Community Benefits Report

Fiscal Year 2025

Beth Israel Lahey Health
Mount Auburn Hospital

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SECTION I: SUMMARY AND MISSION STATEMENT

Mount Auburn Hospital (MAH) is a member of Beth Israel Lahey Health (BILH). The BILH network of affiliates is an integrated health care system committed to expanding access to extraordinary patient care across Eastern Massachusetts and southern New Hampshire and advancing the science and practice of medicine through groundbreaking research and education. The BILH system is comprised of academic and teaching hospitals, a premier orthopedics hospital, primary care and specialty care providers, ambulatory surgery centers, urgent care centers, community hospitals, homecare services, outpatient behavioral health centers, and addiction treatment programs. BILH's community of clinicians, caregivers and staff includes approximately 5,900 physicians and 36,000 employees.

At the heart of BILH is the belief that everyone deserves high-quality, affordable health care. This belief is what drives BILH to work with community partners across the region to promote health, expand access, and deliver the best care in the communities BILH serves. MAH's Community Benefits staff are committed to working collaboratively with its communities to address the leading health issues and create a healthy future for individuals, families and communities.

While MAH oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Community and Health Impact Officer. This structure makes sure that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WE CARE:*

- ***W****ellbeing - We provide a health-focused workplace and support a healthy work-life balance*
- ***E****mpathy - We do our best to understand others' feelings, needs and perspectives*
- ***C****ollaboration - We work together to achieve extraordinary results*
- ***A****ccountability - We hold ourselves and each other to behaviors necessary to achieve our collective goals*
- ***R****espect - We value diversity and treat all members of our community with dignity and inclusiveness*
- ***E****quity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.*

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

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

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

More broadly, Mount Auburn Hospital's Community Benefits mission is fulfilled by:

- **Involving Mount Auburn Hospital's staff**, including its leadership and dozens of community partners in the Community Health Needs Assessment (CHNA) process as well as in the development, implementation, and oversight of the hospital's three-year Implementation Strategy (IS);

- **Engaging and learning from residents** throughout MAH's Community Benefits Service Area (CBSA) in all aspects of the Community Benefits process, with special attention focused on engaging diverse perspectives, from those, patients and non-patients alike, who are often left out of similar assessment, planning and program implementation processes;

- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to understand unmet health-related needs and identify communities and population segments disproportionately impacted by health issues and other social, economic and systemic factors;

- **Implementing community health programs and services** MAH's CBSA that address the underlying social determinants of health, barriers to accessing care, as well as promote equity to improve the health status of those who are often disadvantaged, face disparities in health-related outcomes, experience poverty, and have been historically underserved;

- **Promoting health equity** by addressing inequities and ensuring that all patients are welcomed and received with respect and have access to culturally responsive care; and

- **Facilitating collaboration and partnership within and across sectors** (e.g., state/local public health agencies, health care providers, social service organizations, businesses, academic institutions, community health collaboratives, and other community health organizations) to advocate for, support, and implement effective health policies, community programs, and services.

The following annual report provides specific details on how MAH is honoring its commitment and includes information on MAH's CBSA, community health priorities,

priority cohorts, community partners, and detailed descriptions of its Community Benefits programs and their impact.

Priority Cohorts

Mount Auburn Hospital's CBSA Arlington, Belmont, Cambridge, Somerville, Waltham and Watertown. In FY 2025, MAH conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included extensive data collection activities, substantial efforts to engage MAH's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines (February 2018). While MAH is committed to improving the health status and well-being of those living throughout its entire CBSA, per the Commonwealth's updated community benefits guidelines, Mount Auburn Hospital's FY 2026 - 2028 Implementation Strategy (IS) will focus its Community Benefits resources focused on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved living in its CBSA.

Based upon Mount Auburn Hospital's FY 2025 CHNA, the community characteristics that were thought to have the greatest impact on health status and access to care in its CBSA were issues related to age, race/ethnicity, language, gender identity, immigration status, household composition, and economic security. There was consensus among interviewees, focus groups, and community listening session participants that people of color, recent immigrants, and non-English speakers were more likely to have poor health status and face systemic challenges accessing needed services than white, English speakers who were born in the United States. These segments of the population are impacted by language and cultural barriers that limit access to appropriate services, pose health literacy challenges, exacerbate isolation, and may lead to discrimination and disparities in access and health outcomes.

For its FY 2026 – 2028 IS, MAH 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, MAH's Community Benefits investments and resources will focus on improving the health status of the following priority cohorts:

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

Basis for Selection

Community health needs assessments; public health data available from government (public school districts, Massachusetts Department of Public Health, federal agencies) and private resources (foundations, advocacy groups); and MAH's areas of expertise.

Key Accomplishments for Reporting Year

MAH's most recent FY 2025 CHNA and FY 2026-FY 2028 IS were approved and adopted, respectively, by the MAH's Board of Trustees during the fiscal year ended September 30, 2025. That CHNA and IS will inform the Community Benefits mission and activities of MAH for the fiscal years ending September 30, 2026; September 30, 2027; and September 30, 2028.

This report covers MAH's fiscal year ending September 30, 2025. The previous FY 2022 CHNA and accompanying FY 2023-FY 2025 IS were approved by the MAH Board before September 30, 2022 and an amended FY 2022 CHNA report and amended FY 2023-2025 IS were approved by the MAH Board on June 10, 2025. These documents informed MAH's Community Benefits initiatives for the fiscal years ending September 30, 2023; September 30, 2024; and September 30, 2025. As such, the accomplishments and activities included in this section as well as in Section IV: Community Benefits Programs relate to the CHNA and Implementation Strategy and the amended versions approved as of September 30, 2022 and June 10, 2025, respectively.

Program accomplishments include:

- Provided a new grant opportunity to community based organizations. MAH was able to fund five organizations to work on programs that help to increase their capacity to address the top health concerns identified in MAH's CHNA and in their community.
- Provided Health Education through MAH's Health Literacy program to over 170 English language learners.
- Financial Counselors assisted 3,957 people with new applications, renewals and public assistance programs including help to enroll in and receive health insurance benefits. This includes both MAH and at Charles River Community Health sites.
- Through the MAH Collaborative Care Model behavioral health services was able to provide 1,771 behavioral health services across 11 sites.
- 55 clients received case management supports, such as safety planning, food or clothing assistance, housing navigation, technology assistance, help completing paperwork, referral for legal or medical services, and accompaniment to court hearings, among other services, through De Novo Center for Justice and Healing case management services.
- Reduced food insecurity by providing food for distribution to those who have been severely impacted by food insecurity. Provided and distributed 300 dozen eggs and 300 loaves of bread.
- Contributed to supporting an increase in SNAP Match enrollments and healthy food incentives for use at farmer's markets within our service area by collaborating with

cities and towns to promote enrollment. The total number of individuals benefiting from this SNAP Match program was 1,952.

- Provided over 300 women with navigational and emotional support as well as referrals to community resources. This included over 2,500 encounters of support including, helping with governmental assistance programs, birth certificates, SSI office visits, immigration status, baby first appointments, billing issues and helping to prepare moms for appointment and hospital follow-up visits.

Plans for Next Reporting Year

In FY 2025, MAH conducted a comprehensive and inclusive CHNA that included extensive data collection activities, substantial efforts to engage Mount Auburn Hospital's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines. In response to the FY 2025 CHNA, MAH will focus its FY 2026 - 2028 IS on four priority areas. These priority areas collectively address the broad range of health and social issues facing residents living in Mount Auburn Hospital's CBSA who face the greatest health disparities. These four priority areas are:

- Equitable Access to Care
- Social Determinants of Health
- Mental Health and Substance Use
- Complex and Chronic Conditions.

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). Mount Auburn Hospital's priorities are also aligned with the priorities identified by the Massachusetts Department of Public Health (DPH) to guide the Community-based Health Initiative (CHI) investments funded by the Determination of Need (DoN) process, which underscore the importance of investing in the Social Determinants of Health (i.e., built environment, social environment, housing, violence, education, and employment).

The FY 2025 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions being used to inform and refine Mount Auburn Hospital's efforts. In completing the FY 2025 CHNA and creating its FY 2026 - 2028 IS, Mount Auburn Hospital, along with its other health, public health, social service, and community partners, 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. As discussed above, based on the FY 2025 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that for Mount Auburn Hospital's FY 2026 - 2028 IS, it should work with its community partners to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, Mount Auburn Hospital's Community

Benefits investments and resources will continue to focus on improving the health status, addressing disparities in health outcomes, and promoting health equity for its priority cohorts, which include youth; low-resourced populations; older adults; racially, ethnically and diverse populations; and LGBTQIA+ communities.

MAH will partner with clinical and social service providers, community-based organizations, public health officials, elected/appointed officials, hospital leadership, and other key collaborators throughout its CBSA to execute its FY 2026 – 2028 IS.

- **Equitable Access to Care**
  - MAH will work with the Charles River Community Health to support its Prenatal/Post Natal Bilingual Outreach Program.
  - MAH will continue to provide effective and high-quality interpreter services for patients who request this service in order to improve access to care.

- **Social Determinants of Health**
  - MAH will continue to support the SNAP Match programs at the local farmers market to improve access to healthy foods.
  - MAH will continue to partner with Housing Rehab Inc. to help support housing stabilization for those individuals who are at risk of losing their housing.
- **Mental Health and Substance Use**
  - MAH will continue to collaborate with De Novo Center for Justice and Healing to help support its Culturally Informed Counseling Program.
  - MAH will continue to connect people to behavioral health services through its Collaborative Care model.
- **Complex and Chronic Conditions**
  - MAH will continue its healthy aging program which partners with local Councils on Aging and provides a venue for older adults to learn about preventing and/or managing chronic conditions as well as healthy aging.
  - MAH will continue to partner with many area agencies to promote stroke prevention and how to recognize the signs of stroke for early intervention to save lives.

Hospital Self-Assessment Form
Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), the MAH Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 63). The MAH Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members and asked them to submit the form to the AGO website.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team
MAH's Board of Trustees along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its CBSA and beyond. World-class clinical expertise, education and research along with an underlying commitment to health equity are the primary tenets of its mission. 's Community Benefits Department, under the direct oversight of MAH's Board of Trustees, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations. Hospital senior leadership is actively engaged in the development and implementation of the MAH's Implementation Strategy, ensuring that hospital policies and resources are allocated to support planned activities.

It is not only the MAH's Board of Trustee members and senior leadership who are held accountable for fulfilling MAH's Community Benefits mission. Among MAH's core values are the recognition that the most successful Community Benefits programs are implemented organization wide and integrated into the very fabric of the hospital's culture, policies, and procedures. A commitment to Community Benefits is a focus and value manifested throughout BILH and MAH's structure and reflected in how care is provided at the hospital and in affiliated practices.

While MAH oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Community and Health Impact Officer. This structure makes sure that Community Benefits efforts, prioritization, planning, and strategy focus on equity and align and are integrated with local and system strategic and regulatory priorities to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WE CARE:*

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The MAH Community Benefits program is spearheaded by the Director of Community Benefits who has direct access to and is accountable to the MAH President and the BILH Vice President of Community Benefits and Community Relations, the latter of whom reports

directly to the BILH Chief Community and Health Impact Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of cohorts who have been historically underserved are considered every day in discussions on resource allocation, policies, and program development.

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

Community Benefits Advisory Committee (CBAC)
The MAH Community Benefits Advisory Committee (CBAC) works in collaboration with MAH's hospital leadership, including the hospital's governing board and senior management to support Mount Auburn Hospital's Community Benefits mission to serve its patients compassionately and effectively, and to create a healthy future for them, their families, and Mount Auburn Hospital's community. The CBAC provides input into the development and implementation of MAH's Community Benefits programs in furtherance of MAH's Community Benefits mission. The membership of MAH's CBAC aspires to be representative of the constituencies and priority cohorts served by MAH's programmatic endeavors, including those from diverse racial and ethnic backgrounds, age, gender, sexual orientation and gender identity, as well as those from corporate and non-profit community organizations.

The MAH CBAC met on the following dates:

December 19, 2024
March 20, 2025
June 12, 2025
September 18, 2025

Community Partners
MAH recognizes its role as a tertiary/academic resource in a larger health system and knows that to be successful it needs to collaborate with its community partners and those it serves. MAH's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy (IS) were completed in close collaboration with MAH staff, community residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership and other key collaborators from throughout its CBSA. Mount Auburn Hospital's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of MAH's mission.

MAH currently supports numerous educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA. In the work, MAH collaborates with many of its local community-based organizations, public health departments, municipalities, and clinical and social service organizations. MAH has a particularly strong relationship with Charles River Community Health (CRCH) in Waltham. This relationship includes providing a strong OB/GYN and Midwifery program.

The following is a comprehensive listing of the community partners with which MAH joins in assessing community need as well as planning, implementing, and overseeing its Community Benefits Implementation Strategy. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment (Section VII, page 63).

• Africano Waltham	• Lamplight Literacy Center
• Arlington Eats	• Local Municipalities and Health Departments
• Arlington Youth Counseling Services	• Metro Housing Boston
• Belmont Food Collaborative	• More Than Words, Waltham
• Cambridge Engagement Center	• Paine Senior Services
• Cambridge Health Alliance	• Project Literacy, Watertown
• Cambridge Neighbors	• Rainbow Coalition, Arlington
• Cambridge, Comm. for Persons with Disabilities	• Somerville Cambridge Elder Services
• Community Day Center of Waltham	• Somerville Farmer's Market
• CORE Mental Health	• Somerville Homeless Coalition
• Councils on Aging	• Springwell (Area Agency on Aging)
• Charles River Community Health	• Transition House, Cambridge
• Data Plus Soul Consulting	• Waltham Connections for Healthy Aging
• De Novo Center for Justice and Healing	• Waltham Family School
• Find It Cambridge	• Waltham Fields Community Farm
• Greater Boston PFLAG	• Waltham Partnership for Youth
• Healthy Waltham	• Watch CDC
• Homeowner's Rehab INC	• Watertown Wellness
• Housing Corp of Arlington	• Wayside Youth and Family Services
• Kingdom Empowerment Center	• Y2Y Network

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY 2025 Community Health Needs Assessment (CHNA) along with the associated FY 2026-2028 Implementation Strategy was developed over a fifteen-month period from June 2024 to September 2025. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill the LHMC's need to conduct a community health needs assessment, engage the community, identify priority health issues, inventory community assets, assess impact, and develop an Implementation Strategy. However, these activities are driven primarily by MAH's dedication to its mission, its covenant to cohorts who have been historically underserved, and its commitment to community health improvement.

As mentioned above, MAH's most recent CHNA was completed during FY 2025. FY 2025 Community Benefits programming was informed by the FY 2022 CHNA and aligns with MAH's FY 2023 – FY 2025 Implementation Strategy. The following is a summary description of the FY 2025 CHNA approach, methods, and key findings.

Approach and Methods
The FY 2025 assessment and planning process was conducted in three phases between June 2024 and September 2025, which allowed MAH to:

- assess community health, defined broadly to include health status, social determinants, environmental factors and service system strengths/weaknesses;
- engage members of the community including local health departments, clinical and social service providers, community-based organizations, community residents and MAH's leadership/staff;
- prioritize leading health issues/population segments most at risk for poor health, based on review of quantitative and qualitative evidence;
- develop a three-year Implementation Strategy to address community health needs in collaboration with community partners, and;
- meet all federal and Commonwealth Community Benefits requirements per the Internal Revenue Service, as part of the Affordable Care Act, the Massachusetts Attorney General's Office, and the Massachusetts Department of Public Health.

MAH's Community Benefits program is predicated on the hospital'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 inequities and socioeconomic barriers to accessing care. Throughout the CHNA 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. MAH's understanding of these communities' needs is derived from collecting a wide range of quantitative data to identify disparities and clarify the needs of specific communities and comparing it against data collected at the regional, Commonwealth and national levels wherever possible to support analysis and the prioritization process, as well as employing a variety of strategies to ensure community members were informed, consulted, involved, and empowered throughout the assessment process.

Through the FY 2025 Community Health Needs Assessment process, MAH conducted 15 interviews with key collaborators in the community, facilitated five focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 700 residents, and organized one community listening session. In total, the assessment process collected information from more than 800 community residents, clinical and social service providers, and other community partners.

The articulation of each specific community's needs (done in partnership between MAH and community partners) is used to inform MAH's decision-making about priorities for its Community Benefits efforts. MAH works in concert with community residents and leaders to design specific actions to be collaboratively undertaken each year. Each component of the plan is developed and eventually woven into the annual goals and agenda for the MAH's Implementation Strategy that is adopted by the MAH's Board of Trustees.

Summary of FY 2025 CHNA Key Health-Related Findings

Equitable Access to Care

- 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 full provider panels, which prevented providers from 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 forego 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.

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, access to care/navigation issues, and other important social There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, surveys, and the listening session reinforced that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, food security/nutrition, transportation and economic stability.

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; trauma experienced by immigrants, migrants, and refugees, and social isolation among older adults.
- In addition to the overall burden and prevalence of mental health issues, residents identified a need for assistance navigating a complex behavioral health system, as it can be overwhelming for individuals experiencing mental health challenges. Providing navigation assistance ensures people can access the right services at the right time, improving continuity of care and health outcomes.
- Youth mental health was a concern in the CBSA, including the prevalence of chronic stress, anxiety, and behavioral issues. These conditions were exacerbated throughout the pandemic, because of isolation, uncertainty, remote learning, and family dynamics.

Complex and Chronic Conditions

- Chronic conditions like cancer, heart disease, chronic lower respiratory disease, and stroke account for four of the six leading causes of death statewide, and it is estimated that there are more than $41 billion in annual costs associated with chronic disease. Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

For more detailed information, see the full FY 2025 MAH Community Health Needs Assessment Report and Implementation Strategy on the hospital's website.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Equitable Access to Care **Program Name: Addressing BILH Patient Health Disparities** **Health Issue: Additional Health Need Identified by the Community**		
Brief Description or Objective	BILH Health Equity Division sits within the Office of Community and Health Impact. BILH's Health Equity team focuses on addressing health disparities to ensure equitable health outcomes across the patient populations served by BILH.	
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Meet or exceed goal of 2.65% reduction in the occurrence of Severe Maternal Morbidity-Blood Transfusions during the measurement period ending September 30, 2025.	
Goal 1 Status	Goal Not Met: 2.91% of BILH patients received Severe Maternal Morbidity-Blood Transfusions	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal 2	Meet or exceed goal of 69.6% of BILH patients 18-85 years of age with a diagnosis of both diabetes and hypertension who meet control targets for both conditions (HbA1c <= 9.0% AND BP < 140/90 mmHg criteria) during the measurement period ending September 30, 2025	
Goal 2 Status	Goal Met: 70.4% of the focus population met the control targets for both conditions (HbA1c <= 9.0% AND BP < 140/90 mmHg criteria) during the measurement period through September 2025	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal 3	Meet or exceed goal of 74.8% of BILH patients 18-85 years of age with a diagnosis of hypertension whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period ending September 30,	
Goal 3 Status	Goal Met: 75% of the focus population had blood pressure that was adequately controlled (< 140/90 mmHg) during the measurement period	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal 4	Meet or exceed goal of 76.5% of BILH patients 18-85 years of age diagnosed with diabetes (Type 1 and Type 2) who had a hemoglobin A1c (HbA1c) level of <= 9.0% during the measurement period ending September 30, 2025	
Goal 4 Status	Goal Met: The average percentage, of the identified population above, whose hemoglobin A1c (HbA1c) level was <= 9.0% during the measurement period was 78.4% which exceeded the target average goal of 76.5%	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Addressing Substance Use in the Homeless Community** **Health Issue: Homelessness**			
Brief Description or Objective	MAH has partnered with Community Day Center of Waltham (CDCW) which provides food, shelter, clothing and referrals for medical, dental, and mental health services for those who are unsheltered. This program supports a part-time, in-house drug counselor who collaborates closely with the case management team. The counselor provides targeted support to two key client groups with active alcohol and substance use challenges: individuals seeking housing who are not yet "housing ready" and newly housed clients at risk of losing their apartments.		
Program Type	☐Direct Clinical Services ☐Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	Over 50% of program participants will have completed 5 or more recovery meetings by the end of FY25.		
Goal 1 Status	Complete: Over 50% of program participants have completed 5 or more recovery meetings.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal 2	Successfully place over 25 clients into stable housing.		
Goal 2 Status	Complete: 29 clients were successfully placed into stabilized housing since the start of the grant period.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Behavioral Health Crisis Consultation** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	To provide 24/7/365 behavioral health crisis evaluation in the emergency department (ED) and throughout other hospital units for individuals experiencing mental health and substance use related crisis. Services are payer agnostic and provided via in-person or telehealth by a multidisciplinary team of qualified professionals, including Psychiatrists, independently licensed and Master level clinicians, Nurse Practitioners, Registered Nurses, Certified Peer Specialists, and Family Partners. The services include initial assessments for risks, clinical stabilization, treatment initiation, care coordination, and ongoing evaluation to ensure appropriate level of care placement.	
Program Type	☒ Direct Clinical Services ☐Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Increase access to clinical and non-clinical support services for those with mental health and substance use issues, by providing behavioral health services in the hospital.	
Goal 1 Status	A multidisciplinary team, comprised of qualified behavioral health providers, psychiatry, family partners, and peer specialists, is employed to provide behavioral health crisis consultations in the Emergency Department or medical floors of the hospital. In FY25, the team provided a total of 1,802 screenings.	
Time Frame Year: Year 2	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Bereavement Support Group** **Health Issue: Mental Health/Mental Illness**			
Brief Description or Objective	This support group provides a safe space for adult community members to support each other through the grieving process and gives them the opportunity to share their feelings and stories with others who are losing or have lost a loved one. Those in the support group have an opportunity to meet others who are going through a similar experience.		
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	Provide at least two Bereavement Support Group sessions for community members.		
Goal 1 Status	Three eight week-long sessions were completed and 26 community members attended.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal 2	At least 80% of participants report that they were given the opportunity to express their feelings and felt respected.		
Goal 2 Status	100% of participants who took the survey report that they were given the opportunity to express their feelings and felt respected.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	
Program Goal 3	At least 80% of participants report being satisfied or very satisfied with the program.		
Goal 3 Status	100% of participants who took the survey reported being satisfied or very satisfied with the program.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Equitable Access to Care **Program Name: BILH Workforce Development** **Health Issue: Additional Health Needs Identified by the Community**			
Brief Description or Objective	BILH is strongly committed to workforce development programs that enhance the skills of its diverse employees and provide career advancement opportunities. BILH offers incumbent employees pipeline programs to train for professions such as Patient Care Technician, Central Processing Technician and Associate Degree Nurse Resident. BILH Employee Career Initiative provides career and academic counseling, academic assessment, and pre-college and college-level science courses to employees at no charge, along with tuition reimbursement, competitive scholarships and English for Speakers of Other Languages (ESOL) classes. BILH is also committed to making employment opportunities available to qualified community residents through training internships conducted in partnership with community agencies and hiring candidates referred by community programs.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	In FY25, Workforce Development will offer paid trainings for community members across BILH.		
Goal 1 Status	In FY25, BILH trained total of 97 community members to pipeline programs, including Patient Care Technician/ Nursing Assistant, Pharmacy Tech, Medical Assistant, CPT, Surg Tech, Research Admin, Endoscopy Tech, and he Associate Degree Nursing Residency program. MAH participated in offering these trainings.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal 2	In FY25, Workforce Development will offer internships in BILH hospitals to community members over the age of 18.		
Goal 2 Status	In FY25, 131 community members placed in internships across BILH hospitals to learn valuable skills. MAH participated in offering these internships.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal 3	In FY25, Workforce Development will offer English for Speakers of Other Languages (ESOL) classes to BILH employees.		
Goal 3 Status	In FY25, 126 employees across BILH were enrolled in ESOL classes.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal 4	In FY25, Workforce Development will offer employees career development services.		
Program Status 4	In FY25, 831 BILH employees received career development services.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**	

Program Goal 5	In FY25, Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees.		
Program Status 5	In FY25, A 12 BILH employees attended citizenship classes, 102 BILH employees attended career development workshops and 138 BILH employees attended financial literacy classes.		
Time Frame Year: Year 3		**Time Frame Duration: Year 3**	**Goal Type:** Process **Goal**
Program Goal 6	In FY25, Workforce Development will hire interns hired after internships and place in BILH hospitals.		
Program Status 6	In FY25, 36 interns were hired permanently in BILH hospitals. MAH participated in these hirings.		
Time Frame Year: Year 3		**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 7	In FY25, Workforce Development will continue to encourage community referrals and hires.		
Program Status 7	In FY25, 306 job seekers were referred to BILH and 79 were hired across BILH hospitals.		
Time Frame Year: Year 3		**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 8	In FY25, Workforce Development will attend events and give presentations about employment opportunities to community partners.		
Program Status 8	In FY25, 42 events and presentations were conducted with community partners across the BILH service area		
Time Frame Year: Year 3		**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: MAH Workforce Development** **Health Issue: Additional Health Needs Identified by the Community**		
Brief Description or Objective	MAH offers career development and health care training information to high school and college level students as well as adults in the community.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	In FY25, MAH will offer career development and health care training information to college level students and adults in the community	
Program Status 1	In FY25, MAH provided career development and health care training information to 70 college level students and 10 adults in a career development program.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: BILH Behavioral Health Access Initiative** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	To support increased access to mental health and substance use services and supports, MAH participated with other BILH hospitals to pilot Behavioral Health Navigator grant programs, offer Mental Health First Aid (MHFA) trainings, provide behavioral health navigation and digital literacy trainings to BILH physical health navigators and amplify anti-stigma messaging, resources and supports.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Increase knowledge and awareness of available behavioral health services and supports among clinical and non-clinical staff who provide patients/clients with physical and/or social determinants of health navigation services.	
Goal 1 Status	Two (2) Behavioral Health Navigation and Digital Literacy workshops were conducted in FY25 with 13 participants, including RNs, CHWs/Navigators, Social Workers and a Housing Case Manager. In the program evaluation, 82% of participants felt confident to help navigate patients to appropriate behavioral health care and 70% felt confident to guide patients to web-based apps to help them meet their behavioral health needs.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal 2	Offer Mental Health First Aid (MHFA) trainings to community residents and BILH staff across the BILH Community Benefits Service Area (CBSA).	
Goal 2 Status	More than 146 community residents and BILH staff attended one of 11 MHFA trainings (9 Adult and 2 Youth, with 1 of the Adult trainings conducted in Spanish) provided across the BILH CBSA, of which 53% (78) completed all pre- and post-training requirements to receive Mental Health First Aid certification.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Birthing Center Program** **Health Issue: Access to Care**		
Brief Description or Objective	BILH supports the Cambridge Health Alliance (CHA) birthing center through funding that focuses on and supports low-resourced patients. This program provided funding for the CHA birthing center to re-open.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	In FY25, the CHA birthing center will work towards accreditation and compliance in order to re-op to increase access to outpatient birthing centers for low resourced community members.	
Goal 1 Status	In FY25, CHA worked to renovate the space and plan for re-opening the birthing center. The projected date of opening is July 2026.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Co-Location Program** **Health Issue: Housing Stability/Homelessness**		
Brief Description or Objective	This program is a partnership with Metro Housing Boston (MHB). MAH collaborates with MHB to improve access for patients and community members. This program connects patients to community resources and supports a case manager for people experiencing housing instability. The Co-Location program provides free counseling services to individuals and families to help access housing stability and economic mobility resources with the aim of improving their health and quality of life.	
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	In FY25, Metro Housing will serve at least 50 participants who present with a housing concern or crisis.	
Goal 1 Status	In FY25, Metro Housing served 70 participants who presented a housing concern or crisis.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health **Program Name: Coalition Building** **Health Issue: Access to Care**		
Brief Description or Objective	To address the social determinants of health, healthy aging, prevention and self-management of chronic illness, mental health and substance use disorders, MAH continues to support a wide range of community groups by supporting them through technical assistance and participation at regular meetings. At these meetings, stakeholders share experiences, ideas and best practices. This gives MAH an opportunity to listen to concerns of the community in order to help strategize community benefits work. This work also helps to inform MAH's Community Health Needs Assessment process.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Build connections between community members and hospital staff as well as provide community engagement opportunities.	
Goal 1 Status	In FY25, MAH staff attended 46 community coalition, community building and or community task force meetings in its service area	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Collaboration with CORE MH to support its fellowship program** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	MAH collaborates with CORE MH to help support its fellowship in mental health program. MAH provides funding, technical assistance and active steering committee membership.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	To help support CORE MH to fulfill its mission to promote healthier people and communities by fostering community engagement, elevating innovative and best practices and supporting its mental health fellowship program.	
Goal 1 Status	MAH provided funding, technical assistance and active steering committee membership.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use Disorder **Program Name: Collaborative Care Model** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	To increase access to mental health services, MAH has implemented the Collaborative Care model, a nationally recognized primary care led program that specializes in providing behavioral health services in the primary care setting. The services provided by a BILH licensed behavioral health clinician, include counseling sessions, phone consultations with a psychiatrist, and coordination and follow-up care. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treat a variety of medical and mental health conditions.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	To increase access to behavioral health services through the Collaborative Care model.	
Goal 1 Status	Provided behavioral health services to 1,771 patients across eleven sites.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Equitable Access to Care **Program Name: Community and Professional Education for Emergency Care** **Health Issue: Access to Care**			
Brief Description or Objective	MAH Emergency Department (ED) physicians work with Arlington, Belmont, Cambridge, Watertown, Lexington Fire and Police departments, and privately owned Professional EMS to increase their capacity to serve community members in need of emergent care. MAH provides an EMS medical director who works with affiliated EMS services to provide credentialing, continuous review/quality assurance, and education for affiliated community EMTs and paramedics. This involves protocol reviews, medical control, monthly education sessions, and other educational opportunities.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	MAH ED Physicians will meet with Belmont, Watertown, Cambridge, and Lexington Fire Department pre-hospital providers as well as Pro EMS and MIT EMS providers to review cases and discuss best practices and processes for treatment and outcome improvement.		
Goal 1 Status	Six peer review sessions were provided by MAH ED Physicians for Belmont, Watertown, Cambridge and Lexington Fire Departments and Pro Ambulance EMS service. Arlington's education is done once per year and MIT EMS twice per year.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal 2	MAH Emergency Physicians will provide at least 2 "Life Threatening Emergency - what to do" classes to community organizations who are requesting training.		
Goal 2 Status	3 sessions of "Life Threatening Emergency - What to do" were provided to community organizations and municipal staff. Approximately 50 people were trained.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal 3	At least eighty percent of those who participated in the Life Threatening Emergency" program report they learned new information about how to identify a medical emergency.		
Goal 3 Status	95% of participants who took the survey after the training reported they learned new information about how to identify a medical emergency.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	
Program Goal 4	At least 80% of participants who participated in the Life Threatening Emergency" program report they are more likely to take steps such as administering compressions and utilizing the AED during a medical emergency if they have the opportunity.		
Goal 4 Status	90% of participants who took the survey after the training reported they are more likely to take steps such as administering compressions and utilizing the AED during a medical emergency if they have the opportunity.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Program Goal 5	MAH Physicians will serve as EMS Medical Directors to local municipalities and organizations.
Goal 5 Status	MAH Physicians served as EMS Medical Directors to Arlington, Belmont, Cambridge and Watertown as well as MIT EMS, Harvard University EMS and Pro Ambulance EMS.
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal 6	Train Cambridge Public Safety Stakeholder group to understand common threats and response capabilities to enhance readiness for emergency management procedures.
Goal 6 Status	In FY25, MAH trained 21 participants including MIT Emergency Management, MIT Police, Cambridge Fire Department, Pro EMS, Cambridge Police Department, Cambridge Public Health Department, Cambridge Health Alliance, Harvard University Emergency Management, Harvard University Police, Cambridge 911.
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal 7	Work with MIT Nuclear Lab to create and carry out a hazardous material decontamination training including procedures.
Goal 7 Status	In FY25, MAH trained over 40 participants including MIT Nuclear Lab, MIT Emergency management team, Cambridge Fire Department, Pro Ambulance, MAH Emergency Department, MAH Intensive Care Unit and the MAH emergency management team.
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal 8	Work with the Waltham Local Emergency Planning Committee (LEPC) to train city partners to understand common threats and response capabilities to enhance readiness for emergency management procedures.
Goal 8 Status	In FY25, MAH trained 85 participants including City of Waltham municipal workers, Waltham Fire Department, Waltham Police Department, Raytheon employees, Partners Healthcare, Armstrong Ambulance, municipal biotech companies, City of Cambridge municipal workers, Brandies College, Bentley University, The Red Cross, Somerville municipal workers, NSTAR, Waltham public schools, National Grid and Eversource.
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Community Benefits Administration and Infrastructure** **Health Issue: Additional Health Needs Identified by the Community**			
Brief Description or Objective	Community Benefits and Community Relations staff implement programs and services in our Community Benefits Services Area, encourage collaborative relationships with other providers and government entities to support and enhance community health initiatives, conduct Community Health Needs Assessments and address priority needs and ensure regulatory compliance and reporting. Additionally, Community Benefits and Community Relations staff at BILH hospitals work together and across institutions to plan, implement, and evaluate Community Benefits programs. In FY24, the staff worked collaboratively to begin the Community Health Needs Assessment and continued through FY25, sharing community outreach ideas and support, and help to distribute the community survey and identify key community residents for interviews and focus groups.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits	
Program Goal 1	Implement effective and efficient programs that support the community health needs of the Community Benefits Service Area.		
Goal 1 Status	MAH supported and implemented 40 programs and granted $142,125 to local organizations.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal 2	Offer evaluation capacity workshops to partner organizations and grantees to better understand impact.		
Goal 2 Status	BILH offered five (5) evaluation workshops in FY25 focusing on data collection, analysis, interpretation, reporting and storytelling, with 96% of attendees reporting increased knowledge.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Social Determinants of Health **Program Name: Community Development and Housing Support** **Health Issue: Housing Stability/Homelessness**		
Brief Description or Objective	This program supports community development corporations and their mission of housing stability for all. Activities supported include housing stabilization programs, community engagement programs and or providing social services to residents.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	In FY25, MAH supported Homeowners Rehab Inc. to support household stabilization assistance to households to complete benefits applications and connect clients to RAFT or other housing stabilization funds.	
Goal 1 Status	In FY25, 371 households received housing stabilization assistance: 69 households completed benefits applications including food stamps and MassHealth. 42 households connected with RAFT or other housing stabilization funds.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Culturally Informed Psychological Care** **Health Issue: Mental Health/Mental Illness**			
Brief Description or Objective	De Novo Center for Justice and Healing provides culturally informed psychological counseling to uninsured or underinsured adults who are unable to access help by other means, filling a critical gap in access to mental health services for people with low incomes. MAH helps support this program, which offers free or low-cost mental health services including individual therapy, group counseling, assessments and referrals, and case management to help clients heal the emotional effects of violence, abuse, torture and poverty.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	Provide access to healing to 125-150 adults by delivering free or low-cost mental health services, including long-term individual therapy, group counseling, assessments and referrals.		
Goal 1 Status	In FY25, 222 adults received free or low-cost individual counseling services, including 57 residing in MAH service area. Of these, 134 clients received ongoing individual therapy to address trauma symptoms and mental health concerns		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**	
Program Goal 2	Assist 25 - 30 survivors of torture, gender-based violence, war crimes or other human rights violations with specialized services through our Torture Treatment Program, including forensic psychological evaluations.		
Goal 2 Status	In FY25, 32 survivors of torture, gender-based violence, war crimes or other human rights violations received specialized services through our Torture Treatment Program.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**	
Program Goal 3	Support 50-60 clients with case management services, such as safety planning, food or clothing assistance, housing navigation, technology assistance, help completing paperwork, referral for legal or medical services, and accompaniment to court hearings, among other services.		
Goal 3 Status	In FY25, 55 clients received case management supports, such as safety planning, food or clothing assistance, housing navigation, technology assistance, help completing paperwork, referral for legal or medical services, and accompaniment to court hearings, among other services.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**	
Program Goal 4	At least 90% of clients will report a reduction in the persistence of symptoms, development of effective coping skills, and improved daily function, as indicated on client treatment evaluations.		
Goal 4 Status	In FY 25, all clients who have participated in ongoing therapy have reported they have found a better understanding of their mental health symptoms, reduced		

	symptoms related to trauma and abuse, and/or have identified better coping skills, allowing them to live more productively. Clients who have received case management services experience reduced stress related to poverty and lack of resources, allowing them to live more stable lives.

Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Eviction Homelessness Prevention Program Housing Corporation of Arlington** **Health Issue: Housing Stability/Homelessness**		
Brief Description or Objective	This program supports an integrated set of social services that provide eviction and homelessness prevention, connecting families to vital resources. In addition, low resourced individuals will have an opportunity to develop as leaders so that they may advocate for themselves and their community. These social services will help to resolve urgent financial, housing, and employment issues through the provision of direct social services and referrals to partner agencies.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	In FY25, prevent homelessness and create more stable tenancies by providing homelessness prevention grants. See at least 80% of grantees remain stable in their homes for at least 18 months after receiving assistance.	
Goal 1 Status	In FY25, HCA supported 15 households with eviction prevention grants that supported back rent, security deposit or moving expenses to help very low-income families at risk of losing housing remain stable and housed. 80% of these grantees remained stable.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 2	Expand tenant voice. Establish Tenant Councils throughout HCA's housing. Train at least 12 HCA tenants as leaders to facilitate Councils. See at least 2 HCA tenants newly join the HCA Board. Engage at least 25 HCA tenants and/or social service clients in housing or other relevant local advocacy.	
Goal 2 Status	In FY25 at least 41 total households out of a total of 149 have been active with the Tenant Council. In FY25, 3 HCA tenants joined the HCA Board.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 3	Support at least 30 families in resolving urgent financial, housing, employment, or other issues through the provision of direct social services and referrals to partner agencies as needed.	
Goal 3 Status	In FY25, HCA supported 38 households in resolving urgent financial, housing, employment, or other issues through the provision of direct social services and referrals to partner agencies as needed.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Equitable Access to Care **Program Name: Facilitating Primary Care Access** **Health Issue: Additional Health Needs Identified by the Community**			
Brief Description or Objective	Using our purchasing power, MAH purchases healthy foods and fresh produce and delivers to local distribution markets in MAH's service area which provide free food to community members in need.		
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	Provide access to primary care for uninsured and underinsured patients		
Goal 1 Status	In FY25, MAH provided access to primary care in its CBSA.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Social Determinants of Health **Program Name: Food Insecurity** **Health Issue: Food Insecurity**			
Brief Description or Objective	Using our purchasing power, MAH purchases healthy foods and fresh produce and delivers to local distribution markets in MAH's service area which provide free food to community members in need.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	Provide eggs and bread to local food distribution locations to support food insecure families and individuals.		
Goal 1 Status	Provided 3 deliveries of food which included 300 dozen eggs and 300 loaves of whole grain bread which was distributed to food insecure families and individuals in the city of Waltham.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Social Determinants of Health **Program Name: Farmers Market Incentive Program** **Health Issue: Food Insecurity**			
Brief Description or Objective	MAH supports a number of local farmers market programs to increase their capacity to provide low resourced residents with increased access to healthy foods. This program helps support through funding the Supplemental Nutrition Assistance Programs (SNAP), Healthy Incentives Programs (HIP) and farmers market voucher programs. This funding supports Arlington, Belmont, Watertown and Somerville programs. It also supports the efforts to increase enrollment with outreach and education about the various market's food assistance programs.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits		
Program Goal 1	Collaborate with local farmers markets to help support access to fresh produce for those who are low resourced.		
Goal 1 Status	Collaborated and supported Arlington, Belmont, Somerville and Watertown farmers markets incentive programs in order to increase access to fresh produce for those who are low resourced.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal 2	Increase the number of SNAP Match shoppers at the Belmont Farmers Market by promoting the program and educational awareness.		
Goal 2 Status	In FY25, utilization of SNAP match benefit dollars increased by 17%. This represented an average of 57 shoppers utilizing this program per week.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**	
Program Goal 3	Fresh Bucks is a program through Arlington Eats to provide food vouchers at the farmers market to those who qualify. In FY25, increase fruit and vegetable intake among those utilizing the Fresh Bucks program.		
Goal 3 Status	80% of respondents to our survey reported they had increase their fruit and vegetable intake.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**	
Program Goal 4	Fresh Bucks is a program through Arlington Eats to provide food vouchers at the farmers market to those who qualify. In FY25, increase the number of households using Fresh Bucks.		
Goal 4 Status	In FY25, there was an 11% increase in the number of households utilizing the Fresh Bucks incentive program at the farmers market. This represented a total of 940 individuals utilizing the program.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**	

Program Goal 5	Increase the SNAP Match usage at the Watertown Farmers Market.		
Goal 5 Status	In FY25 SNAP Match usage was approximately equal to the Watertown Farmers Market usage from the previous year. In FY25, the total SNAP match users at the farmers market was 880.		
Time Frame Year: Year 3		**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal 6	Provide support and funding to the Somerville Winter Farmers Market (SWFM) hosted and managed by The Center for the Arts at the Armory (CAA). This funding is to support their farmers market incentive programs for low resourced families and individuals.		
Goal 6 Status	In FY25, on average 75 SNAP eligible customers, visited the SWFM each Saturday during the winter months increasing access for this population to fresh local produce.		
Time Frame Year: Year 1		**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Financial Assistance Counselors** **Health Issue: Access to Care**			
Brief Description or Objective	Significant segments of the community population living within the hospital's CBSA, particularly low-resourced populations, face significant barriers to care. The hospital's Financial Assistance Program offers emergency and other medically necessary services at low or no cost to qualified patients (when qualifying family income is at or below 400% of the Federal Poverty Level). The hospital's Certified Application Counselors (CAC's) screen people and assist them in applying for all eligible financial assistance programs.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	To assist patients throughout the BILH Systems who are uninsured and under insured to obtain eligibility for and align them with state financial assistance and hospital-based financial assistance programs. This includes MassHealth, MassHealth ACOs, Health Connector, Pharmacy Programs and Hospital Charity programs.		
Goal 1 Status	In FY 2025 Charles River provided 2,094 encounters assisting patients with enrollment and reenrollment and charity care applications. MAH processed 3,115 applications of which 2,869 were approved. The number of charity applications processed were 32 of which 14 were approved for charity.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	
Program Goal 2	Support community members through the process of enrollment for health insurance and public assistance programs.		
Goal 2 Status	4.4 full time equivalents (FTE's) provide support and enrollment services, at both MAH and Charles River Community Health Center. These staff are Certified Application Counselors (CACs).		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal 3	Facilitate connection to health care by providing CACS to work on site at Charles River Community Health in Waltham.		
Goal 3 Status	2.0 MAH full time equivalents are provided to Charles River Community Health Center to provide these services.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Social Determinants of Health **Program Name: Health Literacy Education Program** **Health Issue: Social Determinants of Health**		
Brief Description or Objective	MAH provides presentations to local English Language Learners programs in the hospital's service area. Topics of presentations are on a variety of health issues and include tips on how to navigate the health system. The goal is to provide an educational forum that will uplift people who historically experience health disparities and help to improve access to care. An interpreter is provided when requested or needed to aid in the learning experience.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Provide at least four health literacy education programs for those who are English language learners.	
Goal 1 Status	In FY25 MAH provided 6 health literacy education programs in the community and total of 170 people attended these programs.100% of participants reported learning some new information about breast cancer screening.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal 2	Breast Health and Cancer Prevention Education: At least 80% of participants who take the survey report they learned new information about what their risks are for breast cancer.	
Goal 2 Status	100% of participants reported learning some new information about what their risks are for breast cancer.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 3	Breast Health and Cancer Prevention Education: At least 80% of participants who took the survey report learning some new information about breast cancer screening.	
Goal 3 Status	100% of participants reported learning some new information about breast cancer screening.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 4	Skin Cancer Presentation: 80% of participants who took the survey report increasing their knowledge about how to protect themselves and their family from skin cancer.	

Goal 4 Status	85% of participants reported increasing their knowledge about how to protect themselves and their family from skin cancer.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal 5	Navigating the Health Care System Education: At least 80% of participants who take the survey report increasing their knowledge about navigating our health care system.	
Goal 5 Status	89% of participants reported increasing their knowledge about navigating our health care system.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 6	Navigating the Health Care System Education: At least 80% of those participating who took the survey report they increased their knowledge on how to prepare for their doctors appointment.	
Goal 6 Status	88% reported they increased their knowledge on how to prepare for their doctor's appointment.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 7	Healthy Eating Education: At least 80% of participants will report they learned some new healthy eating tips or ideas they will use when they go grocery shopping.	
Goal 7 Status	100% of participants reported they learned some new healthy eating tips or ideas they will use when they go grocery shopping.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 8	Healthy Eating Education: At least 80% of participants will report learning new tips or ideas about how to substitute foods in their diet with healthier foods.	
Goal 8 Status	82% of participants reported learning new tips or ideas about how to substitute foods in their diet with healthier foods.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 9	Lyme Disease Presentation: At least 80% of participants who took the survey report increasing their knowledge about protecting themselves and their families against Lyme disease.	
Goal 9 Status	85% of participants reported increasing their knowledge about protecting themselves and their families against Lyme disease.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health **Program Name: Healthcare Careers Pathway Program** **Health Issue: Social Determinants of Health**			
Brief Description or Objective	MAH partners with Lamplight Women's Literacy Center to support its Healthcare Careers Pathway Program. Healthcare Careers Pathway seeks to address the barriers to career advancement facing entry level health care workers. This program prepares Clinical Nurse Assistants (CNAs) for the English portions of the Test of Essential Academic Skills (TEAS) exam. The TEAS is the entrance exam for nursing degree programs and is often a barrier for applicants whose primary language is not English. This program addresses the barriers to career advancement facing entry level health care workers.		
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	In FY25, 15 entry-level health care workers participate in Pre-TEAS or TEAS preparation courses.		
Goal 1 Status	16 entry-level health care workers participated in Pre-TEAS or TEAS preparation courses.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**	
Program Goal 2	In FY25, at least 15 entry-level health care workers will have received career advising tailored to their individual situation and have an actionable plan for pursuing their career in nursing.		
Goal 2 Status	18 entry-level health care workers received individual career advising tailored to their particular situation and have an actionable plan for pursuing their career in nursing.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Chronic and Complex Conditions **Program Name: Healthy Aging Program** **Health Issue: Chronic Disease**	
Brief Description or Objective	This program provides health and wellness education specifically geared towards our older adult population. Collaboration occurs between MAH, the Councils on Aging, Aging Services Access Points (ASAP), as well other agencies or municipal departments looking to support older adults with healthy aging.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Provide at least four health education presentations geared towards older adults in order to increase knowledge and reduce the feeling of isolation.
Goal 1 Status	Four presentations were coordinated and presented with a total of 50 older adults in attendance. Presentation topics included: Diabetes, Breast Health and Cancer Prevention, and Heart Health including stroke awareness.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**
Program Goal 2	Heart Health: At least 80% of participants will report they increased their knowledge of the risks of heart disease.
Goal 2 Status	94% of participants reported they increased their knowledge of the risks of heart disease.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**
Program Goal 3	Heart Health: At least 80% of participants will report they increased their knowledge of the signs and symptoms of heart disease.
Goal 3 Status	92% of participants reported they increased their knowledge of the risks of heart disease.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**
Program Goal 4	Diabetes Education: At least 80% of participants report that they learned something new about the signs and symptoms of diabetes.
Goal 4 Status	100% of participants reported that they learned something new about the signs and symptoms of diabetes.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**
Program Goal 5	Diabetes Education: At least 80% of participants report that they learned something new about how to help themselves prevent diabetes.
Goal 5 Status	100% of participants reported they learned something new about how to help themselves prevent diabetes.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Individual and Group Treatment for High-Risk Kids** **Health Issue: Mental Health**			
Brief Description or Objective	This program supports the individual and group treatment services at no cost to children and teens who are court-involved or at risk of court involvement. MAH has partnered with Adolescent Consultation Services (ASC) to help support this program called THRIVE Group Treatment program to increase access for teens who benefit from this therapy and as research shows, will benefit from early intervention.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	In FY25, ASC will serve 65 eligible youth through individual and or group treatment.		
Goal 1 Status	In FY25, ACS has served 55 youth through individual and group treatment.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal 2	For THRIVE participants who complete the group treatment cycle, we expect that 90% of participants will demonstrate an increased understanding of at least two areas of their mental health and functioning.		
Goal 2 Status	Of teens who completed THRIVE Group Treatment in FY25, 95% demonstrated an increased understanding of at least two areas of their mental health and functioning. Also, 95% reported an improvement in the following four areas: understanding of emotions, ability to manage stress, ability to handle conflict, and attitude and outlook.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal 3	In FY25, 90% of youth in our Individual Treatment program will make progress toward their treatment goals.		
Goal 3 Status	FY25, we exceeded this target, with 100% of youth in Individual Treatment making progress toward their treatment goals.		
Time Frame Year: Year 21	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Equitable Access to Care **Program Name: Medical Interpreter Services (IS)** **Health Issue: Additional Health Needs Identified by the Community**		
Brief Description or Objective	Free Interpreter Services (IS) are available to non-English speaking, limited-English speaking, deaf, and hard-of-hearing patients. These services are provided in person; by phone using a portable speakerphone to connect patients, their care team, and an interpreter; and through a video-based remote interpreter service using a computer to connect patients with an interpreter. Professional interpretation services in hundreds of languages are available 24 hours a day.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Provide free, timely, medical professional interpreter services for patients of all cultural and linguistic backgrounds with limited English proficiency, non-English speaking, and deaf or hard of hearing patients (ASL).	
Goal 1 Status	In FY25 MAH provided 23,789 individual encounters either face to face, video, telephonic and ASL	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health **Program Name: Patient Clothing Closet** **Health Issue: Additional Health Needs Identified by the Community**			
Brief Description or Objective	MAH supports a patient clothing closet for patients in need of additional, clean clothing upon discharge. Staff donate new and used clean clothes; the closet is open every day 24 hours a day.		
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	Provide emergency clothing 24 hours a day for patients in need upon discharge from an inpatient location or the emergency department.		
Goal 1 Status	Provided emergency clothing 24 hours a day for patients in need upon discharge from an inpatient location or the emergency department.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Equitable Access to Care **Program Name: Pharmacy Benefit** **Health Issue: Access to Care**			
Brief Description or Objective	MAH provides free, one-time prescriptions to help those who would otherwise not be able to afford or have access to medicine. The social work department works with these patients to help them transition to an affordable health insurance plan or connect them to other resources.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	Provide free medications for our most under-resourced populations who otherwise would not be able to pay for or have access to medication when being discharged from the hospital.		
Goal 1 Status	Provided and filled 229 free medication prescriptions for our most under-resourced populations who otherwise would not be able to pay for or have access to medication when being discharged from the hospital. This represented 96 patients who benefited.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Postpartum Support Group** **Health Issue: Mental Health/Mental Illness**			
Brief Description or Objective	The Postpartum Support Group is a free virtual group that meets weekly. This group has been an important resource for parents to connect with each other. Open to all parents who are in the early postpartum period or who are struggling with perinatal mental health issues preventing them from leaving the house. This group offers a safe space for parents to be together. It also provides resources and information, which supports new parents.		
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	Provide a postpartum support group by offering one virtual and one in person each week for community members.		
Goal 1 Status	In FY25, 195 community members participated in the postpartum support group which was a 41% increase in participation compared to FY24.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal 2	At least 80% of participants report that they felt supported and it felt like a safe space for them to share their feelings and experiences.		
Goal 2 Status	100% percent of participants reported that they felt supported and it felt like a safe space for them to share their feelings and experiences.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**	
Program Goal 3	At least 80% of participants report that they gained confidence in caring for themselves and their baby because of their participation in the postpartum support group.		
Goal 3 Status	99% of participants report that they gained confidence in caring for themselves and their baby because of their participation in the postpartum support group.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**	

Priority Health Need: Equitable Access to Care **Program Name: Prenatal/Postpartum Bilingual Outreach Program** **Health Issue: Mental Health/Mental Illness**			
Brief Description or Objective	This program provides a prenatal and postpartum community outreach worker at the Charles River Community Health Center (CRCH). The outreach worker helps patients navigate the health care system and provides support for families navigating and enrolling in government benefit programs and supporting connections to community resources. The outreach worker is the bridge between hospital social work and behavioral health teams. This program also provides doula support for patients at CRCH who request this service during labor and delivery.		
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	Provide a doula for historically underserved populations who request this support during birth.		
Goal 1 Status	A doula support coach is on call to support women at the time of delivery in person.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal 2	Provide community navigational support through a community health worker for at least 150 women or families where navigating the system is a barrier to care.		
Goal 2 Status	Provided over 300 women with navigational and emotional support as well as referrals to community resources. This included over 2,500 encounters of support or referrals including, helping with governmental assistance program certificates, SSI office visits, immigration status, babies first appointments, billing issues and helping to prepare moms for appointment and hospital follow-up visits.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal 3	Provide an outreach worker to support women through pregnancy, birth and post-partum issues to help them navigate the system and support them in their own health and wellbeing.		
Goal 3 Status	A bi-lingual (Spanish) community outreach worker is available to provide accessibility help with resources and to provide emotional support.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Social Determinants of Health **Program Name: Produce Prescription Program** **Health Issue: Chronic Disease**			
Brief Description or Objective	MAH supports a free Community Supported Agriculture (CSA) share program offered by Waltham Fields Community Farm. This program provides a 20-week CSA share of produce to up to thirty families and/or individual participants. Participants are chosen by their health care provider and are clinically at risk for an identifiable diet or nutrient related disease (e.g., pre-diabetic). The healthcare provider writes a vegetable prescription to the participant, who may be a child, in which case their parent/guardian has agreed to participate as well. The weekly share reflects what has been recently harvested and typically is ample vegetables for a family of four. The "veggie prescription" is written for a particular patient or family member but the produce is for the whole household. Change is more likely to be lasting when habits are changed at the household level and food prepared with fresh vegetables is for all to try.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	Provide weekly vegetable CSA shares to up to thirty low-income households with underlying health conditions weekly for twenty weeks from mid-June to mid-October.		
Goal 1 Status	CSA shares were provided to 30 households in FY25. This represented over 5,000 pounds of fresh produce to low income medically identified families.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Equitable Access to Care **Program Name: Safe Beds** **Health Issue: Mental Health/Mental Illness**			
Brief Description or Objective	MAH provides temporary Safe Beds for victims of domestic violence in partnership with local police departments and emergency services.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	Facilitate connection to safe care for all people and their dependents who are victims of domestic violence.		
Goal 1 Status	Provided a safe bed for all people and their dependents who were victims of domestic violence and were not able to go home because of an unsafe situation.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Social Determinants of Health **Program Name: Social Enterprise Youth Development Program** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	This program provides job training, youth development, intense case management, education and employment coaching for high-risk teens. The education coaching helps these teens stay in school and develop life skills that contribute toward improving high school graduation rates. The Social Enterprise Youth Development Program is run by More Than Words (MTW) in Waltham.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	In FY25, MTW will provide job training, youth development programming, intensive case management, education and employment coaching, and individual advocacy to approximately 50 young people at our Waltham location.	
Goal 1 Status	FY25, MTW provided job training, youth development programming, intensive case management, education and employment coaching, and individual advocacy to 52 young people at our Waltham location.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 2	In FY25, 90% of MTW graduates will have or be on track to earn their high school diploma or HiSET certification.	
Goal 2 Status	In FY25, 99% of MTW graduates either had, earned, or were on track to earn their high school diploma or HiSET certification.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 3	In FY25, 75% of MTW graduates will be productively engaged in school and/or work for at least 30 hours each week.	
Goal 3 Status	In FY25, 77% of MTW graduates were productively engaged in school and/or work for at least 30 hours each week.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Equitable Access to Care **Program Name: Strengthening Y2Y Harvard Square's Case Management Program** **Health Issue: Housing Stability/Homelessness**		
Brief Description or Objective	Y2Y operates a youth-led shelter in Cambridge for young people experiencing homelessness. Support for this program includes strengthening the case management team with increased training in order to improve outcomes. This model includes getting young adults off the streets, providing stability and facilitating access to needed resources.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	Strengthen Y2Y's Case Management Team via improved training and practices.	
Goal 1 Status	In FY25, 10 case managers were trained. Due to the increase in case managers data tracking, case management workflows were improved, including tracking discrete outcomes.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**
Program Goal 2	Increase Case Management utilization rates and outcomes.	
Goal 2 Status	77 of the 125 unique guests served had some interaction with case management programs. Of those 77 guests, over 88% worked with case managers more than once during their stay. This was an increase of 5% compared to last year.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic and Complex Conditions **Program Name: Stroke Navigation and Prevention** **Health Issue: Chronic Disease**		
Brief Description or Objective	This program supports a stroke-certified nurse who provides stroke education and awareness to patients, families, hospital staff, and community members. MAH also collaborates with the local private EMS and local fire departments to provide staff with updated information and education about recognizing the signs of stroke, performing national stroke assessments, and alerting the hospital prior to arrival to provide patients with efficient, time-sensitive care.	
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Provide stroke education and awareness within the hospital to patients and their family members.	
Goal 1 Status	Provided stroke education and support to over 180 patients and their family members by the stroke nurse coordinator.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 2	Create a Stroke awareness campaign during Stroke Awareness Month.	
Goal 2 Status	Distributed stroke education materials and conducted stroke awareness presentations for community members. Engaged over 250 community members with stroke education materials.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal 3	Provide in person stroke awareness presentations at local community-based organizations, English Language Learning organizations and Councils on Aging locations.	
Goal 3 Status	Provided 5 stroke awareness presentations with 93 people in attendance.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal 4	Over 80% of presentation participants report an increase in their knowledge of the risks of having a stroke.	
Goal 4 Status	88% of presentation participants reported an increase in their knowledge of the risks of having a stroke.	

Time Frame Year: Year 1	Time Frame Duration: Year 3	Goal Type: Outcomes Goal
Program Goal 5	Over 80% of presentation participants will report an increase of their knowledge of the signs and symptoms of stroke.	
Goal 5 Status	90% of presentation participants reported an increase of their knowledge of the signs and symptoms of stroke.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Chronic and Complex Conditions **Program Name: Support for Community Members with Cancer** **Health Issue: Chronic Disease**			
Brief Description or Objective	This program works with cancer patients to create a sense of support, confidence, courage, and community by increasing hope and empowerment for those affected by cancer and to improve mental health and wellbeing.		
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits ☐ Total Population or Community Wide Intervention	
Program Goal 1	Organize a survivorship day for community members with cancer to celebrate and empower those affected by cancer and to improve mental health and overall wellbeing.		
Goal 1 Status	Survivorship Day Event completed in June 2025 (in person) with 82 people attending.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	
Program Goal 2	80% of those who participated in survivorship day will report they learned something of lasting value by participating.		
Goal 2 Status	100% of those who took the survey reported they learned something of lasting value by participating in the event.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**	
Program Goal 3	80% of those who participated in survivorship day will report they will be able to take what they learned or a skill they practiced during the event and use it to improve their own health and wellbeing.		
Goal 3 Status	100% of those who took the survey reported they will be able to take what they learned or a skill they practiced and use it to improve their own health and wellbeing.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	
Program Goal 4	Provide a free breast cancer support group to women who have completed treatment.		
Goal 4 Status	A support group is provided and meets twice a month throughout the year. At least 10 participants attend regularly.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	

Priority Health Need: Equitable Access to Care **Program Name: Transportation as a Barrier to Medical Care** **Health Issue: Access to Care**			
Brief Description or Objective	MAH in partnership with local transportation agencies provides transportation to medical appointments for community members when transportation is a barrier to care.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	Facilitate the connection to health care by providing transportation connections at no cost when transportation is a barrier to medical care.		
Goal 1 Status	Approximately 820 rides provided free of charge to those where transportation is a barrier to medical care. Transportation is provided via SCM Transportation and Metro Cab vouchers authorized as determined by the social work staff.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	
Program Goal 2	Mount Auburn staff to participate in Cambridge Transportation Task Force and The Alewife Transportation Management Association in order to address transportation access and environmental issues.		
Goal 2 Status	The director of community affairs attends these meetings to address transportation as a barrier to care and environmental issues as they pertain to transportation.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Trauma Informed Counselors Representing the Diverse Community at Transition House** **Health Issue: Mental Health/Mental Illness**			
Brief Description or Objective	MAH's partnership with Transition House helps to support training and recruitment of counselors who speak languages other than English. We aim to expand the community team's counseling capacity and make counseling services more accessible to people from these historically underserved communities. Transition house is a domestic violence prevention and services agency. The Housing Continuum model at Transition House serves individuals and families displaced by domestic violence providing trauma recovery, connections to education, job training, legal assistance, etc. and access to emergency shelter, longer-term transitional housing, and permanent supported housing.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits		
Program Goal 1	By the end of FY25, three additional clinicians will continue to be on staff at Transition House, doubling the counseling capacity at Transition House and at least one of them will be fluent in a language other than English that is commonly spoken in Cambridge.		
Goal 1 Status	Complete: In FY25, Transition House continues to maintain and employ 3 diverse clinicians.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	
Program Goal 2	In FY25, 8 new Transition House clients will access counseling within 2 weeks of the request. 5 of these 8 will continue to actively engage in counseling past 3 sessions, aligning with our focus of promoting health access for diverse trauma survivors.		
Goal 2 Status	Complete: In FY25, the counseling program actively engaged 18 clients in counseling, and all had a first session within 2 weeks of their referral.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**	
Program Goal 3	In FY25, 75% of clients who report counseling as a service they engage in, will report being satisfied with their experience via the semi-annual client satisfaction survey.		
Goal 3 Status	100% of client responses reported strongly agree or agree to all the satisfaction questions.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: WHOLE Program (We Heal Ourselves with Love and Empowerment)** **Health Issue: Mental Health/Mental Illness**			
Brief Description or Objective	The mission of the WHOLE program is to provide opportunities to learn and heal in order to improve the health outcomes for people of color and faith-based communities and to break down barriers to access to care. Its goal is to provide support within diverse communities reduce stigma associated with mental health. This program offers two separate group therapy programs . These programs seek to create a safe space and collective healing as well as removing roadblocks to receiving traditional therapy.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	Partner with local clinical practitioners to offer group sessions which include a safe place and brave space to discuss the stresses, challenges, and rewards of providing care for an adult that is led by individuals with lived and/or clinical experience in caregiving.		
Goal 1 Status	In FY25 WHOLE offered Things We Carry Men's Group. 100% of the men said that they felt affirmed as a person, supported by the other participants, and supported by the facilitator, who they believed was knowledgeable and helpful. Participants shared that they learned skills that they could apply to improve their own well-being.		
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

SECTION V: EXPENDITURES

Item/Description	Amount
CB Expenditures by Program Type	
Direct Clinical Services	$1,673,086
Community-Clinical Linkages	$193,807
Total Population or Community Wide Interventions	$285,336
Access/Coverage Supports	$995,180
Infrastructure to Support CB Collaborations	$182,512
Total Expenditures by Program Type	$3,329,921
CB Expenditures by Health Need	
Chronic Disease	$200,561
Mental Health/Mental Illness	$1,537,208
Substance Use Disorders	$320,643
Housing Stability/Homelessness	$53,035
Additional Health Needs Identified by the Community	$1,218,474
Total Expenditures by Health Need	$3,329,921
Leveraged Resources	
Total Leveraged Resources	0
Net Charity Care Expenditures	
HSN Assessment	4,168,209
Free/Discounted Care	N/A
HSN Denied Claims	$3,371,851
Total Net Charity Care	$7,540,060
Total CB Expenditures	$10,869,981

Additional Information	
Net Patient Services Revenue	$352,750,057
CB Expenditure as % of Net Patient Services Revenue	3.08%

Approved CB Budget for FY26 (*Excluding expenditures that cannot be projected at the time of the report)	**$5,001,479**
Bad Debt	**$3,927,238**
Bad Debt Certification	**Yes**
Optional Supplement	
Comments	

SECTION VI: CONTACT INFORMATION

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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Year 1
Note: This form is to be completed in the Fiscal Year in which the hospital completed its triennial Community Health Needs Assessment

I. Community Benefits Process:

1. Community Benefits in the Context of the Organization's Overall Mission:

- Are Community Benefits planning and investments part of your hospital's strategic plan? ☒Yes ☐No
    - If yes, please provide a description of how Community Benefits planning fits into your hospital's strategic plan. If no, please explain why not:

While Mount Auburn Hospital (MAH) oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the Beth Israel Lahey Health (BILH) Chief Community and Health Impact Officer. This structure makes sure that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity and values, encompassed by the acronym WE CARE:

Wellbeing - We provide a health-focused workplace and support a healthy work-life balance
Empathy - We do our best to understand others' feelings, needs and perspectives
Collaboration - We work together to achieve extraordinary results
Accountability - We hold ourselves and each other to behaviors necessary to achieve our collective goals
Respect - We value diversity and treat all members of our community with dignity and inclusiveness
Equity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.

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

2. Community Benefits Advisory Committee (CBAC):

- Members (and titles):

Elizabeth Aguilo, Executive Director, Paine Senior

Services
Felicity Beal, Director of Development, Somerville Homeless Coalition
Eric Burton, Interim Chief Financial Officer, Charles River Community Health
Karin Carroll, Director, Somerville Health and Human Services
Pietra Check, Interim Director, CORE MH
Wesley Chin, Director, Belmont Health Department
Stacy Carruth, Executive Director, Arlington Youth Counseling Center
Michelle Feeley, Director, Waltham Health Department
Dr. Dina Gorelik, Primary Care Provider, Mount Auburn Hospital
Claire Hoffman, Senior Public Health Planner, MAPC
Doug Kress, Chief Community Officer, Cambridge Health Alliance
Laura Kurman, Senior Program Director, Wayside Multi-Service Center
Colleen Leger, Director of Health and Human Services, Town of Arlington
Derrick Neal, Chief Public Health Officer, Cambridge Health Department
BJ Osuagwu, Executive Director, Healthy Waltham
Jenica Phelps, LICSW, Social Work Team Lead, Mount Auburn Hospital
Dr. Jackie Spencer, Director of Primary Care, VA New England Healthcare System; Mount Auburn Hospital Board of Trustees
Rachel Tanenhaus, ADA Coordinator/Executive Director, Commission for Persons with Disabilities
Viet Van, Community Support Service Manager, Somerville Cambridge Elder Services
Stephanie Venizelos, Community Wellness Program Manager, City of Watertown

- Leadership:

Steven Kapfhammer, Chief Operating Officer
Katherine Rafferty, Director of Community Affairs
Heather Gibbons-Perez, Director of Performance Improvement and Regulatory Affairs
Marie McCune, RN, Stroke Nurse Coordinator
Mary DeCourcey, Director, Community Benefits

- Frequency of meetings: Quarterly

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

Place a checkmark next to each leadership group if it is involved in the specified aspect of your Community Benefits process:

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

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

Hospital Board:
MAH's Board of Trustees – reviewed and approved its CHNA and adopted its Implementation Strategy.

Community Benefits Advisory Committee - oversaw CHNA and Implementation Strategy process.

Senior Leadership:
• Ed Huang, MD, President: Designated a member of the senior leadership team to the CBAC and participated in the approval process
• Steven Kapfhammer, Chief Operating Officer a member of the senior leadership team to the CBAC and participated in the approval process
• Nancy Kasen, Vice President of Community Benefits and Community Relations, and Community Benefits team: designed, directed and oversaw the CHNA and IS, managed prioritization process, drafted Implementation Strategy
•Mary DeCourcey, Director, Community Benefits: Led the community engagement efforts at MAH, oversaw the CHNA and IS process at MAH
• BILH Board of Trustees Community Benefits Committee (CBC): guided the process for the system

4. Hospital Approach to Assessing and Addressing Social Determinants of Health

- How does the hospital approach assessing community needs relating to social determinants of health? (150-word limit)

MAH undertook a robust, collaborative and transparent assessment and planning process. The approach involved extensive quantitative and qualitative data collection and substantial efforts to engage community residents, with special emphasis on population segments often left out of similar efforts. The assessment was supported

by MAH's Community Benefits Advisory Committee (CBAC). The CBAC is comprised of community members, service providers, and other stakeholders who live and/or work in MAH's CBSA. MAH's Implementation Strategy (IS) reflects the hospital and the CBAC's prioritization of the following social determinants of health: economic stability, food security and nutrition, housing, racism and discrimination, and transportation.

- How does the hospital incorporate health equity in its approach to Community Benefits? (150-word limit)

MAH and BILH are committed to health equity, the attainment of the highest level of health for all people. Throughout the assessment process, MAH worked to understand the needs of all populations in the Community Benefits Service Area, including those who have been historically underserved. Health equity is an overarching lens applied to all four pillars within MAH's Implementation Strategy. The Implementation Strategy is designed to address the underlying social determinants of health and barriers to accessing care

- How does the hospital approach allocating resources to Total Population or Community-Wide Interventions? (150-word limit)

MAH's Implementation Strategy includes a range of programs and resources to address the prioritized needs within the hospital's Community Benefits Service Area. The majority of MAH's community benefits initiatives are focused on cohorts and geographies based on identified needs. Additionally, MAH collaborates with many community partners to own, catalyze and/or support total population and community-wide interventions.

5. Maternal Health Focus

- How does your organization assess maternal health status in the Community Needs Assessment Process? (150-word limit)

MAH's Community Health Needs Assessment (CHNA) process includes comprehensive collection and review of primary and secondary data sources. Secondary data sources include the Center for Health Information Analysis (CHIA), Community Health Equity Survey (CHES), County Health Rankings, MA DPH, National Center for Health Statistics and U.S. Census Bureau. The hospital's data table has a section for Maternal and Child Health/Reproductive Health which includes infant mortality rate (%) and low birth weight (%). In addition to secondary data capture and review, throughout the CHNA MAH engages with the community to collect primary data via a survey, focus groups and listening sessions to directly enable community residents to identify priorities.

- How have you measured the impact of your Community Benefits programs and what challenges have you faced in this measurement?

MAH partners with Charles River Community Health on maternal health initiative(s) and has done so for over 20 years. This year, MAH created a new partnership with NeighborHealth in East Boston. MAH provides OB/GYN and midwifery services at NeighborHealth increasing maternal health access for patients. Additionally, MAH is a member of BILH which, as a system is working to address maternal health equity. BILH established its Maternal Health Quality and Equity Council (MHQEC) in September of 2023. The Council's objective is to improve maternal health outcomes and eliminate inequities in care, with an overarching aim to reduce the occurrence of maternal morbidity and mortality. The Council is comprised of representatives from all of the BILH hospitals providing maternity services, as well as BILH leadership, including BILH Health Equity system leadership. BILH's Vice President of Health Equity serves as the Executive Sponsor. Additionally, BILH established a health equity goal beginning in FY 25 – a year over year improvement in maternal transfusion rate (the goal is to reduce disparities in maternal transfusion rates measured at the system level).

- Do you need assistance identifying community-based organizations doing maternal health work in your area?

MAH currently works with Charles River Community Health in Waltham and Brighton as well as NeighborHealth in East Boston. No additional assistance is needed, MAH's maternal health work will continue to be guided by the BILH MHQEC and MAH looks forward to spreading this work and collaborating with its myriad of long-standing community partners in pursuit of maternal health equity.

II. Community Engagement

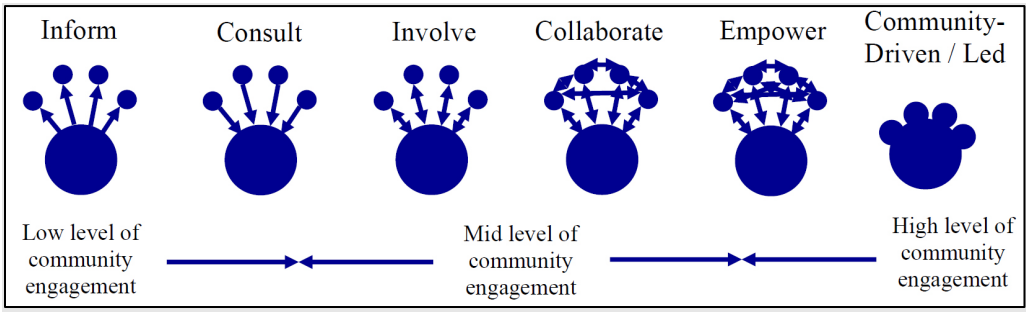
1. Organizations Engaged in CHNA and/or Implementation Strategy

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

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
Healthy Waltham	BJ Osuagwu, Executive Director	Social service organizations	Participates as a member of our CBAC. Participated on prioritization and strategy process. Was interviewed as a key informant for the CHNA.
Cambridge Health Alliance (CHA)	Doug Kress, Chief Community Officer	Other hospitals	Participates as a member of our CBAC. We participate in a monthly meeting with CHA to share information about our health assessments, where we can collaborate and sharing best practices. MAH is represented on CHA Community Advisory Board
Charles River Community Health	Klavdia Brisson, Chief Clinical Officer	Community health centers	MAH engages and collaborates with CRCH on a number of different programs. CRCH sits on MAH's CBAC and is consulted on our community engagement process. We continue to engage in sharing information, data and strategies.
Local Health Departments	Derrick Neal, Chief Public Health Officer, Cambridge; Colleen Leger, Director, Arlington Health and Human Services; Karin Carroll, Director, Somerville Health and Human Services; Wesley Chin, Director, Belmont Health Department	Local health department	MAH collaborates with the local health departments in its service area to assess the health needs of the community by leveraging existing data, and capturing further data to inform the CHNA and IS.
Local Councils on Aging (COA)	Kristine Shah, Director, Arlington COA; Susan Pacheco, Director, Cambridge COA; Patrick O'Brien, Director, Waltham COA; Sofie Daley, Program Director, Belmont COA; Ashley Speliotis, Director,	Social Service Organization	A MAH representative sits on the Board of the Cambridge Council on Aging. MAH participates in local events for older adults and provides health education to clients.

	Somerville COA; Lydia McCoy, Director, Watertown Council on Aging		

2. Level of Engagement Across CHNA and Implementation Strategy
   Please use the spectrum below from the Massachusetts Department of Public Health1 to assess the hospital's level of engagement with the community in implementing its plan to address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.



For a full description of the community engagement spectrum, see page 11 of the Attorney General's Community Benefits Guidelines for Non-Profit Hospitals.

A. Community Health Needs Assessment: Please assess the hospital's level of engagement in developing its CHNA and the effectiveness of its community engagement process.

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in assessing community health needs	Involve	Goal was met	Involve
Collecting data	Involve	Goal was met	Involve
Defining the community to be served	Collaborate	Goal was met	Collaborate
Establishing priorities	Collaborate	Goal was met	Collaborate

[1] "Community Engagement Standards for Community Health Planning Guideline," Massachusetts Department of Public Health, available at: http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf. For a full description of the community engagement spectrum, see page 11 of the Attorney General's Community Benefits Guidelines for Non-profit Hospitals.

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

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

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

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

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

   In FY25, MAH held 3 CBAC meetings, an annual meeting and a community listening session and the latter two of which were broadly advertised to the public. Additionally, four newsletters were distributed to inform the community about the Community Health

Needs Assessment and Implementation Strategy process, including opportunities for input, and other Community Benefits updates.

CBAC meeting dates: December 19, 2024, March 20, 2025, June 12, 2025 and September 18, 2025 (Annual Public Meeting)
Community Listening Session; February 27, 2025

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

What community engagement practices are you most proud of? (150-word limit)

MAH is most proud of its committed CBAC and the long-standing relationships it has with many community-based organizations, the public health department, and other government partners. MAH is proud of its collaboration with these and other organizations that allow for meaningful community engagement. Increased focus was placed on reaching communities typically not engaged in assessments, as such, MAH saw a significant increase in community survey responses from the following populations: Black/African American, Hispanic/Latino, and Non-English speakers.

What lessons have you learned from your community engagement experience? (150-word limit)

Working collaboratively with other hospitals, community-based organizations, public health agencies, residents, and area coalitions enhances the level and quality of MAH's community engagement efforts.

III. Regional Collaboration

1. Are Community Benefits planning and investments part of your hospital's strategic plan? ☒Yes ☐No

   a. If so, briefly describe it. If not, why?

2. If the hospital collaborates with any other filer(s) in conducting its CHNA, Implementation Strategy, or other component of its Community Benefits process (e.g., as part of a regional collaboration), please provide information about the collaboration below.
   - Collaboration
   - Institutions Involved
   - Brief description of goals of collaboration

- Key communities engaged through collaboration. If you did not participate in a collaboration, please explain why not:

For its FY 2025 CHNA, Beth Israel Lahey Health (BILH) took the unique approach of designing and implementing a system-wide, highly coordinated CHNA and prioritization process across each of the system's 11 licensed hospitals, including MAH. While MAH focuses its Community Benefits resources on improving the health status of those in its CBSA experiencing significant barriers to care, this system-wide approach enhances opportunities for collaboration and alignment with respect to addressing unmet need and maximizing impact on community health priorities. Together, BILH hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact.

MAH collaborated with Cambridge Health Alliance (CHA) during its FY25 CHNA (Wellbeing Assessment). We met periodically throughout the process to update each other and share our strategies and data. Our shared service area includes Somerville and Cambridge. We collaborated on our community surveys, sharing data and distribution methods. We shared distribution avenues to reach as many community members as possible, especially with a focus on those populations that experience the greatest health disparities. We worked together to make sure we were not overlapping or overburdening certain segments in our collective service areas when carrying out our community engagement plans. We also share our focus group data and other qualitative and quantitative data to enhance our knowledge of the needs of those living in our service areas.