FY17 to FY19	26%	-50%	33%	0%	-22%	8%	-9%
Prostate Cancer							
FY19 Inpatient Discharges rate per 100,000	1,270	982	1,237	1,039	934	1,156	1,388
Change in Inpatient Discharge Rate FY17 to FY19	6%	-2%	44%	23%	8%	17%	22%
FY19 ED Volume rate per 100,000	434	192	63	245	146	689	297
Change in ED Volume Rate FY17 to FY19	36%	60%	-67%	18%	-19%	63%	80%
Other Cancer							
FY19 Inpatient Discharges rate per 100,000	7,146	7,352	6,499	6,296	6,800	8,856	8,888
Change in Inpatient Discharge Rate FY17 to FY19	13%	24%	49%	24%	9%	16%	28%
FY19 ED Volume rate per 100,000	1,519	659	524	631	529	2,471	1,272
Change in ED Volume Rate FY17 to FY19	33%	31%	-26%	44%	-19%	13%	64%
Chronic Disease							
Asthma							
FY19 Inpatient Discharges rate per 100,000	1,596	1,557	1,090	1,552	1,610	1,983	1,883
Change in Inpatient Discharge Rate FY17 to FY19	-16%	8%	-10%	-5%	5%	-7%	50%
FY19 ED Volume rate per 100,000	1,257	946	1,048	1,648	2,026	2,174	1,421
Change in ED Volume Rate FY17 to FY19	8%	8%	39%	-14%	-9%	9%	18%
Congestive Heart Failure							
FY19 Inpatient Discharges rate per 100,000	8,161	7,376	5,870	6,556	8,950	8,357	9,417
Change in Inpatient Discharge Rate FY17 to FY19	9%	26%	37%	46%	52%	19%	54%
FY19 ED Volume rate per 100,000	1,705	958	629	1,381	2,083	2,142	1,421
Change in ED Volume Rate FY17 to FY19	34%	-8%	-32%	6%	-1%	24%	6%
COPD and Lung Disease							
FY19 Inpatient Discharges rate per 100,000	7,130	5,209	3,795	4,031	6,754	6,310	6,113
Change in Inpatient Discharge Rate FY17 to FY19	5%	21%	32%	23%	26%	26%	27%
FY19 ED Volume rate per 100,000	2,422	1,006	650	1,730	2,646	2,439	1,900
Change in ED Volume Rate FY17 to FY19	18%	-23%	-23%	-10%	9%	10%	-6%
Diabetes Mellitus							
FY19 Inpatient Discharges rate per 100,000	8,376	6,478	4,801	6,088	8,578	8,134	8,046
Change in Inpatient Discharge Rate FY17 to FY19	5%	42%	79%	31%	30%	18%	33%
FY19 ED Volume rate per 100,000	5,867	3,089	2,243	5,635	7,542	5,886	4,477
Change in ED Volume Rate FY17 to FY19	18%	-13%	-17%	7%	3%	5%	-6%
Heart Disease							
FY19 Inpatient Discharges rate per 100,000	18,344	17,411	15,241	14,960	18,395	19,345	22,518
Change in Inpatient Discharge Rate FY17 to FY19	6%	41%	62%	39%	35%	19%	64%
FY19 ED Volume rate per 100,000	3,975	2,467	2,558	3,237	3,625	5,653	3,420
Change in ED Volume Rate FY17 to FY19	16%	-18%	-15%	27%	16%	3%	-11%
Hypertension							
FY19 Inpatient Discharges rate per 100,000	10,397	8,969	8,134	7,818	7,925	10,234	10,342
Change in Inpatient Discharge Rate FY17 to FY19	-1%	18%	48%	11%	3%	6%	17%
FY19 ED Volume rate per 100,000	12,665	8,203	8,239	11,159	12,991	12,875	10,094
Change in ED Volume Rate FY17 to FY19	14%	-12%	-13%	-7%	-2%	4%	-20%
Liver Disease							
FY19 Inpatient Discharges rate per 100,000	1,956	1,808	964	1,730	2,218	2,121	1,487
Change in Inpatient Discharge Rate FY17 to FY19	16%	50%	-21%	14%	15%	27%	29%
FY19 ED Volume rate per 100,000	258	96	0	52	79	350	50
Change in ED Volume Rate FY17 to FY19	36%	167%	-100%	-46%	-53%	200%	-57%

Obesity							
FY19 Inpatient Discharges rate per 100,000	3,869	2,467	1,677	1,967	2,961	3,617	3,717
Change in Inpatient Discharge Rate FY17 to FY19	14%	63%	63%	55%	49%	14%	69%
FY19 ED Volume rate per 100,000	367	84	84	698	1,306	647	330
Change in ED Volume Rate FY17 to FY19	26%	-59%	100%	3%	-2%	97%	-5%
Stroke and Other Neurovascular Diseases							
FY19 Inpatient Discharges rate per 100,000	2,064	2,407	1,656	1,819	2,184	1,867	1,966
Change in Inpatient Discharge Rate FY17 to FY19	5%	79%	46%	15%	49%	-3%	12%
FY19 ED Volume rate per 100,000	380	168	147	356	248	286	215
Change in ED Volume Rate FY17 to FY19	10%	8%	40%	78%	-15%	29%	-7%
Injuries and Infections							
Allergy							
FY19 Inpatient Discharges rate per 100,000	3,711	2,838	2,327	2,019	2,803	3,977	3,304
Change in Inpatient Discharge Rate FY17 to FY19	32%	55%	17%	11%	41%	106%	13%
FY19 ED Volume rate per 100,000	5,138	6,562	5,556	7,870	9,344	6,215	7,633
Change in ED Volume Rate FY17 to FY19	88%	43%	-5%	-9%	3%	77%	3%
Hepatitis							
FY19 Inpatient Discharges rate per 100,000	273	192	105	527	259	286	182
Change in Inpatient Discharge Rate FY17 to FY19	-3%	-24%	150%	3%	-34%	17%	-27%
FY19 ED Volume rate per 100,000	70	60	0	30	0	64	50
Change in ED Volume Rate FY17 to FY19	36%	-17%	-100%	-64%	0%	100%	-50%
HIV Infection							
FY19 Inpatient Discharges rate per 100,000	53	48	0	126	56	11	17
Change in Inpatient Discharge Rate FY17 to FY19	2%	0%	0%	-23%	-17%	-75%	0%
FY19 ED Volume rate per 100,000	47	0	0	89	23	32	66
Change in ED Volume Rate FY17 to FY19	34%	0%	0%	300%	0%	0%	0%
Infections							
FY19 Inpatient Discharges rate per 100,000	12,591	11,400	9,308	9,429	10,605	12,409	13,580
Change in Inpatient Discharge Rate FY17 to FY19	6%	22%	23%	7%	14%	28%	28%
FY19 ED Volume rate per 100,000	4,213	2,539	1,845	3,838	4,571	3,107	2,825
Change in ED Volume Rate FY17 to FY19	3%	0%	-34%	-4%	0%	9%	-23%
Injuries							
FY19 Inpatient Discharges rate per 100,000	11,877	13,124	10,210	10,929	10,481	13,830	14,885
Change in Inpatient Discharge Rate FY17 to FY19	15%	30%	30%	38%	21%	28%	52%
FY19 ED Volume rate per 100,000	10,393	7,149	8,302	8,894	9,355	10,648	8,971
Change in ED Volume Rate FY17 to FY19	11%	3%	21%	10%	2%	25%	0%
Poisonings							
FY19 Inpatient Discharges rate per 100,000	281	216	210	171	270	170	132
Change in Inpatient Discharge Rate FY17 to FY19	7%	0%	100%	-4%	26%	-30%	-64%
FY19 ED Volume rate per 100,000	185	144	42	200	191	180	116
Change in ED Volume Rate FY17 to FY19	27%	0%	100%	125%	13%	143%	75%
Pneumonia/Influenza							
FY19 Inpatient Discharges rate per 100,000	4,188	3,413	2,306	2,717	3,726	3,256	3,948
Change in Inpatient Discharge Rate FY17 to FY19	0%	-1%	-17%	-4%	13%	2%	14%
FY19 ED Volume rate per 100,000	569	263	231	549	608	477	330
Change in ED Volume Rate FY17 to FY19	1%	-12%	-27%	-6%	-24%	-25%	-35%
Sexually Transmitted Diseases							
FY19 Inpatient Discharges rate per 100,000	30	12	0	0	34	0	17
Change in Inpatient Discharge Rate FY17 to FY19	9%	0%	-100%	-100%	50%	-100%	-80%
FY19 ED Volume rate per 100,000	5	0	0	22	0	0	0
Change in ED Volume Rate FY17 to FY19	0%	0%	0%	200%	0%	-100%	-100%
Tuberculosis							
FY19 Inpatient Discharges rate per 100,000	52	60	105	74	56	95	17
Change in Inpatient Discharge Rate FY17 to FY19	-11%	400%	150%	-44%	-17%	200%	-83%
FY19 ED Volume rate per 100,000	6	0	0	0	0	0	17
Change in ED Volume Rate FY17 to FY19	13%	0%	0%	-100%	-100%	0%	0%
Other							
Dementia and Cognitive Disorders							
FY19 Inpatient Discharges rate per 100,000	6,264	6,179	5,052	5,457	5,595	5,398	7,600
Change in Inpatient Discharge Rate FY17 to FY19	6%	31%	32%	20%	11%	10%	63%
FY19 ED Volume rate per 100,000	2,053	707	650	1,069	1,002	1,092	909
Change in ED Volume Rate FY17 to FY19	11%	-33%	-34%	-7%	-32%	-13%	-21%
Mental Health							
FY19 Inpatient Discharges rate per 100,000	10,900	10,358	7,966	9,912	10,447	13,225	13,927
Change in Inpatient Discharge Rate FY17 to FY19	15%	37%	74%	29%	29%	45%	58%
FY19 ED Volume rate per 100,000	3,500	1,341	692	1,693	1,632	2,238	1,751
Change in ED Volume Rate FY17 to FY19	35%	-26%	-18%	-11%	0%	-48%	-36%
Parkinsons and Movement Disorders							
FY19 Inpatient Discharges rate per 100,000	1,523	1,892	1,761	1,841	1,137	1,347	2,495
Change in Inpatient Discharge Rate FY17 to FY19	10%	42%	75%	36%	1%	17%	84%
FY19 ED Volume rate per 100,000	602	347	273	393	371	509	463
Change in ED Volume Rate FY17 to FY19	11%	-17%	-28%	-2%	3%	12%	4%
Substance Use Disorders							
FY19 Inpatient Discharges rate per 100,000	2,956	2,263	1,405	2,309	2,409	2,694	2,974
Change in Inpatient Discharge Rate FY17 to FY19	13%	34%	24%	26%	9%	31%	35%
FY19 ED Volume rate per 100,000	2,258	1,174	566	3,237	3,141	1,898	1,322
Change in ED Volume Rate FY17 to FY19	22%	-12%	-41%	7%	30%	-6%	-32%
Complication of Medical Care							
FY19 Inpatient Discharges rate per 100,000	4,867	4,359	3,878	3,905	3,974	5,388	4,791
Change in Inpatient Discharge Rate FY17 to FY19	13%	32%	65%	16%	10%	22%	17%
FY19 ED Volume rate per 100,000	835	647	503	943	1,148	891	661
Change in ED Volume Rate FY17 to FY19	9%	4%	-29%	2%	17%	11%	-17%

Notes:

Population counts: Sg2 Claritas Demographic Data, 2021.
Data is broken out into four age groupings (0-17, 18-44, 45-64, 65+). One age group per tab.

Included data is a calculated rate of inpatient discharge or ED volume per 100,000 population, by town. Inpatient discharge and ED data retrieved from CHIA FY17 and FY19.
Categorization of the Health Conditions listed above determined by Sg2 CARE Family (ICD-9 and -10 diagnosis code to disease grouping)
Percent change based on rate per 100,000 in FY17 compared to rate per 100,000 in FY19, using identical Sg2 CARE Family definitions. Please note the % change in rate for some health conditions is large, likely due to small volumes or coding changes.
Volumes noted as <11 are supressed per CHIA cell suppression guidelines.

Community Health Survey

- MAH Community Health Survey
  - Survey output
  - Survey Distribution Channels

Beth Israel Lahey Health

Community Health Survey for Beth Israel Lahey Health
2022 Community Health Needs Assessment

Beth Israel Lahey Health and its member hospitals are conducting a Community Health Needs Assessment to better understand the most pressing health-related issues for residents in the communities we serve. It is important that each hospital gather input from people living, working, and learning in the community. The information gathered will help each hospital to improve its patient and community services.

Please take about 15 minutes to complete this survey. Your responses will be private. If you do not feel comfortable answering a question, you may skip it. Taking this survey will not affect any services that you receive. Findings from this survey that are shared back with the community will be combined across all respondents. It will not be possible to identify you or your responses. Thank you for completing this survey.

You will have the option at the end of the survey to enter a drawing for a $100 gift card

We have shared this survey widely. Please complete this survey only once.

Time in Community

1. We are interested in your experiences in the community where you spend the most time. This may be the place where you live, work, play, or learn.
   Please enter the zip code of the community in which you spend the most time.
   Zip code: _____

1. How many years have you lived in the selected community?
   - ❑ Less than 1 year
   - ❑ 1-5 years
   - ❑ 6-10 years
   - ❑ Over 10 years but not all my life
   - ❑ I have lived here all my life
   - ❑ I used to live here, but not anymore
   - ❑ I have never lived here

2. How many years have you worked in the selected community?
   - ❑ Less than 1 year
   - ❑ 1-5 years
   - ❑ 6-10 years
   - ❑ Over 10 years
   - ❑ I do not work here

3. If you do not live or work in the selected community, how are you connected to it?
   _____

Your Community

4. Please check the response that best describes how much you agree or disagree with each statement about your community.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know
I feel like I belong in my community.	☐	☐	☐	☐	☐
Overall, I am satisfied with the quality of life in my community. (Think about things like health care, raising children, getting older, job opportunities, safety, and support.)	☐	☐	☐	☐	☐
My community is a good place to raise children. (Think about things like schools, day care, after school programs, housing, and places to play)	☐	☐	☐	☐	☐
My community is a good place to grow old. (Think about things like housing, transportation, houses of worship, shopping, health care, and social support)	☐	☐	☐	☐	☐
My community has good access to resources. (Think about organizations, agencies, healthcare, etc.).	☐	☐	☐	☐	☐

5. What are the most important things you would like to improve about your community? Please select up to 5 items from the list below.

- ☐ Better access to good jobs
- ☐ Better access to health care
- ☐ Better access to healthy food
- ☐ Better access to internet
- ☐ Better access to public transportation
- ☐ Better parks and recreation
- ☐ Better roads
- ☐ Better schools
- ☐ Better sidewalks and trails Cleaner environment
- ☐ Lower crime and violence
- ☐ More affordable childcare
- ☐ More affordable housing
- ☐ More arts and cultural events
- ☐ More effective city services (like water, trash, fire department, and police)
- ☐ More inclusion for diverse members of the community
- ☐ Stronger community leadership
- ☐ Stronger sense of community
- ☐ Other (_____)

Social + Cultural Environment

6. We are interested to know about your experiences finding support in your community. For each of the statements below, please check the response that best describes how much you agree or disagree with each statement.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know
There are people and/or organizations in my community that support me during times of stress and need.	☐	☐	☐	☐	☐
I believe that all residents, including myself, can make the community a better place to live.	☐	☐	☐	☐	☐
During COVID-19, information I need to stay healthy and safe has been readily available in my community.	☐	☐	☐	☐	☐
During COVID-19, resources I need to stay healthy and safe have been readily available in my community.	☐	☐	☐	☐	☐

Natural + Built Environment

7. The natural and built environment impacts the health and wellbeing of people and communities. For each statement below, check the response that best describes how true you think the statement is.

	True	Somewhat true	Not at all true	I don't know
My community feels safe.	☐	☐	☐	☐
People like me have access to safe, clean parks and open spaces.	☐	☐	☐	☐
People like me have access to reliable transportation.	☐	☐	☐	☐
People like me have housing that is safe and good quality.	☐	☐	☐	☐
The air in my community is healthy to breathe.	☐	☐	☐	☐
The water in my community is safe to drink.	☐	☐	☐	☐
My community is prepared to protect ourselves during climate disasters, such as flooding, hurricanes, or blizzards.	☐	☐	☐	☐
During extreme heat, people like me have access to options for staying cool.	☐	☐	☐	☐

Economic + Educational Environment

8. The economic and educational environment impacts the health and wellbeing of people and communities. For each statement below, check the response that best describes how true you think the statement is.

	True	Somewhat true	Not at all true	I don't know
People like me have access to good local jobs with living wages and benefits.	☐	☐	☐	☐
People like me have access to local investment opportunities, such as owning homes or businesses.	☐	☐	☐	☐
Housing in my community is affordable for people with different income levels.	☐	☐	☐	☐
People like me have access to affordable childcare services.	☐	☐	☐	☐
People like me have access to good education for their children.	☐	☐	☐	☐

9. How much do you agree or disagree with the statements below?

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
The built, economic, and educational environments in my community are impacted by **systemic racism**. This is the kind of racism that happens when big institutions—like government, health care, housing, etc.—work in ways that provide resources and power to people who are white, and fewer or none to people of color. This kind of racism is aimed at whole groups of people instead of at individuals and is not always done on purpose.	☐	☐	☐	☐	☐
The built, economic, and educational environments in my community are impacted by **individual racism**. This is the racism that happens when one person (or group of people) has negative attitudes towards another person (or group of people)—because of the color of their skin, physical features, culture and/or language—and treats the other person/group badly/unfairly.	☐	☐	☐	☐	☐

Health + Access to care

10. The healthcare environment impacts the health and wellbeing of people and communities. For each statement below, check the response that best describes how true you think the statement is.

	True	Somewhat true	Not at all true	I don't know
Health care in my community meets the physical health needs of people like me.	☐	☐	☐	☐
Health care in my community meets the mental health needs of people like me.	☐	☐	☐	☐

11. In the last 12 months, did you ever need any of the following types of health care? Please check the response that best describes your experience.

	I needed this type of care and was able to access it.	I needed this type of care but was not able to access it.	I did not need this type of care.
Routine medical care	☐	☐	☐
Dental (mouth) care	☐	☐	☐
Mental health care	☐	☐	☐
Reproductive health care	☐	☐	☐
Emergency care for a mental health crisis, including suicidal thoughts	☐	☐	☐
Treatment for a substance use disorder	☐	☐	☐
Vision care	☐	☐	☐
Medication for a chronic illness	☐	☐	☐

12. For any types of care that you needed <u>but were not able to access</u>, select the reason(s) why you were unable to access care.

	Concern about COVID exposure	Unable to afford the costs	Unable to get transportation	Hours did not fit my schedule	Fear or distrust of health care system	No providers speak my language	Another reason not listed
Routine medical care	☐	☐	☐	☐	☐	☐	☐
Dental care	☐	☐	☐	☐	☐	☐	☐
Mental health care	☐	☐	☐	☐	☐	☐	☐
Reproductive health care	☐	☐	☐	☐	☐	☐	☐
Emergency care for a mental health crisis, including suicidal thoughts	☐	☐	☐	☐	☐	☐	☐
Treatment for a substance use disorder	☐	☐	☐	☐	☐	☐	☐
Vision care	☐	☐	☐	☐	☐	☐	☐
Medication for a chronic illness	☐	☐	☐	☐	☐	☐	☐

If you selected "Another reason not listed" in the table above, please explain why you were unable to get the care you needed:

_____

13. How much do you agree with the following statements?

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
Healthcare in my community is impacted by systemic racism. This is the kind of racism that happens when big institutions—like government, health care, housing, etc.—work in ways that provide resources and power to people who are white, and fewer or none to people of color. This kind of racism is aimed at whole groups of people instead of at individuals and is not always done on purpose.	☐	☐	☐	☐	☐
Healthcare in my community is impacted by individual racism. This is the racism that happens when one person (or group of people) has negative attitudes towards another person (or group of people)—because of the color of their skin, physical features, culture and/or language—and treats the other person/group badly/unfairly.	☐	☐	☐	☐	☐

Experiences with Discrimination

14. It has been shown that experiencing discrimination negatively impacts the health and well-being of individuals and communities. In order to better understand these impacts, BILH would like to hear about your lived experience regarding discrimination. In the following questions, we are interested in the ways you are treated. To the extent that you are comfortable, can you tell us if any of the following happens to you, and if so, how often?

	Never	Less than once a year	A few times a year	A few times a month	At least once a week	Almost every day
You are not hired for jobs for unfair reasons, are unfairly fired, or are denied a raise.	☐	☐	☐	☐	☐	☐
You are unfairly stopped, searched, questioned, threatened, or abused by the police.	☐	☐	☐	☐	☐	☐
You receive worse service than other people at stores, restaurants, or service providers.	☐	☐	☐	☐	☐	☐
Landlords or realtors refused to rent or sell you an apartment or house.	☐	☐	☐	☐	☐	☐
Healthcare providers treat you with less respect or provide worse services to you compared to other people.	☐	☐	☐	☐	☐	☐

15. If you answered a few times a year or more, what do you think is the main reason for these experiences? You may select more than one.

- ☐ Ableism (discrimination on the basis of disability)
- ☐ Ageism (discrimination on the basis of age)
- ☐ Discrimination based on income or education level
- ☐ Discrimination based on the basis of religion
- ☐ Discrimination based on the basis of weight or body size
- ☐ Homophobia (discrimination against gay, lesbian, bisexual, or queer people)
- ☐ Racism (discrimination on the basis of racial or ethnic group identity)
- ☐ Sexism (discrimination on the basis of sex)
- ☐ Transphobia (discrimination against transgender or gender non-binary people)
- ☐ Xenophobia (discrimination against people born in another country)
- ☐ Don't know
- ☐ Prefer not to answer

16. Is there anything else you would like to share about the community you selected in the first question? If not, leave blank.

_____

_____

_____

About You

The following questions help us to better understand how people of diverse identities and life experiences may have similar or different experiences of the community. You may skip any question you prefer not to answer.

17. What is your age?

- ☐ Under 18
- ☐ 18-24
- ☐ 25-44
- ☐ 45-64
- ☐ 65-74
- ☐ 75-84
- ☐ 85 and over
- ☐ Prefer not to answer

18. What is your current gender identity?

- ☐ Genderqueer or gender non-conforming
- ☐ Man
- ☐ Transgender
- ☐ Woman
- ☐ Prefer to self-describe: _____

19. What is your sexual orientation?

- ❑ Bisexual
- ❑ Gay or lesbian
- ❑ Straight/heterosexual
- ❑ Prefer to self-describe: _____
- ❑ Prefer not to answer

20. Which of these groups best represents your race? You will have space to enter ethnicity in the next question. (Please check all that apply.)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic/Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Not listed above/Other: _____
- ☐ Prefer not to answer

21. What is your ethnicity? (You can specify one or more)

- ☐ African (specify_____)
- ☐ African American
- ☐ American
- ☐ Brazilian
- ☐ Cambodian
- ☐ Cape Verdean
- ☐ Caribbean Islander (specify_____)
- ☐ Chinese
- ☐ Colombian
- ☐ Cuban
- ☐ Dominican
- ☐ European (specify_____)
- ☐ Filipino
- ☐ Guatemalan
- ☐ Haitian
- ☐ Honduran
- ☐ Indian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mexican, Mexican-American, Chicano
- ☐ Middle Eastern (specify_____)
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadoran
- ☐ Vietnamese
- ☐ Other (specify_____)
- ☐ Unknown/not specified

22. What is the primary language(s) spoken in your home? (Please check all that apply.)

- ☐ Armenian
- ☐ Cape Verdean Creole
- ☐ Chinese (including Mandarin and Cantonese)
- ☐ English
- ☐ Haitian Creole
- ☐ Hindi
- ☐ Khmer
- ☐ Portuguese
- ☐ Russian
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other: _____
- ☐ Prefer not to answer

23. What is the highest grade or level of school that you have completed?
- ☐ Never attended school
- ☐ Grades 1 through 8
- ☐ Grades 9 through 11/ Some high school
- ☐ Grade 12/Completed high school or GED
- ☐ Some college, Associates Degree, or Technical Degree
- ☐ Bachelor's Degree
- ☐ Any post graduate studies
- ☐ Prefer not to answer

24. Are you currently:
- ☐ Employed full-time (40 hours or more per week)
- ☐ Employed part-time (Less than 40 hours per week)
- ☐ Self-employed (Full- or part-time)
- ☐ A stay at home parent
- ☐ A student (Full- or part-time)
- ☐ Unemployed
- ☐ Unable to work for health reasons
- ☐ Retired
- ☐ Other (specify_____)
- ☐ Prefer not to answer

25. How long have you lived in the United States?
- ☐ Less than one year
- ☐ 1 to 3 years
- ☐ 4 to 6 years
- ☐ More than 6 years, but not my whole life
- ☐ I have always lived in the United States
- ☐ Prefer not to answer

26. Have you served on active duty in the U.S. Armed Forces, Reserves, or National Guard?
- ☐ Never served in the military
- ☐ On active duty now (in any branch)
- ☐ On active duty in the past, but not now (includes retirement from any branch)
- ☐ Prefer not to answer

27. Do you identify as a person with a disability?
- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

28. How would you describe your current housing situation?
- ☐ I rent my home
- ☐ I own my home
- ☐ I am staying with another household
- ☐ I am experiencing homelessness or staying in a shelter
- ☐ Other (specify_____)
- ☐ Prefer not to answer

29. Are you the parent or caregiver of a child under the age of 18?
- ☐ Yes (Please answer question 30)
- ☐ No
- ☐ Prefer not to answer

30. If you are the parent or caregiver for a child under 18, please indicate the age(s) of the child(ren) you care for. (Please check all that apply.)
- ☐ 0-3 years
- ☐ 4-5 years
- ☐ 6-10 years
- ☐ 11-14 years
- ☐ 15-17 years

31. Many people feel a sense of belonging to communities other than the city or town where they spend the most time. Which of the following communities do you feel you belong to? (Select all that apply)
- ☐ My neighborhood or building
- ☐ Faith community (*such as a church, mosque, temple, or faith-based organization)*
- ☐ School community *(such as a college or education program that you attend, or a school that you child attends)*
- ☐ Work community *(such as your place of employment, or a professional association)*
- ☐ A shared identity or experience *(such as a group of people who share an immigration experience, a racial or ethnic identity, a cultural heritage, or a gender identity)*
- ☐ A shared interest group *(such as a club, sports team, political group, or advocacy group)*
- ☐ Another city or town where I do not live
- ☐ Other (Feel free to share: _____)

MAH Community Health Survey Output

Response Counts

Completion Rate:	**100%**	
	Complete	266

Totals: 266

1. Select a language.

Value	Percent	Responses
Take the survey in English	83.7%	221
Մասնակցեք հարցմանը հայերեն լեզվով	0.4%	1
参加简体中文调查	9.5%	25
參加繁體中文調查	0.4%	1
Reponn sondaj la nan lang kreyòl ayisyen	0.4%	1
हिंदी में सर्वेक्षण में भाग लें	0.4%	1
Participe da pesquisa em português	0.4%	1
Пройдите анкету на русском языке	0.4%	1
Responda la encuesta en español	4.5%	12

Totals: 264

3. How many years have you lived in the selected community?

Value	Percent	Responses
Less than 1 year	7.2%	19
1-5 years	23.1%	61
6-10 years	16.7%	44
Over 10 years but not all my life	37.1%	98
I have lived here all my life	11.0%	29
I used to live here, but not anymore	1.1%	3
I have never lived here	3.8%	10

Totals: 264

4. How many years have you worked in the selected community?

Value	Percent	Responses
Less than 1 year	6.9%	18
1-5 years	18.0%	47
6-10 years	11.1%	29
Over 10 years	23.4%	61
I do not work here	40.6%	106

Totals: 261

6. Please check the response that best describes how much you agree or disagree with each statement about your community.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Responses
I feel like I belong in my community. Count Row %	8 3.1%	11 4.3%	128 49.6%	104 40.3%	7 2.7%	258
Overall, I am satisfied with the quality of life in my community. (Think about things like health care, raising children, getting older, job opportunities, safety, and support.) Count Row %	5 1.9%	19 7.4%	123 47.7%	104 40.3%	7 2.7%	258
My community is a good place to raise children. (Think about things like schools, day care, after school programs, housing, and places to play) Count Row %	3 1.2%	13 5.0%	107 41.5%	97 37.6%	38 14.7%	258
My community is a good place to grow old. (Think about things like housing, transportation, houses of worship, shopping, health care, and social support) Count Row %	7 2.7%	32 12.3%	109 41.8%	89 34.1%	24 9.2%	261
My community has good access to resources. (Think about organizations, agencies, healthcare, etc.). Count Row %	6 2.3%	10 3.9%	125 48.3%	105 40.5%	13 5.0%	259
Totals Total Responses						261

7. What are the most important things you would like to improve about your community? Please select up to 5 items from the list below.

Value	Percent	Responses
Better access to good jobs	14.9%	39
Better access to health care	22.2%	58
Better access to healthy food	22.6%	59
Better access to internet	17.2%	45
Better access to public transportation	25.3%	66
Better parks and recreation	16.9%	44
Better roads	30.7%	80
Better schools	13.8%	36
Better sidewalks and trails	27.2%	71
Cleaner environment	20.3%	53
Lower crime and violence	15.7%	41
More affordable childcare	22.6%	59
More affordable housing	56.3%	147
More arts and cultural events	15.7%	41
More effective city services (like water, trash, fire department, and police)	11.9%	31
More inclusion for diverse members of the community	29.5%	77
Stronger community leadership	9.6%	25
Stronger sense of community	11.1%	29
Other	8.4%	22

8. For each of the statements below, please check the response that best describes how much you agree or disagree with each statement.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know	Responses
There are people and/or organizations in my community that support me during times of stress and need. Count Row %	9 3.4%	25 9.5%	128 48.5%	64 24.2%	38 14.4%	264
I believe that all residents, including myself, can make the community a better place to live. Count Row %	4 1.5%	3 1.1%	125 47.5%	128 48.7%	3 1.1%	263
During COVID-19, information I need to stay healthy and safe has been readily available in my community. Count Row %	4 1.5%	16 6.1%	110 41.7%	125 47.3%	9 3.4%	264
During COVID-19, resources I need to stay healthy and safe have been readily available in my community. Count Row %	4 1.5%	16 6.1%	125 47.5%	106 40.3%	12 4.6%	263
Totals Total Responses						264

9. For each statement below, check the response that best describes how true you think the statement is.

	True	Somewhat True	Not At All True	Don't Know	Responses
My community feels safe. Count Row %	184 69.7%	73 27.7%	2 0.8%	5 1.9%	264
People like me have access to safe, clean parks and open spaces. Count Row %	201 76.7%	54 20.6%	7 2.7%	0 0.0%	262
People like me have access to reliable transportation. Count Row %	158 60.3%	94 35.9%	4 1.5%	6 2.3%	262
People like me have housing that is safe and good quality. Count Row %	154 58.3%	85 32.2%	22 8.3%	3 1.1%	264
The air in my community is healthy to breathe. Count Row %	165 62.3%	79 29.8%	12 4.5%	9 3.4%	265
The water in my community is safe to drink. Count Row %	188 72.0%	45 17.2%	12 4.6%	16 6.1%	261
My community is prepared to protect ourselves during climate disasters, such as flooding, hurricanes, or blizzards. Count Row %	92 35.0%	89 33.8%	14 5.3%	68 25.9%	263
During extreme heat, people like me have access to options for staying cool. Count Row %	146 55.1%	65 24.5%	15 5.7%	39 14.7%	265
Totals Total Responses					265

10. For each statement below, check the response that best describes how true you think the statement is.

	True	Somewhat True	Not At All True	Don't Know	Responses
People like me have access to good local jobs with living wages and benefits. Count Row %	97 37.6%	89 34.5%	31 12.0%	41 15.9%	258
People like me have access to local investment opportunities, such as owning homes or businesses. Count Row %	65 25.1%	86 33.2%	74 28.6%	34 13.1%	259
Housing in my community is affordable for people with different income levels. Count Row %	30 11.5%	74 28.2%	140 53.4%	18 6.9%	262
People like me have access to affordable childcare services. Count Row %	31 12.1%	68 26.5%	61 23.7%	97 37.7%	257
People like me have access to good education for their children. Count Row %	115 44.4%	78 30.1%	13 5.0%	53 20.5%	259
Totals Total Responses					262

11. How much do you agree or disagree with the statements below?

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Responses
The built, economic, and educational environments in my community are impacted by **systemic racism.** This is the kind of racism that happens when big institutions—like government, health care, housing, etc.—work in ways that provide resources and power to people who are white, and fewer or none to people of color. This kind of racism is aimed at whole groups of people instead of at individuals and is not always done on purpose. Count Row %	19 7.2%	38 14.4%	71 27.0%	84 31.9%	51 19.4%	263
The built, economic, and educational environments in my community are impacted by **individual racism.** This is the racism that happens when one person (or group of people) has negative attitudes towards another person (or group of people)—because of the color of their skin, physical features, culture and/or language—and treats the other person/group badly/unfairly. Count Row %	16 6.1%	46 17.6%	76 29.0%	88 33.6%	36 13.7%	262
Totals Total Responses						263

12. For each statement below, check the response that best describes how true you think the statement is.

	True	Somewhat True	Not at all True	Don't Know	Responses
Health care in my community meets the physical health needs of people like me. Count Row %	140 53.4%	83 31.7%	15 5.7%	24 9.2%	262
Health care in my community meets the mental health needs of people like me. Count Row %	79 30.3%	87 33.3%	45 17.2%	50 19.2%	261
Totals Total Responses					262

13. In the last 12 months, did you ever need any of the following types of health care? Please check the response that best describes your experience.

	I needed this type of care and was able to access it.	I needed this type of care but was not able to access it.	I did not need this type of care.	Responses
Routine medical care Count Row %	215 82.7%	16 6.2%	29 11.2%	260
Dental (mouth) care Count Row %	199 76.2%	32 12.3%	30 11.5%	261
Mental health care Count Row %	76 29.5%	33 12.8%	149 57.8%	258
Reproductive health care Count Row %	44 17.1%	8 3.1%	205 79.8%	257
Emergency care for a mental health crisis, including suicidal thoughts Count Row %	24 9.3%	7 2.7%	226 87.9%	257
Treatment for a substance use disorder Count Row %	10 3.9%	3 1.2%	241 94.9%	254
Vision care Count Row %	162 62.3%	20 7.7%	78 30.0%	260
Medication for a chronic illness Count Row %	108 41.7%	6 2.3%	145 56.0%	259
Totals Total Responses				261

14. For any types of care that you needed but were not able to access, select the reason(s) why you were unable to access care.

	Concern about COVID exposure	Unable to afford the costs	Unable to get transportation	Hours did not fit my schedule	Fear or distrust of health care system	No providers speak my language	Another reason not listed	Responses
Routine medical care Count Row %	22 28.2%	8 10.3%	4 5.1%	9 11.5%	4 5.1%	5 6.4%	26 33.3%	78
Dental care Count Row %	20 22.7%	32 36.4%	3 3.4%	7 8.0%	3 3.4%	4 4.5%	19 21.6%	88
Mental health care Count Row %	8 9.6%	12 14.5%	2 2.4%	7 8.4%	3 3.6%	4 4.8%	47 56.6%	83
Reproductive health care Count Row %	9 14.5%	7 11.3%	2 3.2%	3 4.8%	2 3.2%	1 1.6%	38 61.3%	62
Emergency care for a mental health crisis, including suicidal thoughts Count Row %	11 17.5%	4 6.3%	1 1.6%	2 3.2%	1 1.6%	2 3.2%	42 66.7%	63
Treatment for a substance use disorder Count Row %	7 13.0%	4 7.4%	2 3.7%	2 3.7%	0 0.0%	2 3.7%	37 68.5%	54
Vision care Count Row %	19 26.8%	7 9.9%	3 4.2%	8 11.3%	3 4.2%	3 4.2%	28 39.4%	71
Medication for a chronic illness Count Row %	12 21.4%	4 7.1%	0 0.0%	4 7.1%	3 5.4%	2 3.6%	31 55.4%	56

	Concern about COVID exposure	Unable to afford the costs	Unable to get transportation	Hours did not fit my schedule	Fear or distrust of health care system	No providers speak my language	Another reason not listed	Responses
Totals								
Total Responses								88

16. How much do you agree with the following statements?

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Responses
Healthcare in my community is impacted by systemic racism. This is the kind of racism that happens when big institutions—like government, health care, housing, etc.—work in ways that provide resources and power to people who are white, and fewer or none to people of color. This kind of racism is aimed at whole groups of people instead of at individuals and is not always done on purpose. Count Row %	31 12.1%	50 19.5%	78 30.5%	62 24.2%	35 13.7%	256
Healthcare in my community is impacted by individual racism. This is the racism that happens when one person (or group of people) has negative attitudes towards another person (or group of people)—because of the color of their skin, physical features, culture and/or language—and treats the other person/group badly/unfairly. Count Row %	32 12.4%	62 24.0%	75 29.1%	64 24.8%	25 9.7%	258
Totals Total Responses						258

17. To the extent that you are comfortable, can you tell us if any of the following happens to you, and if so, how often?

	Never	Less than once a year	A few times a year	A few times a month	At least once a week	Almost every day	Responses
You are not hired for jobs for unfair reasons, are unfairly fired, or are denied a raise. Count Row %	186 76.5%	41 16.9%	13 5.3%	1 0.4%	0 0.0%	2 0.8%	243
You are unfairly stopped, searched, questioned, threatened, or abused by the police. Count Row %	224 90.7%	19 7.7%	3 1.2%	0 0.0%	0 0.0%	1 0.4%	247
You receive worse service than other people at stores, restaurants, or service providers. Count Row %	192 76.5%	25 10.0%	28 11.2%	4 1.6%	2 0.8%	0 0.0%	251
Landlords or realtors refused to rent or sell you an apartment or house. Count Row %	228 92.7%	10 4.1%	5 2.0%	1 0.4%	0 0.0%	2 0.8%	246
Healthcare providers treat you with less respect or provide worse services to you compared to other people. Count Row %	200 80.6%	26 10.5%	16 6.5%	4 1.6%	1 0.4%	1 0.4%	248
Totals Total Responses							251

18. What do you think is the main reason for these experiences? You may select more than one.

Value	Percent	Responses
Ableism (discrimination on the basis of disability)	14.0%	7
Ageism (discrimination on the basis of age)	24.0%	12
Discrimination based on income or education level	22.0%	11
Discrimination based on the basis of religion	10.0%	5
Discrimination based on the basis of weight or body size	12.0%	6
Homophobia (discrimination against gay, lesbian, bisexual, or queer people)	8.0%	4
Racism (discrimination on the basis of racial or ethnic group identity)	46.0%	23
Sexism (discrimination on the basis of sex)	22.0%	11
Transphobia (discrimination against transgender or gender non-binary people)	4.0%	2
Xenophobia (discrimination against people born in another country)	14.0%	7
Don't know	22.0%	11

20. What is your age?

Value	Percent	Responses
18-24	3.0%	8
25-44	30.5%	81
45-64	39.1%	104
65-74	13.5%	36
75-84	10.9%	29
85 and over	2.3%	6
Prefer not to answer	0.8%	2

Totals: 266

21. What is your current gender identity?

Value	Percent	Responses
Genderqueer or gender non-conforming	0.4%	1
Man	20.8%	55
Woman	78.9%	209

Totals: 265

22. What is your sexual orientation?

Value	Percent	Responses
Bisexual	5.5%	14
Gay or lesbian	3.5%	9
Straight/heterosexual	84.7%	216
Prefer to self-describe:	2.0%	5
Prefer not to answer	4.3%	11

Totals: 255

23. Which of these groups best represents your race? You will have space to enter ethnicity in the next question. Please select all that apply.

Value	Percent	Responses
American Indian or Alaska Native	0.4%	1
Asian	18.6%	49
Black or African American	4.2%	11
Hispanic/Latino	11.4%	30
White	63.5%	167
Not listed above/Other:	1.9%	5
Prefer not to answer	3.0%	8

24. What is your ethnicity? Please select all that apply.

Value	Percent	Responses
American	34.9%	88
Chinese	16.3%	41
European (specify):	27.4%	69
Guatemalan	3.6%	9
Other (specify):	7.1%	18
African (specify):	0.8%	2
African American	2.4%	6
Brazilian	1.6%	4
Cape Verdean	0.4%	1
Caribbean Islander (specify):	1.6%	4
Colombian	1.2%	3
Cuban	1.2%	3
Dominican	0.8%	2
Filipino	0.8%	2
Haitian	0.8%	2
Honduran	0.4%	1
Indian	0.8%	2
Korean	0.4%	1
Mexican, Mexican-American, Chicano	1.2%	3
Middle Eastern (specify):	0.8%	2
Portuguese	1.2%	3
Puerto Rican	0.8%	2
Russian	1.2%	3
Salvadoran	0.8%	2
Vietnamese	0.4%	1

Value	Percent	Responses
Unknown/Not specified	2.0%	5

25. What is the primary language(s) spoken in your home? Please select all that apply.

Value	Percent	Responses
Armenian	2.3%	6
Cape Verdean Creole	0.4%	1
Chinese (including Mandarin and Cantonese)	14.5%	37
English	77.7%	199
Haitian Creole	0.8%	2
Hindi	0.8%	2
Portuguese	1.6%	4
Russian	0.4%	1
Spanish	7.4%	19
Other (specify):	2.0%	5
Prefer not to answer	1.2%	3

26. What is the highest grade or level of school that you have completed?

Value	Percent	Responses
Never attended school	0.4%	1
Grades 1 through 8	1.9%	5
Grades 9 through 11/ Some high school	1.5%	4
Grade 12/Completed high school or GED	6.1%	16
Some college, Associates Degree, or Technical Degree	14.4%	38
Bachelor's Degree	27.3%	72
Any post graduate studies	46.2%	122
Prefer not to answer	2.3%	6

Totals: 264

27. Are you currently:

Value	Percent	Responses
Employed full-time (40 hours or more per week)	50.2%	133
Employed part-time (Less than 40 hours per week)	15.5%	41
Self-employed (Full- or part-time)	4.9%	13
A stay at home parent	2.3%	6
A student (Full- or part-time)	1.1%	3
Unemployed	1.5%	4
Unable to work for health reasons	1.5%	4
Retired	21.1%	56
Other (specify):	1.5%	4
Prefer not to answer	0.4%	1

Totals: 265

28. How long have you lived in the United States?

Value	Percent	Responses
Less than one year	1.1%	3
1 to 3 years	2.3%	6
4 to 6 years	3.8%	10
More than 6 years, but not my whole life	27.1%	72
I have always lived in the United States	64.7%	172
Prefer not to answer	1.1%	3

Totals: 266

29. Have you served on active duty in the U.S. Armed Forces, Reserves, or National Guard?

Value	Percent	Responses
Never served in the military	96.2%	254
On active duty now (in any branch)	0.4%	1
On active duty in the past, but not now (includes retirement from any branch)	2.7%	7
Prefer not to answer	0.8%	2

Totals: 264

30. Do you identify as a person with a disability?

Value	Percent	Responses
Yes	13.6%	36
No	82.6%	218
Prefer not to answer	3.8%	10

Totals: 264

31. How would you describe your current housing situation?

Value	Percent	Responses
I rent my home	39.4%	104
I own my home	49.2%	130
I am staying with another household	4.5%	12
I am experiencing homelessness or staying in a shelter	0.4%	1
Other (specify):	4.2%	11
Prefer not to answer	2.3%	6

Totals: 264

32. Are you the parent or caregiver of a child under the age of 18?

Value	Percent	Responses
Yes	25.4%	67
No	74.2%	196
Prefer not to answer	0.4%	1

Totals: 264

33. Please indicate the age(s) of the child(ren) you care for. Please select all that apply.

Value	Percent	Responses
0-3 years	22.4%	15
4-5 years	19.4%	13
6-10 years	38.8%	26
11-14 years	28.4%	19
15-17 years	26.9%	18

34. Which of the following communities do you feel you belong to? Please select all that apply.

Value	Percent	Responses
My neighborhood or building	58.0%	148
Faith community (such as a church, mosque, temple, or faith-based organization)	22.7%	58
School community (such as a college or education program that you attend, or a school that you child attends)	12.5%	32
Work community (such as your place of employment, or a professional association)	49.4%	126
A shared identity or experience (such as a group of people who share an immigration experience, a racial or ethnic identity, a cultural heritage, or a gender identity)	18.0%	46
A shared interest group (such as a club, sports team, political group, or advocacy group)	34.1%	87
Another city or town where I do not live	11.4%	29
Other (Feel free to share):	4.7%	12

Beth Israel Lahey Health

Community Health Needs Assessment
11.1.2021

Engaging with Diverse Communities

Survey Campaign Dates: November 1, 2021 – November 15, 2021.

Connecting with our diverse communities to understand and address the most pressing health-related concerns for residents is priority for BILH. GVC have deployed a marketing campaign to reach our target populations through a three-phase approach. First is an online survey which is followed by a listening session and then an annual meeting.

Our Approach

Research was conducted to determine the diverse target audiences based on zip codes surrounding our 10 hospitals and then cross-referenced with the top 2-to-3 diverse populations and languages based on the largest cohorts. That research indicated the following audiences: Hispanic, Black/African American, Chinese, Haitian, Indian, and Cape Verdean.

Winchester Hospital	**Beverly/Addison Gilbert Hospital**	**Lahey Hospital and Medical Center**	**Anna Jaques Hospital**	**Beth Israel Deaconess Medical Center**
01801 01806 01807 01808 01813 01815 01864 01867 01876 01880 01887 01888 01889 01890 02155 02156 02180 02153	01901 01902 01903 01904 01905 01910 01915 01923 01929 01930 01931 01937 01938 01944 01965 01966 01949	02420 02421 02474 02475 02476 01850 01851 01852 01853 01854 01960 01961 01730 01731 01803 01805 01821 01822 01862 01865 01940	01830 01831 01832 01833 01834 01835 01860 01913 01950 01951 01952 01985 01969	02445 02446 02447 02173 02492 02467
Mt. Auburn Hospital	**New England Baptist**	**BID – Milton Hospital**	**BID - Needham Hospital**	**BID – Plymouth Hospital**
02138 02139 02140 02141 02142 02143 02144 02145 02238 02239 02451 02452 02453 02454 02455 02474 02472 02474 02475 02476 02477 02478 02479	02445 02446 02447 02467 02026 02027	02169 02170 02171 02186 02187 02269 02368	02492 02494 02026 02027 02030 02090	02330 02331 02332 02345 02355 02360 02361 02362 02364 02366 02381

Channels

GVC utilized three types of marketing channels to expand our reach. Diverse print publications, precision audio, and digital advertising.

1. Print

The following print publications were selected based on reach or hyper targeted audiences. Translation was used if the publication publishes in languages other than English.

A. El Mundo – Spanish Translation

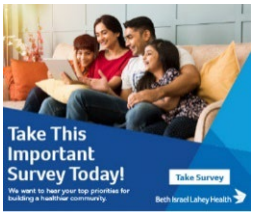
B. Sampan – Chinese Translation

C. Thang Long – Vietnamese Translation

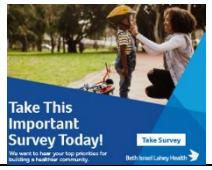
D. Bay State Banner – Black/African American, Cape Verdean/English

E. Chelsea Record – Hispanic/English

F. Indian New England – English (online only)



G. Haitian Reporter – English (online only)



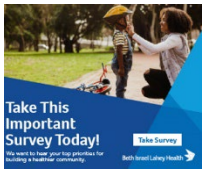
For the printed newspapers the publish dates are as follows:

Bay State	4-Nov
El Mundo	4-Nov
Sampan	5-Nov
Haitian Report (digital only)	2 weeks
Thang Long	2-Nov
India New England (digital only)	2 weeks
Chelsea	4-Nov

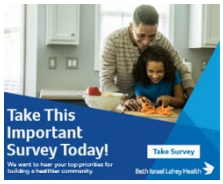
2. Digital Advertising

Digital ads will be served across various websites. GVC utilized a people-based marketing approach. The digital ads will be served up based on the zip codes provided and will include both English and translations based on user preferences. For social media and audio these ads run for a full 2 weeks from Nov 1 through Nov 15.

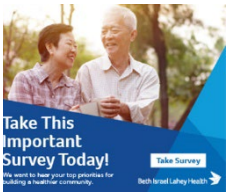
A. African American/Black, Haitian, Cape Verdean



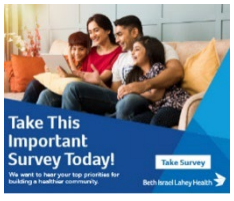
B. Hispanic



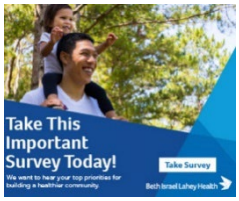
C. Chinese



D. Indian



E. Vietnamese



C. Precision Audio

GVC streamed :30 audio spots across multiple platforms (iHeart, NPF, PODcasts, Pandora, Spotify, etc.). GVC served up audio commercial voiceover for each hospital using zip codes. For social media and audio these ads run for a full 2 weeks from Nov 1 through Nov 15.

Sample audio script. Note: Script was customized for each of the 10 hospitals.

Beth Israel Deaconess Hospital in Needham wants to hear what you think the most important health-related priorities are in our community. Please take an online survey at bilh.org/chna. Your responses will help to inform innovative solutions to improve the health of our community. Simply go to bilh.org/chna and fill out the survey. That's b-i-l-h.org/c-h-n-a.

Note: For social media and precision audio, this campaign is people based, so GVC is following each audience member and serving ad messaging where ever and whenever they are consuming online content (within the set frequency for the campaign).

For example, one person could be more active online early mornings – reading articles when he/she/they wake up; listening to streamed music while he/she/they commute – so GVC would then be sure to serve Mike his daily ad frequency during the times he is more active online, increasing the likelihood for click conversion with display ads – or in the case of audio, listening to the ad through to 100% completion. So basically going off of the targets media consumption.

Organization	Promotion other than flyers or print (e.g., Social Media, Newsletter, other Electronic Publication, etc.)	Contact Person/Name	Title (if Applicable)
African Waltham		Juliet Najjumba	CEO
Alice Taylor Housing Development			
Arlington Eats	x	Susan Dorson	Program Manager
Arlington Health Department		Christine Bongiorno	Director
Arlington Housing Authority	x	Jack Nagle	Executive Director
Arlington Recreation Dept.	x	Joe Connolly	Director of Recreation
Arlington Youth Counseling Center (AYCC)		Colleen Leger	Executive Director
Belmont Chinese American Association (BCAA)	x	Lixin Qin, Michael Gao	Members of BCAA
Belmont Council on Aging	x	Nava Niv-Vogal	Director
Belmont Health Department		Wes Chin	Director
Cambridge and Somerville Programs for Addiction Recovery (CASPAR)		Julia Londergan	Director of Development, CASPAR , Inc.
Cambridge Community Engagement Team (CCET)		Lynn Rosenbaum	Member, CCET
Cambridge Community Learning Center	x	Lisa Gimbel	Education Advisor, Cambridge Community Learning Center
Cambridge Council on Aging	x	Susan Pacheco	Director, Cambidge COA
Cambridge Disability Commission		Kate Thurmsn	
Cambridge Health Alliance		Renee Cammarata Hamilton	Director, Community Health Improvement Team
Cambridge Health Department	x	Jose Wendel	Director of Population Health Initiatives, Cambridge Public Health Department
Cambridge Housing Authority	x	Brenda Downing	Deputy Executive Director
Cambridge LGBTQ+ Commission		Amelia Joselow	Member
Cambridge Neighbors		Meghan Maloney	Assistant Director, Cambridge Neighbors, Inc.
MAH Community Benefits Advisory Committee (CBAC)		21 Community Members on CBAC	
Charles River Community Health	x	Amy Knudsen	Grants Manager
Community Day Center in Waltham		Carolyn Montalto	Executive Director
Greater Cambridge/Somerville Community Health Network (CHNA) 17	x	Stacy Carruth	Planning Director, CHNA 17
Council on Aging - Waterton		Anne- Marie Gagnon	Director Watertown COA
DEI Director for Arlington		Jill Harvey	DEI Director, Town of Arlington
Disability Policy Consortium,,. MA		Harry Weissman	Director of Advocacy
Healthy Waltham	x	Joe Privitera	Pantry Operations Manager
Healthy Waltham	x	Maria DiMaggio	Operations Director
Housing Corp. of Arlington	x	Jeff Katz	Interim Executive Director
Mass. Alliance of Portuguese Speakers		Lois Josimovich	Director of Development
Rainbow Coalition in Arlington		Andy Rubinson and Lisa Krinsky	Co-Chairs
Somerville Cambridge Elder Services (SCES)		Colleen Morrisey	Director of Volunteers and Special Projects
Somerville Center for Adult Learning Experience (SCALE)	x	Lisa Cook	Director
Somerville Disability Commission		Denise Molina Capers	Member
Somerville Health and Human Services Department		Nancy Bacci	Deputy Director
Somerville Health and Human Services Department		Doug Kress	Director
Somerville Homeless Coalition		Mike Libby	Executive Director
Somerville Housing Authority	x	Shannon Bennett	Director of Resident Services
Somerville Stakeholders Coalition, Somerville Police Dept.		Patty Contente	Director, Community Outreach, Helap and Recovery
Springwell		Donlynn Cannella	Associate Director of Community Services
Transition House		Shamika Gregory	Director of Equity and Justice
Waltham Connections		Walter Leutz	Member
Waltham Family School		Jaqueline Herrera	Program Coordinator
Waltham Interagency Network		Daria Gere	Executive Director
Watertown Cares		Stephanie Venezelos	Chair of Coalition
Watertown Community Wellness		Stephanie Venezelos	Manager
Watertown Health Department		Larry Ramdin	Director
Wayside Family Services		Laura Kurman	Senior Program Director
Youth 2 Youth Network, Inc. (Y2Y)		Ari Taylor	Senior Manager of Development

Appendix C:
Resource Inventory

Mount Auburn Hospital Community Resource List

Community Benefits Service Area includes: Arlington, Belmont, Cambridge, Somerville, Waltham, and Watertown

Health Issue	Organization	Brief Description	Address	Phone	Website
Statewide Resources	Department of Mental Health-Handhold program	Provides tips, tools, and resources to help families navigate children's mental health journey.			www.handholdma.org
	Executive Office of Elder Affairs	Provides access to the resources for older adults to live healthy in every community in the Commonwealth.	1 Ashburton Place 5th Floor Boston	617.727.7750	www.mass.gov/orgs/executive-office-of-elder-affairs
	MA 211	Available 24 hours a day, 7 days a week, Mass 211 is an easy way to find or give help in your community.		211 or 877.211.6277	www.mass211.org
	Massachusetts Elder Abuse Hotline	Hotline is available 24 hours a day or by phone. Older adult abuse includes: physical, sexual, and emotional abuse, caretaker neglect, financial exploitation and self-neglect. Elder Protective Services can only investigate cases of abuse where the person is age 60 and over and lives in the community.	1 Ashburton Place 5th Floor Boston	800.922.2275	www.mass.gov/orgs/executive-office-of-elder-affairs
	MA Women, Infants and Children (WIC) Nutrition Program	Provides free nutrition, health education and other services to families who qualify.		800.942.1007	www.mass.gov/orgs/women-infants-children-nutrition-program
	MassOptions	Provides connection to services for older adults and persons with disabilities.		800.243.4636	www.massoptions.org
	Massachusetts Substance Use Helpline	24/7 Free and confidential public resource for finding substance use treatment and recovery services.		800.327.5050	www.helplinema.org
	National Suicide Prevention Lifeline	Provides 24/7, free and confidential support.		800.273.8255 crisis text line - text hello to 741741	www.suicidepreventionlifeline.org

Mount Auburn Hospital Community Resource List

Community Benefits Service Area includes: Arlington, Belmont, Cambridge, Somerville, Waltham, and Watertown

Health Issue	Organization	Brief Description	Address	Phone	Website
Statewide Resources	Network of Care Massachusetts	Provides a searchable directory of over 5,000 Behavioral Health service providers in Massachusetts.			www.massachusetts.networkofcare.org
	Project Bread Foodsource Hotline	Provides information about food resources in the community and assistance with SNAP applications by phone.		1.800.645.8333	www.projectbread.org/get-help
	SafeLink	Massachusetts' statewide 24/7 toll-free domestic violence hotline and a resource for anyone affected by domestic or dating violence.		877.785.2020	www.casamyrna.org/get-support/safelink
	SAMHSA's National Helpline	Provides a free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families in need of mental health resources and/or information for those with substance use disorders.		800.662.HELP (4357)	www.samhsa.gov/find-help/national-helpline
	Supplemental Nutritional Assistance Program (SNAP)	Provides nutrition benefits to individuals and families to help subsidize food costs.		877.382.2363	www.mass.gov/snap-benefits-formerly-food-stamps
	Veteran Crisis Hotline	Free, every day, 24/7 confidential support for Veterans and their families who may be experiencing challenges.		800.273.8255	www.veteranscrisisline.net
Domestic Violence	Boston Area Rape Crisis Center	Provides free, confidential support and services to survivors of sexual violence.	989 Commonwealth Ave Boston	617.492.8306 24/7 Hotline: 800.841.8371	www.barcc.org

Mount Auburn Hospital Community Resource List

Community Benefits Service Area includes: Arlington, Belmont, Cambridge, Somerville, Waltham, and Watertown

Health Issue	Organization	Brief Description	Address	Phone	Website
Domestic Violence	REACH Beyond Domestic Violence	Provides support to survivors of domestic violence in four areas of intervention: safety and shelter; advocacy; education and prevention; community engagement.	PO Box 540024 Waltham	781.891.0724 Hotline: 800.899.4000	www.reachma.org
	RESPOND	Provides support to survivors of domestic violence in four areas of intervention: safety and shelter; advocacy; education and prevention; community engagement.	66-70 Union Sq. #205 Somerville	617.623.5900	www.respondinc.org
	Transition House	Offers help and resources to survivors of domestic violence, intimate partner abuse, dating violence and family violence.	PO Box 392016 Cambridge	617.661.7203	www.transitionhouse.org
Food Assistance	Arlington EATS Market	Provides food assistance to residents of Arlington.	74 Pleasant St Arlington	339.707.6757	www.arlingtoneats.org
	Belmont Food Pantry	Provides food assistance to residents of Belmont.	404 Concord Ave Belmont		www.uubelmont.org/social-action/belmont-food-pantry-2/
	Cambridge Community Center	Provides food assistance to residents of Cambridge.	5 Callender St Cambridge	617.547.6811	www.cambridgecc.org/food--supply-pantry
	Cambridge Economic Opportunity Committee	Provides food assistance to residents of Cambridge.		617.868.2900	www.ceoccambridge.org/services/food-pantry
	East End House	Provides food assistance to residents of Cambridge and greater Boston area.	105 Spring St Cambridge	617.876.4444	www.eastendhouse.org
	Healthy Waltham	Provides food assistance to residents of Waltham.	510 Moody St Waltham	781.314.5647	www.healthywaltham.org
	Project Soup	Provides food assistance to residents of Somerville.	165 Broadway Somerville	617.776.7687	www.somervillehomelesscoalition.org/food security

Mount Auburn Hospital Community Resource List

Community Benefits Service Area includes: Arlington, Belmont, Cambridge, Somerville, Waltham, and Watertown

Health Issue	Organization	Brief Description	Address	Phone	Website
Food Assistance	Watertown Food Pantry	Provides food assistance to residents of Watertown.	80 Mount Auburn St Watertown	617.972.6490	www.watertown-ma.gov/330/Watertown-Food-Pantry
Housing Support	Arlington Housing Authority	Provides housing assistance programs to low-resource individuals and families.	4 Winslow St # 1 Arlington	781.646.3400	www.arlingtonhousing.org
	Belmont Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families, older adults, veterans and persons with disabilities.	59 Pearson Rd Belmont	617.484.2160	www.belmontha.org
	Cambridge Community Development Department	Provides affordable housing opportunities for those who qualify.	344 Broadway Cambridge	617.349.4622	www.cambridgema.gov/CDD/housing.aspx
	Cambridge Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families, older adults and persons with disabilities.	362 Green St Cambridge	617.864.3020	www.cambridge-housing.org
	Cambridge Multi Service Center	Provides information and resources for low and moderate resource individuals in Cambridge.	362 Green St Cambridge	617.349.6340	www.cambridgema.gov/DHSP/programsforadults/cambridgemultiservicecenter
	Community Action Agency of Somerville	Provides access to resources and services for residents of Somerville.	66-70 Union Sq. Ste 104 Somerville	617.623.7370	www.caasomerville.org/housing-advocacy-program
	Housing Corporation of Arlington	Provides information and resources for low and moderate resource families and individuals in Arlington.	252 Massachusetts Ave Arlington	781.859.5294	www.housingcorparlington.org
	Jump-A-Start Corporation	Provides affordable housing, education and job training, and support services.	1035 Cambridge St Cambridge	617.494.0444	www.justastart.org

Mount Auburn Hospital Community Resource List

Community Benefits Service Area includes: Arlington, Belmont, Cambridge, Somerville, Waltham, and Watertown

Health Issue	Organization	Brief Description	Address	Phone	Website
Housing Support	Metro Housing Boston	Provides information and resources for low and moderate resource families and individuals.	1411 Tremont St Boston	617.859.0400	www.MetroHousingBoston.org
	Middlesex Human Service Agency	Provides community-based shelter, nutrition and recovery programs throughout Greater Boston to individuals and families.	50 Prospect St Ste 3 Waltham		www.MHSAinc.org
	Somerville Homeless Coalition	Provides information and resources for low and moderate resource families and individuals.	1 Davis Sq. Somerville	617.623.6111	www.somervillehomelesscoalition.org
	Somerville Housing Authority	Provides affordable, subsidized rental housing for low-resource families and older adults.	30 Memorial Rd Somerville	617.625.1152	www.sha-web.org
	Waltham Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families, older adults and persons with disabilities.	110 Pond St Waltham	781.894.3357	www.walhouse.org
	Watch CDC	Provides information and resources for low and moderate resource families and individuals.	24 Crescent St Ste 201 Waltham	781.891.6689	www.watchcdc.org
	Watertown Housing Authority	Provides affordable, subsidized rental housing for residents of Watertown.		617.923.3950	www.watertownha.org
	YWCA Cambridge	Provides safe, affordable accommodations for women and families.	7 Temple St Cambridge	617.491.6050	www.ywcacam.org

Mount Auburn Hospital Community Resource List

Community Benefits Service Area includes: Arlington, Belmont, Cambridge, Somerville, Waltham, and Watertown

Health Issue	Organization	Brief Description	Address	Phone	Website
Mental Health and Substance Use	Arlington Youth Counseling Center	Provides a variety of high quality, innovative, and therapeutic outpatient and school-based mental health services including individual, group, and family counseling, psychiatric evaluation and medication management.	670R Mass Ave Arlington	781.316.3255	www.arlingtonma.gov/departments/health-human-services/arlington-youth-counseling-center-aycc/services
	Beth Israel Lahey Health (BILH) Behavioral Services	Provides high-quality mental health and addiction treatment for children and adults ranging from inpatient to community-based services.		978.968.1700	www.nebhealth.org
	Boston Treatment Center	Provides inpatient detoxification and treatment services to both men and women from alcohol, opiates and benzodiazepines.	784 Massachusetts Ave Boston	617.247.1001	www.nebhealth.org
	Column Health	Provides outpatient mental health and addiction treatment.	401 Highland Ave Somerville	844.910.2034	www.columnhealth.com
	Column Health	Provides outpatient mental health and addiction treatment.	339 Massachusetts Ave Arlington	844.910.2034	www.columnhealth.com
	DeNovo Center for Justice and Healing	Provides access to mental health counseling and forensic psychological evaluations to survivors of torture, violence, abuse and poverty.	47 Thorndike St Cambridge	617.661.1010	www.denovo.org

Mount Auburn Hospital Community Resource List

Community Benefits Service Area includes: Arlington, Belmont, Cambridge, Somerville, Waltham, and Watertown

Health Issue	Organization	Brief Description	Address	Phone	Website
Mental Health and Substance Use	Eliot Community Human Services	Provides services for people of all ages throughout Massachusetts through a continuum of services includes diagnostic evaluation, 24-hour emergency services, and crisis stabilization, outpatient and court-mandated substance-use prevention services; individual, group and family outpatient counseling, early intervention, specialized psychological testing; day, residential, social and vocational programs for individuals with developmental disabilities, outreach and support services for people experiencing homelessness.	125 Hartwell Ave Lexington	781.861.0890	www.eliotchs.org
	Jewish Family & Children's Services	Provides direct services and advancing best practices that support the resilience and well-being of its target populations: new parents and their children, older adults and family caregivers, children and adults with disabilities, and people experiencing poverty, hunger, or domestic abuse.	1430 Main St Waltham	781.647.5327	www.jfcsboston.org
	LifeStance Health	Provides mental health treatment services for patients of all ages with telehealth and in-person appointments.	22 Mill St Stes 004 & 308 Arlington	781.646.0500	www.cfpsych.org
	Neighborhood Counseling and Community Services, Inc.	Provides community wellness, mental health, and support services to individuals and groups across their lifespan.	403 Highland Ave Somerville	781.600.6074	www.neighborhoodcounselingservices.org

Mount Auburn Hospital Community Resource List

Community Benefits Service Area includes: Arlington, Belmont, Cambridge, Somerville, Waltham, and Watertown

Health Issue	Organization	Brief Description	Address	Phone	Website
Mental Health and Substance Use	Right Turn	Provides a broad range of evidence-based treatment programs for individuals, and families recovering from substance use disorders and co-occurring disorders.	440 Arsenal St Watertown	781.646.3800	www.right-turn.net
	Riverside Community Care	Offers comprehensive mental health services for children and families.	117 Summer St Somerville	617.354.2275	www.riversidecc.org
	Spectrum Outpatient Treatment Center	Provides Medication-Assisted Treatment via Methadone and naltrexone.	210 Bear Hill Rd Waltham	781.290.4970	www.spectrumhealthsystems.org
	Walden Behavioral Care	Provides inpatient treatment for patients in need of psychiatric care.	51 Sawyer Rd Waltham	781.647.6700	www.waldenbehavioralcare.com
	Wayside Watertown	Offers a comprehensive array of services, ranging from outpatient counseling to in-home family therapy and emergency mental health services.	127 N Beacon St Watertown	781.891.0555	www.waysideyouth.org
Senior Services	Arlington Council on Aging	Provides services for older adults in Arlington including fitness, education, social services, recreation, and transportation.	27 Maple St Arlington	781.316.3400	www.arlingtonma.gov/departmetns/health-human-services/council-on-aging
	Citywide Senior Center	Provides services for older adults in Cambridge including fitness, education, social services, and recreation.	806 Massachusetts Ave Cambridge	617.349.6060	www.cambridgema.gov/DHSP/programsforadults/seniorscouncilonaging/citywideseniorcenter
	Minuteman Senior Services	Provide supportive services for older adults and persons with disabilities.	26 Crosby Dr Bedford	781.272.7177	www.minutemansenior.org
	North Cambridge Senior Center	Provides services for older adults in Cambridge including fitness, education, social services, and recreation.	266B Rindge Ave Cambridge	617.349.6320	www.cambridgema.gov/dhsp/programsforadults/seniorscouncilonaging/northcambridgeseniorcenter

Mount Auburn Hospital Community Resource List

Community Benefits Service Area includes: Arlington, Belmont, Cambridge, Somerville, Waltham, and Watertown

Health Issue	Organization	Brief Description	Address	Phone	Website
Senior Services	Somerville Cambridge Elder Services	Provides programs for older adults or people with disabilities and caregivers.	61 Medford St Somerville	617.628.2601	www.eldercare.org
	Springwell Elder Services	Provide supportive services for older adults and persons with disabilities.	307 Waverley Oaks Rd Ste 205 Waltham	617.926.4100	www.springwell.com
	Waltham Council On Aging	Provides services for older adults in Waltham including fitness, education, social services, and recreation.	488 Main St Waltham	781.314.3499	www.city.waltham.ma.us/council-on-aging
	Watertown Council On Aging	Provides services for older adults in Watertown including fitness, education, social services, and recreation.	31 Marshall St Watertown	617.972.6490	www.watertown-ma.gov/284/Council-on-Aging-Senior-Center
Transportation	MBTA	Provides transportation thru out Boston and surrounding communities.			www.mbta.com
	THE RIDE (MBTA)	Provides a 365 days a year door-to door, shared-ride transportation to persons who are unable to use bus, subway or trolley transportation.		800.533.6282	www.mbta.com/accessibility/the-ride
	Springwell Senior Medical Escort Program	Provides transportation to medical appointments.	307 Waverley Oaks Rd Ste 205 Waltham	617.926.4100	www.springwell.com/service/medical-escort
Additional Resources	Arlington Boys & Girls Club	Offers programs in Five Core Program Areas: The Arts, Health & Life Skills, Character & Leadership Development, Education & Career Development and Sports, Fitness and Recreation.	60 Pond Ln Arlington	781.648.1617	www.abgclub.org

Mount Auburn Hospital Community Resource List

Community Benefits Service Area includes: Arlington, Belmont, Cambridge, Somerville, Waltham, and Watertown

Health Issue	Organization	Brief Description	Address	Phone	Website
Additional Resources	Somerville YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	101 Highland Ave Somerville	617.625.5050	www.somervilleymca.org
	Waltham Boys & Girls Club	Offers programs in Five Core Program Areas: The Arts, Health & Life Skills, Character & Leadership Development, Education & Career Development and Sports, Fitness and Recreation.	20 Exchange St Waltham	781.893.6620	www.walthambgc.org
	Waltham YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	725 Lexington St Waltham	781.894.5295	www.ymcaboston.org

Appendix D:

Evaluation of 2020-2022 Implementation Strategy

Mount Auburn Hospital (MAH)

Evaluation of 2022 Implementation Strategy

Below are highlights of the work that has been accomplished since the last Implementation Strategy. For full reports, please see submissions to the Massachusetts Attorney General Community Benefits office (https://massago.onbaseonline.com/massago/1801CBS/annualreport.aspx).

Priority: Racial Equity

Goal 1: Promote Health Equity and Reduce Disparities for those Facing Racism and Discrimination, Particularly for Communities of Color			
Population	Objectives	Activities	Progress, Outcomes, and Impact
• Black, Indigenous, and People of Color • Immigrants and Dual-Language Learners • Older Adults • LGBTQ+ Community • Individuals Experiencing Material Poverty	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.	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	i. The MAH Disparities Committee has developed action items to improve care/services to BIPOC and LGBTQ+ community members by expanding disparity metrics and collecting baseline data on these populations. ii. Provided staff education on promoting DE and I principles with workshops/training. iii. Community Benefit Director is a member of CHNA 17 steering committee. iv. Increased the grant funding to CHNA 17 to promote its fellowship program as well as support its work on racial equity in mental health. v. Shifted gears and created a Community Health Grant opportunity for CBO's and municipalities.

		v. Provide grant support and funding for local public health departments to promote racial equity	

Priority: 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			
Population	Objectives	Activities	Progress, Outcomes, and Impact
• Black, Indigenous, and People of Color • Immigrants and Dual-Language Learners • Older Adults • LGBTQ+ Community • Individuals Experiencing Material Poverty	i. Expand access to mental health and substance use disorder treatment/support services ii. Expand access to linguistically/culturally sensitive mental health and substance use treatment/support services iii. Increase and enhance support for those affected by trauma, and or emotional stress iv. Increase access to "care navigation" services for those with mental illness and substance use disorders v. Promote collaboration, share knowledge, and coordinate activities	i. ED Social Work Navigator to support the START program (Substance Treatment and Referral Team) ii. 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 iii. Organize and support mindfulness-based programs for community members in response to COVID 19 iv. Social workers to attend community meetings where they share best practices, identify opportunities to improve collaborations and optimize health for vulnerable community members v. Provide grant support and funding for local public health departments to support evidence-based programs that	i. Provided behavioral health services to 511 patients across 7 sites. ii. Caregiver support group meets twice a month. A Bereavement support group ran 5 times in the past 2 years with one more scheduled to run in the spring 2022. A breast cancer support group runs two times per month. iii. A Mindfulness Based Stress Reduction Class© was offered 3 times in the past 2 years. 33 people attended and 100% of participants reported that they will be able to take what they learned and use it to improve their own health and wellbeing. iv. Social workers regularly attended community based meetings to make connections, and to help with the transition of our most vulnerable community members. Over 50 meetings attended in the past 2 years. v. This year MAH piloted a Community Health Grant Program providing 8 organizations with grant funds up to $10,000 to work on programs, which coincided with the five health priorities identified in our most recent CHNA. vi. Provided grant funds to CHNA 17 to address mental health and racial equity.

	internally at MAH and externally with community partners	promote mental health and substance use education and prevention services vi. Support CHNA 17 with funding in its efforts to address mental health in African American/Black population and other vulnerable segments facing discrimination	

Priority: Chronic and Complex Conditions and Risk Factors

Goal 1: Enhance Access to Health Education, Screening, and Referral Services in Clinical and Non-Clinical Settings			
Population	Objectives	Activities	Progress, Outcomes, and Impact
• Black, Indigenous, and People of Color • Immigrants and Dual-Language Learners • Older Adults • LGBTQ+ Community • Individuals Experiencing Material Poverty	i. Increase the number of adults who receive health education and screening, for chronic/complex conditions ii. Increase the number of adults participating in cancer education, screening, and referral events iii. Promote healthy aging and one's ability to Age in Place	i. Provide adults with health education regarding risk factors and healthy behaviors in settings convenient to those community members who are most vulnerable ii. Facilitate an elder service provider working group in order to share best practices, listen to needs to improve programming and to promote healthy aging iii. Partner with area COA and ASAPs to provide monthly health education and venue space for older adults iv. Collaborate with CRCH to provide free mammogram event/s for those who are uninsured or underinsured v. Organize blood pressure screening events in the community vi. Provide emergency response services (Lifeline) at below cost to underserved elders and	i. Provided a series of health and wellness education classes where a total of over 85 people participated. i. 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. i. 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. ii. Hosted an Elder Services Provider working group which has met at least 5 times. iii. Provided monthly presentations geared towards older adults in order to increase knowledge and reduce the feeling of isolation (over zoom platform). A total of 198 older adults were in attendance. iv. Due to the COVID 19 pandemic we were not able to hold our annual mammogram screening event with CRCH. v. Due to the COVID 19 pandemic we were not able to coordinate community blood pressure screening events.

		disabled persons who are in need, as identified by regional elder services agencies vii. 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	vi. Over 1,000 eligible seniors and or disabled adults received a personal emergency response system installed at below cost. vii. Volunteer opportunities were very limited due to the COVID 19 pandemic. viii. This year MAH piloted a Community Health Grant Program providing 8 organizations with grant funds up to $10,000 to work on programs, which coincided with the five health priorities identified in our most recent CHNA.

Goal 2: Enhance Access to Self-Management and other Supportive Services for Individuals with or Recovering from Chronic/Complex Conditions and their Caregivers			
Population	Objectives	Activities	Progress, Outcomes, and Impact
• Black, Indigenous, and People of Color • Immigrants and Dual-Language Learners • Older Adults • LGBTQ+ Community • Individuals Experiencing Material Poverty	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	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	i. 75 participants in the Survivorship Event and 96% of those surveyed reported they learned something of lasting value by participating. ii. The breast cancer support group meets twice a month. iii.The Caregivers support group meets twice a month. iv. Stroke Nurse Educator provided ongoing education and support to patients and their families. Also works

	increase overall wellbeing iii. Increase the ability of older adults to live independently and age in place	education and support for patients and their families	with community health department to provide stroke education initiatives in the community.

Priority: Social Determinants of Health

Goal 1: Provide Supportive Services for those who are Unstably Housed			
Population	Objectives	Activities	Progress, Outcomes, and Impact
• Black, Indigenous, and People of Color • Immigrants and Dual-Language Learners • Older Adults • LGBTQ+ Community • Individuals Experiencing Material Poverty	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	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	i. Created a SDoH working group within the hospital. The working group created and is currently piloting a screening tool for all primary care services. ii. Completed a contract agreement and have implemented a Co-Location program with MBH for ease of transition for patients and to connect our housing unstable patients to a case manager. iii. Our Co – Location program is now up and running and provides resources and information for housing unstable community members. iv. Continuing to explore partnerships and collaborations to address the lack of safe and affordable housing.

Goal 2: Improve Access to Healthy and Nutritious Food for those who Experience Food Insecurity			
Population	Objectives	Activities	Progress, Outcomes, and Impact
• Black, Indigenous, and People of Color • Immigrants and Dual-Language Learners • Older Adults • LGBTQ+ Community • Individuals Experiencing Material Poverty	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	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	i. Partnered with Waltham Fields Community Farm and contributed to the 100 free box shares of fresh produce delivered weekly to housing authority neighborhoods which were low income (13-week program) ii. Provided grant funding to 5 local organizations for the purpose of increasing access and consumption of fresh food to food insecure residents. iii. Supported the Cambridge SNAP Match Coalition where they saw an increase of SNAP Match benefits issued by 43% in 2021 compared to 2020. iii. Supported the City of Watertown SNAP Match program where they saw an increase of SNAP Match benefits issued increase by 50% compared to 2020. iv. Using our purchasing power provided food to Healthy Waltham monthly during their emergency food pantry distribution program.

Goal 3: Promote Transportation Equity			
Population	Objectives	Activities	Progress, Outcomes, and Impact
• Black, Indigenous, and People of Color • Immigrants and Dual-Language Learners • Older Adults • LGBTQ+ Community • Individuals Experiencing Material Poverty	i. Work internally at MAH and with community partners to identify those who have limited access to safe, affordable, accessible transportation ii. Increase access to safe, affordable, accessible transportation where transportation is a barrier to health care iii. Participate in the Cambridge Transportation task force	i. Provide transportation vouchers to priority populations (e.g., low income, older adults, and other segments) ii. Participate in Cambridge's transportation task force	Over 1500 rides provided free of charge to those where transportation is 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. ii. Director of Community Affairs participates in Cambridge's Transportation task Force.

Priority: Access to Care and Community Navigation

Goal 1: Address the Social Determinants of Access to Care			
Population	Objectives	Activities	Progress, Outcomes, and Impact
• Black, Indigenous, and People of Color • Immigrants and Dual-Language Learners • Older Adults • LGBTQ+ Community • Individuals Experiencing Material Poverty	Work internally at MAH and with community partners to identify the community assets and barriers that either promote or hinder access to needed services	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	i. Provide services of Certified Application Counselors at MAH and at Charles River Community Health (Federally Qualified Health Center) to assist those applying for health insurance and public assistance programs. ii. Continued to support CHNA 17 with funding (increased funding in FY21) iii. 94% of coalition members reported they improved their knowledge of programs, services, health initiatives, and other resources in our network. iii. 94% of coalition members increased their awareness of racial inequities in their community. iv. This year MAH piloted a Community Health Grant Program providing 8 organizations with grant funds up to $10,000 to work on programs, which coincided with the five health priorities identified in our most recent CHNA.

Goal 2: Promote Equitable Care and Support for those who are Dual-Language Learners			
Population	Objectives	Activities	Progress, Outcomes, and Impact
• Black, Indigenous, and People of Color • Immigrants and Dual-Language Learners • Older Adults • LGBTQ+ Community • Individuals Experiencing Material Poverty	Promote health literacy internally at MAH and externally with community partners	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	i. A total of 50 English Language Learners participated in the "Navigating the Healthcare System" presentations ii. Provided bias training to employees. Provided 15,265 individual encounters either face to face, video, or telephonic encounters.

Goal 3: Promote Health Equity for LGBTQ+ Populations			
Population	Objectives	Activities	Progress, Outcomes, and Impact
LGBTQ+ community	i. Promote best practices with respect to collecting accurate information on sexual orientation and gender identity internally at MAH and externally with community partners	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	i. Supported Y2Y (youth homeless shelter and drop in center). Many clients identify as LGBTQ+, here they find a supportive environment which help to connect them to resources. ii. Met the standards for Leadership Status for the HRC, LGBTQ+ Healthcare Equality Index.

	ii. Reduce barriers to health care and disparities in health outcomes iii. Share LGBTQ+ resources with external partners	for the LGBTQ+ Healthcare Equality Index iii. Partner with community organizations which support the LGBTQ + community	iii. Focus group conducted with Arlington Rainbow Commission to assess needs.

Goal 4: Promote Resilience and Emergency Preparedness			
Population	Objectives	Activities	Progress, Outcomes, and Impact
• Black, Indigenous, and People of Color • Immigrants and Dual-Language Learners • Older Adults • LGBTQ+ Community • Individuals Experiencing Material Poverty	Support cities/towns to promote resilience, emergency care and emergency preparedness	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	i. Monthly case review sessions were provided by MAH ED Physicians. ii. MAH physicians served as EMS Medical Directors to the City of Cambridge and the towns of Watertown, Belmont, Arlington and Lexington. iii. 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.

Goal 5: Promote Resiliency for new Moms			
Population	Objectives	Activities	Progress, Outcomes, and Impact
• Black, Indigenous, and People of Color • Immigrants and Dual-Language Learners • Older Adults • LGBTQ+ Community • Individuals Experiencing Material Poverty	Support outreach and assistance to new moms to increase awareness about how to create a healthy and safe environment for babies and families	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.	i. This program was postponed due to the COVID 19 pandemic. ii. Provided a free Doula for support for 15 births. Iii. Provided 175 encounters which provided navigational and emotional support. This included helping with governmental assistance programs, birth certificates, SSI office visits, immigration status, babies first appointments, billing issues and helping to prepare moms for appointment and hospital follow-up visits.

Appendix E:
2023-2025 Implementation Strategy

Beth Israel Lahey Health
Mount Auburn Hospital

FY23-FY25 Implementation Strategy

Implementation Strategy

About the 2022 Hospital and Community Health Needs Assessment Process

Mount Auburn Hospital (MAH) is a 217-bed acute-care, Harvard-affiliated community teaching hospital. MAH was founded in 1886, and for over 100 years has been dedicated to maintaining the highest standards of excellence in care for its patients, while also educating the caregivers of tomorrow and participating in critically important research. MAH offers comprehensive inpatient and outpatient medical, surgical, obstetrical, and psychiatric services as well as specialized care in bariatrics, cardiology, cardiac surgery, orthopedics, neurology, vascular surgery, and oncology. In addition, MAH also offers a network of satellite primary care practices in several surrounding communities, as well as a range of community-based programs: MAH Radiology at Arlington; MAH MRI Center, MAH Rehabilitation Services, Outpatient Physical, and Occupational Therapy, MAH Mobile PET Unit, MAH Employee Assistance Program and Occupational Health and Rehabilitation Services in Cambridge; and MAH Imaging and Specimen Collection in Waltham. Medical education and clinical research play an important part in the hospital's mission and are considered necessary to maintain high-quality care for its patients. MAH's dual mission is to provide excellent and compassionate health care and to teach students of medicine and the health professions.

The Community Health Needs Assessment (CHNA) and planning work for this 2022 report was conducted between September 2021 and September 2022. In conducting this assessment and planning process, it would be difficult to overstate MAH's commitment to community engagement and a comprehensive, data-driven, collaborative, and transparent assessment and planning process. MAH's Community Benefits staff and Community Benefits Advisory Committee (CBAC) dedicated hours to ensuring a sound, objective, and inclusive process. This approach involved extensive data collection activities, substantial efforts to engage the hospital's partners and community residents, and a thoughtful prioritization, planning, and reporting process. Special care was taken to include the voices of community residents who have been historically underserved, such as those who are unstably housed or homeless, individuals who speak a language other than English, those who are in substance use recovery, and those who experience barriers and disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

MAH collected a wide range of quantitative data to characterize the communities served across the hospital's Community Benefits Service Area (CBSA). MAH also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data were collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs of specific communities. The data were tested for statistical significance whenever possible and compared against data at the regional, Commonwealth, and national levels to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments, and other sources. Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing cohorts most at-risk, and crafting a collaborative, evidence-informed IS. Between October 2021 and February 2022, MAH conducted 18 one-on-one interviews with key collaborators in the community, facilitated three focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 250 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 300 community residents, clinical and social service providers, and other key community partners.

Prioritization and Implementation Strategy Process

Federal and Commonwealth community benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its IS. By analyzing assessment data, hospitals can identify the health issues that are particularly problematic and rank these issues in order of priority. Accordingly, using an interactive, anonymous polling software, MAH's CBAC and community residents, through the community listening sessions, formally prioritized the community health issues and cohorts that they believed should be the focus of MAH's IS. This prioritization process helps to ensure that MAH maximizes the impact of its community benefits resources and its efforts to improve

health status, address disparities in health outcomes, and promote health equity.

The process of identifying the hospital's community health issues and prioritized cohorts is also informed by a review and careful reflection on the Commonwealth's priorities set by the Massachusetts Department of Public Health's Determination of Need process and the Massachusetts Attorney General's Office.

MAH's IS was designed to address the underlying social determinants of health and barriers to accessing care, as well as promote health equity. The content addresses the leading community health priorities, including activities geared toward health education and wellness (primary prevention), identification, screening, referral (secondary prevention), and disease management and treatment (tertiary prevention).

The following goals and strategies were developed so that they:

- Address the prioritized community health needs and/or populations in the hospital's CBSA.
- Provide approaches across the up-, mid-, and downstream spectrum.
- Are sustainable through hospital or other funding.
- Leverage or enhance community partnerships.
- Have potential for impact.
- Contribute to the systemic, fair, and just treatment of all people.
- Could be scaled to other BILH hospitals.
- Are flexible to respond to emerging community needs.

Recognizing that community benefits planning is ongoing and will change with continued community input, MAH's IS will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies, and other issues that may arise, which may require a change in the IS or the strategies documented within it. MAH is committed to assessing information and updating the plan as needed.

Community Benefits Service Area

MAH's CBSA includes the six municipalities of Arlington, Belmont, Cambridge, Somerville, Watertown, and Waltham to the west of the City of Boston. Collectively, these cities and towns are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education and employment), and geography (e.g., urban and suburban). There is also diversity with respect to community needs. There are segments of MAH's CBSA population that are healthy and have limited unmet health needs, and other segments that face significant disparities in access, underlying social determinants, and health outcomes. MAH is committed to promoting health, enhancing access, and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identity, sexual orientation, disability status, immigration status, or age. MAH is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

MAH's CHNA focused on identifying the leading community health needs and priority cohorts living and/or working within its CBSA. In recognition of the health disparities that exist for some residents, the hospital focuses the bulk of its community benefits resources on improving the health status of those who face health disparities, experience poverty, or have been historically underserved. By prioritizing these cohorts, MAH is able to promote health and well-being, address health disparities and maximize the impact of its community benefits resources.

Beth Israel Lahey Health
Mount Auburn Hospital

Community Benefits Service Area

- H Mount Auburn Hospital
- 1 Mount Auburn Hospital Radiology at Arlington
- 2 Mount Auburn Hospital MRI Center
- 3 Mount Auburn Hospital Rehabilitation Services; Outpatient Physical & Occupational Therapy
- 4 Mount Auburn Hospital Mobile PET Unit
- 5 Mount Auburn Hospital Employee Assistance Program, Occupational Health & Rehabilitation Services
- 6 Mount Auburn Hospital Imaging and Specimen Collection

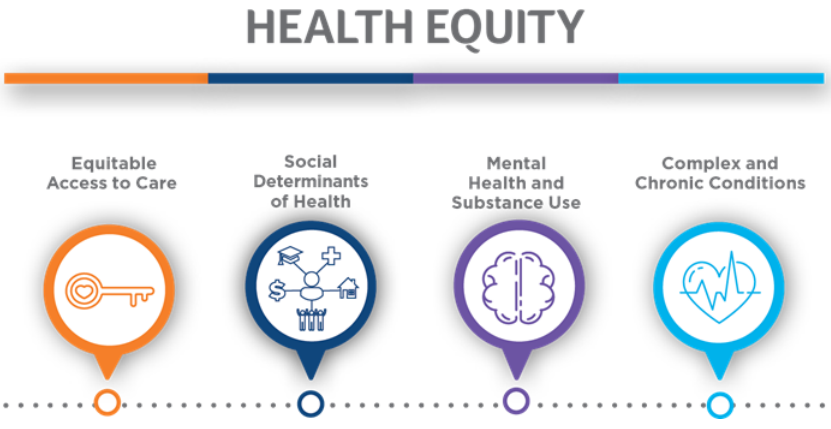
Prioritized Community Health Needs and Cohorts

MAH is committed to promoting health, enhancing access, and delivering the best care for those in its CBSA. Over the next three years, the hospital will work with its community partners to develop and/or continue programming geared to improving overall well-being and creating a healthy future for all individuals, families, and communities. In recognition of the health disparities that exist for certain segments of the population, investments and resources will focus on improving the health status of the following cohorts and community health priority areas.

MAH Priority Cohorts

- Youth
- Low-Resourced Populations
- Older Adults
- Racially, Ethnically and Linguistically Diverse Populations
- LGBTQIA+

MAH Community Health Priority Areas



Community Health Needs Not Prioritized by MAH

It is important to note that there are community health needs that were identified by MAH's assessment that were not prioritized for investment or included in MAH's IS. Specifically, addressing the digital divide (i.e., promoting equitable access to the internet), supporting education across the lifespan, racial equity, and strengthening the built environment (i.e., improving roads/sidewalks and enhancing access to safe recreational spaces/activities) were identified as community needs but were not included in the hospital's IS. While these issues are important, MAH's CBAC and leadership team decided that these issues were outside of the hospital's sphere of influence and investments in other areas were both more feasible and likely to have greater impact. and/or being address by MAH's existing or funded programs. As a result, MAH recognized that other public and private organizations in its CBSA and the Commonwealth were better positioned to focus on these issues. MAH remains open and willing to work with community residents, other hospitals, and other public and private partners to address these issues, particularly as part of a broad, strong collaborative.

Community Health Needs Addressed in MAH's IS

The issues that were identified in the MAH CHNA and are addressed in some way in the hospital's IS are housing issues, food insecurity, transportation, economic insecurity, build capacity of workforce, navigation of healthcare system, linguistic access barriers, cost and insurance barriers, youth mental health, stress, anxiety, depression, isolation, specialists for older adults, mental health stigma, culturally appropriate/competent health and community services, outreach/engagement for specific populations (e.g. non English speakers), resource inventory, and cross sector collaboration/partnerships/ information sharing/ referrals.

Implementation Strategy Details

Priority: Equitable Access to Care

Individuals identified a number of barriers to accessing and navigating the health care system. Many of these barriers are at the system level, and stem from the way in which the system does or does not function. System-level issues include providers not accepting new patients, long wait lists, and an inherently complicated health care system that is difficult for many to navigate.

There are also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forgo or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.

Resources/Financial Investment: MAH expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by MAH and/or its partners to improve the health of those living in its CBSA. Additionally, MAH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, MAH supports residents in its CBSA by providing "charity" care to individuals who are low-resourced who are unable to pay for care and services. Moving forward, MAH will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

Goal: Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic, and economic barriers.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Provide and promote career support services and career mobility programs to hospital employees. Collaborate with local community partners to strengthen the local workforce	• Youth • Older adults • Racially, ethnically, and linguistically diverse populations • Low-resourced populations • LGBTQIA+	• Career and academic advising • Hospital-sponsored community college courses • Hospital-sponsored English Speakers of Other Languages (ESOL) classes • Workforce development partnerships	• # of employees who participated • # and progress of partnerships and opportunities for employment	BILH Workforce Development Somerville Center for Adult Learning Experiences (SCALE) Cambridge Learning Center (CLC) Waltham Partnership for Youth Cole Resource Center First Source Jobs Program Groundwork Somerville	Social Determinants of Health

Promote access to healthcare, health insurance, patient financial counselors, and needed medications for patients who are uninsured or underinsured.	• Youth • Older adults • Racially, ethnically and linguistically diverse • Low-resourced populations • LGBTQIA+	Financial counselors	• # of patients assisted • # financial counselors supported at Charles River Community Health	Charles River Community Health	Social Determinants of Health

Goal: Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic, and economic barriers.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Support partnerships with regional transportation providers and community partners to enhance access to affordable and safe transportation.	• Youth • Older adults • Racially, ethnically, and linguistically diverse populations • Low-resourced populations • LGBTQIA+	• Transportation Program • Cambridge Transportation Advisory Committee • Alewife Transportation Management Association	• # rides provided • Sectors represented • Amount of resources obtained • Skill building/ education shared • # new policies/ protocols implemented	• Somerville, Cambridge, Medford Transportation Services (SCM) • MBTA • Local cab companies • Alewife Transportation Management Association • City of Cambridge Transportation Task Force	Not Applicable
Promote equitable care, health equity, health literacy for patients, especially those who face cultural and linguistic barriers.	• Racially, ethnically, and linguistically diverse populations • Low-resourced populations • LGBTQIA+	• Interpreter Services • Health Literacy and Education Program • Community Health Grant Program – provide an opportunity for grant funding to community organizations and municipalities	• # organizations supported through funding and or technical support • # of patients assisted • # of languages provided • # educational programs • # participants • Evaluation data from program	• LGBTQ+ Alliance of Belmont • Rainbow Commission of Arlington • Arlington Youth Counseling Center • Wayside Youth and Family Services • Y2Y SCALE • Cambridge Community Learning Center • Waltham Family School • Charles River Community Health	Not Applicable

Goal: Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic, and economic barriers.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Promote health equity for new moms.	• Racially, ethnically, and linguistically diverse populations • Low-resourced populations	• Pre/post-natal bilingual outreach worker program. • Doula Program	• # community outreach visits to pre/postnatal patients • # car seats distributed to new moms who otherwise do not have a safe way to transport their newborn • # doula births, evaluation of doula birthing experience	• Charles River Community Health (CRCH)	Not Applicable
Support cities/ towns to promote resilience, emergency care, and emergency preparedness.	• Youth • Older adults • Racially, ethnically, and linguistically diverse populations • Low-resourced populations • LGBTQIA+	• Emergency Medical Services (EMS) training • Serve as EMS Medical Directors for Cambridge, Arlington and Belmont Medical Dispatchers, MIT EMS, and Harvard University EMS • Serve on state and regional EMS advisory boards to lend medical oversight to the region	• # trainings provided • # of participants	• Local health departments • PRO EMS • MIT EMS • Local Police and Fire Departments • Local school systems	Not Applicable

Priority: Social Determinants of Health

The social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions influence and define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to housing, food insecurity, economic insecurity, education and other important social factors.

There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, listening sessions, and the BID Needham Community Health Survey reinforced that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, food insecurity/nutrition, transportation, and economic instability.

Resources/Financial Investment: MAH expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by MAH and/or its partners to improve the health of those living in its CBSA. Additionally, MAH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, MAH supports residents in its CBSA by providing "charity" care to individuals who are low-resourced who are unable to pay for care and services. Moving forward, MAH will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

Goal: Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality of life outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Provide community health grants to support impactful programs that address issues associated with the social determinants of health.	• Older adults • Youth • Linguistically, ethnically, racially diverse • Low-resourced populations • LGBTQIA+	Community Health Grant Program - Grant funding program for community organizations and municipalities	• # Community Health grants awarded • Evaluation data of grant programs funded	To be identified	Not Applicable
Participate in multi-sector community coalitions to convene stakeholders to identify and advocate for policy, systems, and environmental changes to address the social determinants of health.	• Youth • Older adults • Racially, ethnically, and linguistically diverse populations • Low-resourced populations • LGBTQIA+	Join and support multi-sector community coalitions which convene stakeholders to identify and advocate for policy, systems, and environmental changes to address the social determinants of health	• Sectors represented • Amount of resources obtained • # of new partnerships developed • Skill-building/education shared • # new policies/protocols implemented	• Somerville Stakeholders Coalition • Cambridge Council on Aging • Waltham Interagency Network • Waltham Connections • Elder Services Providers Network • Watertown Cares Network • W2B2 Youth Wellness Collaborative	Not Applicable

Goal: Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Support education, systems, programs, and environmental changes to increase healthy eating and access to affordable, healthy foods.	• Youth • Older adults • Racially, ethnically, and linguistically diverse populations • Low-resourced populations • LGBTQIA+	• Community Food Distribution Program • Food Access Program	• Pounds of food distributed • # of Individuals provided food and their demographics • # organizations supported through funding and or technical support	• Arlington Eats • Healthy Waltham • Somerville Homeless Coalition • Local food pantries • Waltham Fields Community Farm	Not Applicable
Screen, assess, and connect patients with health-related social needs.	• Youth • Older adults • Racially, ethnically, and linguistically diverse populations • Low-resourced populations • LGBTQIA+	Social Determinants of Health Screening program	• # families/ residents identified as being food insecure and/or housing insecure • # families/ residents receiving referrals to community resources	• Local SNAP Match programs • Metro Housing Boston • Local community based organizations and social service agencies	Not Applicable
Support programs that stabilize or create access to affordable housing.	• Youth • Older adults • Racially, ethnically, and linguistically diverse populations • Low-resourced populations • LGBTQIA+	Metro Housing Boston (MHB) program	• # patients referred to MHB case manager • # of families prevented from homelessness	Metro Housing Boston	Not Applicable

Priority: Mental Health and Substance Use

Anxiety, chronic stress, depression, and social isolation were leading community health concerns. There were specific concerns about the impact of mental health issues for youth and young adults, and social isolation among older adults. These difficulties were exacerbated by COVID-19.

In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services. Interviewees, focus group, and community listening session participants reflected on the stigma, shame, and isolation that those with mental health challenges face that limit their ability to access care and cope with their illness.

Substance use continued to have a major impact on the CBSA; the opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities. Interviewees reported a need for programs that address common co-occurring issues, including mental health issues and homelessness. Interviewees also reflected on the need for transitional housing and other recovery support services.

Resources/Financial Investment: MAH expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by MAH and/or its partners to improve the health of those living in its CBSA. Additionally, MAH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, MAH supports residents in its CBSA by providing "charity" care to individuals who are low-resourced and are unable to pay for care and services. Moving forward, MAH will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Address the unique mental health needs of historically underserved youth.	• Youth • LGBTQIA+ • Racially, ethnically, and linguistically diverse populations	Community Health Grant Program - Provide an opportunity for grant funding for community organizations and municipalities	Evaluation data of grant programs	• LGBTQ+ Alliance of Belmont • Rainbow Commission of Arlington • Arlington Youth Counseling Center • Wayside Youth and Family Services	Not Applicable

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Provide access to high-quality and culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation, and treatment.	• Youth • Older adults • Racially, ethnically, and linguistically diverse populations • Low-resourced populations • LGBTQIA+	• Emergency Department social work navigator to support START (Substance Treatment and Referral Team) • Provide support groups • Mindfulness Based Stress Reduction Class to community • BILH Collaborative Care model	• # patients screened by social worker • # support groups offered, • # participants, evaluation data of support groups • # MBSR Sessions, # participants, evaluation data of program • # of patients referred through the Collaborative Care model	BILH Behavioral Health	Equitable Access to Care
Promote collaboration, share knowledge, and coordinate activities internally at MAH and externally with community partners.	• Youth • Older adults • Racially, ethnically, and linguistically diverse populations • Low-resourced populations • LGBTQIA+	• Social Work Community Support • Support and partner with community organizations to foster access to mental health care and services	• # of resources shared • Sectors represented • # of new partnerships developed • Increased communication among partners	• Cambridge Police Department (CPD) stakeholders • CPD Homelessness Task Force • Watertown Cares Network • Metro Housing Boston • Access Health, MA • CHNA 17	Not Applicable
Advocate for and support policies and systems that improve behavioral health services.	• Youth • Older adults • Racially, ethnically, and linguistically diverse populations • Low-resourced populations • LGBTQIA+	Support relevant policies when proposed	# of policies and/or support system initiatives supported	BILH Government Relations	Not Applicable

Priority: Chronic and Complex Conditions

Chronic conditions such as cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease contribute to 56% of all mortality in Massachusetts and over 53% of all health care expenditures ($30.9 billion a year). Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

Resources/Financial Investment: MAH expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by MAH and/or its partners to improve the health of those living in its CBSA. Additionally, MAH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, MAH supports residents in its CBSA by providing "charity" care to individuals who are low-resourced who are unable to pay for care and services. Moving forward, MAH will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

Goal: Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications, and other resources.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Ensure older adults have access to coordinated healthcare, supportive services and resources that support overall health and the ability to age in place.	Older adults	• Healthy Aging Program • Blood pressure screenings • Lifeline Services	• # educational programs • # of participants • Evaluation data of program • # of blood pressure clinics provided in the community • # People served • # of community members receiving Lifeline at reduced cost or below rate	• Area Councils on Aging (COAs) • Springwell • Somerville Cambridge Elder Services • Lifeline Services • Local community based services • Local Health Departments	Equitable Access to Care
Provide preventive health information, services, and support for those at risk for complex and/or chronic conditions and support evidence-based chronic disease treatment and self-management programs.	• Older adults • Racially, ethnically, and linguistically diverse populations • Low-resourced populations • LGBTQIA+	• Free Cancer Screening Program • Survivorship Day Event • Stroke Nurse Navigator Program • Breast Cancer Support Group • Caregiver's Support Group	• # free cancer screenings provided • Time between cancer finding and treatment • # people who participated • # of education materials distributed	• CRCH • Community-based organizations • COAs • Elder service providers • Joslin Diabetes Center • Waltham Family School • SCALE • Cambridge Learning Center • Cambridge and Somerville Programs for Addiction Recovery (CASPAR) • American Cancer Society	Not Applicable

General Regulatory Information

Contact Person:	Mary DeCourcey, Director of Community Benefits
Date of written report:	June 30, 2022
Date written report was approved by authorized governing body:	September 13, 2022
Date written plan was approved by authorized governing body:	September 13, 2022
Date written plan was required to be adopted:	February 15, 2023
Date of amended written report:	June 1, 2025
Date amended written report was approved by authorized governing body:	June 10, 2025
Date of amended written plan:	June 1, 2025
Date amended written plan was adopted by authorized governing body:	June 10, 2025
Authorized governing body that adopted the written plan:	Mount Auburn Hospital Board of Trustees
Was the written plan adopted by the authorized governing body on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed?	☑ Yes ☐ No
Date facility's prior written plan was adopted by organization's governing body:	September 14, 2021
Name and EIN of hospital organization operating hospital facility:	Mount Auburn Hospital 327-702-528
Address of hospital organization:	330 Mount Auburn Street, Cambridge, MA 02138

Beth Israel Lahey Health
Mount Auburn Hospital