Community Benefits Report

Fiscal Year 2022

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 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 4,000 physicians and 35,000 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 Diversity, Equity and Inclusion 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 *WECARE:*

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

MAH 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, MAH's Community Benefits mission is fulfilled by:

- **Involving MAH'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 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** in 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 social and institutional inequities, racism, and bigotry and ensuring that all patients are welcomed and received with respect and have access to culturally responsiveness care; and

- **Facilitating collaboration and partnership within and across sectors** (e.g., 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

MAH's CBSA includes Arlington, Belmont, Cambridge, Somerville, Waltham and Watertown. In FY 2022, 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 for FY 2019. 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, MAH's FY 2023 - 2025 Implementation Strategy (IS) will focus its Community Benefits resources 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 MAH's FY22 CHNA, the community characteristics that were thought to have the greatest impact on health status and access to care in the MAH service area were issues related to age, race, ethnicity, language, and immigration status. While the majority of residents in the MAH CBSA were predominantly white and born in the United States, there were people of color, recent immigrants, people with limited English proficiency, and people born outside of the United States in all communities. There was consensus among interviewees and focus group participants that people of color, recent immigrants, and people with limited English proficiency were more likely to have poor health status and face systemic challenges to accessing care and services. These segments of the population are impacted by language, cultural barriers, and racism that limit access to appropriate services, pose health literacy challenges, exacerbate isolation, and may lead to discrimination and disparities in access and health outcomes.

For its FY 2023 – 2025 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, and
- 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 CHNA and IS were conducted and approved by the Board during the fiscal year ended September 30, 2022. That CHNA and IS will inform the Community Benefits mission and activities of MAH for the fiscal years ending September 30, 2023; September 30, 2024; and September 30, 2025.

This report covers MAH's fiscal year ending September 30, 2022. The previous CHNA and accompanying IS were approved by the MAH Board before September 30, 2021 and informed the MAH's Community Benefits initiatives for the fiscal years ending September 30, 2022. 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 approved as of September 30, 2021.

Due to the merger of MAH with BILH, MAH chose to conduct its most recent CHNA during this fiscal year (FY22) in order to align the CHNA cycle with other hospitals in the BILH system.

Program accomplishments include:
The main goals of the MAH Community Benefits program of this reporting year were to implement programs and activities aimed at addressing health concerns identified in the FY21 CHNA. Key accomplishments included:

- Increased the capacity of Community Health Network Area 17 (CHNA 17) to fulfill its mission to promote healthier people and communities by fostering community engagement, elevating innovative and best practices, advancing racial equity, and supporting reciprocal learning opportunities to address the needs of those most impacted by inequities.
- Provided a grant opportunity to community based organizations and municipalities. MAH was able to fund eight organizations to work on programs which helped to increase their capacity to address the top health concerns identified in MAH's most recent CHNA and in their community.
- Continued a virtual healthy aging education program for older adults.
- Reduced food insecurity through providing food for distribution to those who have been severely impacted by the COVID–19 pandemic.
- Contributed to supporting an increase in SNAP Match enrollments for use at farmer's markets within our service area by collaborating with cities and towns to promote enrollment.
- Promoted transportation equity.

- Created the Co-Location Program by partnering with Metro Housing Boston. The Co-Location program provides free counseling services to individuals and families to increase housing stability and economic self-sufficiency.
- Promoted cross-sector collaboration and partnerships.
- Provided substance use navigation and support through a social worker embedded in the emergency department who refers patients to the Substance Treatment and Referral Team and also provides transitional assistance and support.

Plans for Next Reporting Year

In FY 2022, MAH conducted a comprehensive and inclusive 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 for FY 2019. In response to the FY 2022 CHNA, MAH will focus its FY 2023 - 2025 IS on five priority areas. These priority areas collectively address the broad range of health and social issues facing residents living in MAH's CBSA who face the greatest health disparities. These five priority areas are:

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

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

The FY 2022 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions being used to inform and refine MAH's efforts. In completing the FY 2022 CHNA and FY 2023 - 2025 IS, MAH, 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 identify, sexual orientation, disability status, immigration status, or age. As discussed above, based on the FY 2022 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that for MAH FY 2023 - 2025 IS, it will 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 our community service area. In recognition of the health disparities that exist for certain segments of the population, MAH's Community Benefits investments and resources will focus on the 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 2023 – 2025 IS.

- **Equitable Access to Care**
  - MAH will work with Charles River Community Health to support its Prenatal/Post Natal Bilingual Outreach Program.
  - MAH will collaborate with Metro Housing Boston to help improve access to resources for housing issues.

- **Social Determinants of Health**
  - MAH will continue to use its purchasing power to purchase food for distribution through its partnership with Healthy Waltham.
  - MAH will continue its partnership with Africano Waltham to support its Holistic Health Program.

- **Mental Health and Substance Use**
  - MAH will collaborate with De Novo Center for Justice and Healing to help support its Culturally Informed Counseling Program.
  - MAH will partner with Transition House to help support its efforts to increase its trauma informed counselors who are members of BIPOC communities.

- **Complex and Chronic Conditions**
  - MAH will continue its health 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.

- **Racial Equity**
  - MAH will continue to work with Community Health Network Area 17 (CHNA 17) to support their work in promoting racial equity with a focus on increasing access to mental health for those who identify as BIPOC.

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 70). MAH Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members who participated in MAH's CHNA 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. MAH'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 Diversity, Equity and Inclusion 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 *WECARE:*

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The MAH Community Benefits program is spearheaded by the Director of Community Benefits. The Director has direct access and is accountable to the MAH President and the

BILH Vice President of Community Benefits and Community Relations, the latter of whom reports directly to the BILH Chief Diversity, Equity and Inclusion Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of 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 MAH's Community Benefits mission to *improve 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.* 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 16, 2021
March 24, 2022
May 19, 2022
June 16, 2022 (Annual Public Meeting)
September 8, 2022

Community Partners
MAH recognizes its role as a tertiary/academic resource in a larger health system and knows that to be successful it needs to collaborate with its community partners and those it serves. MAH's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy were completed in close collaboration with MAH's staff, 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. MAH's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of MAH's mission.

MAH currently supports numerous of educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA. In this work, MAH collaborates with many of its local community-based organizations, public health departments,

municipalities and clinical and social service organizations. MAH has a particularly strong relationship Charles River Community Health in Waltham. This relationship includes providing a strong OB/GYN and Midwifery program there, particularly supporting Latinas, through pre and post-natal care including outreach and home visits. Other support to CRCH includes providing financial counselors, lab tests and IT support.

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

MAH is also an active participant in the Community Health Network Area 17 Coalition (CHNA 17). CHNA 17's focuses on the intersection of racial justice and mental health, working with grass-roots community groups and residents. This gives MAH an opportunity to meaningfully collaborate with populations most impacted by inequities.

The following is a comprehensive listing of the community partners with which MAH collaborated with on its FY 22 IS, as well as on its FY 2022 CHNA. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment Form (Section VII, page 70)

Africano Waltham	Mass. Institute of Technology EMS
American Cancer Society	Massachusetts Bay Transit Authority
Arlington Council on Aging	Metro Cab of Boston
Arlington Eats	Metro Housing Boston
Arlington Fire Department	Meadowgreen Rehabilitation and Nursing
Arlington Health and Human Services	Metro Cab of Boston
Arlington Police Department	Paine Senior Services
Arlington Youth Counseling Center	Professional Ambulance EMS
Belmont Council on Aging	Rainbow Commission in Arlington
Belmont Department of Public Health	Schenderian Pharmacy
Belmont Fire Department	SCM Community Transportation
Belmont Police Department	Somerville Cambridge Elder Services
BILH at Home	Somerville Center for Adult Learning Experiences (SCALE)
Cambridge Community Foundation	Somerville Council on Aging
Cambridge Community Learning Center	Somerville Health and Human Services

Cambridge Council on Aging	Somerville Homeless Coalition
Cambridge Department of Public Health	Somerville Police Department
Cambridge Fire Department	Somerville Stakeholders Coalition
Cambridge Health Alliance	Springwell Elder Services
Cambridge Police Department	Transition House
Cambridge SNAP Match Coalition	Town of Arlington
CASPAR INC.	Town of Belmont
Charles River Community Health	Town of Watertown
City of Cambridge	Waltham Connections
City of Somerville	Waltham Council on Aging
City of Waltham	Waltham Family School
Community Day Center of Waltham	Waltham Fields Community Farm
Community Health Network Area 17 (CHNA 17)	Waltham Health Department
DeNovo Center for Justice and Healing	Waltham Interagency Group
Harvard University EMS	Waltham Partnership for Youth
Healthy Waltham	Waltham Police Department
Lexington Fire Department	Watertown Cares
Metro Housing Boston	Watertown Council on Aging
Lifeline In Home Services at Mount Auburn	Watertown Fire Dept.
Live Well Watertown	Watertown Health Department
Massachusetts Alliance of Portuguese Speakers	Watertown Police Department
Marino Foundation	Wayside Youth and Family Services

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY 2022 Community Health Needs Assessment (CHNA) along with the associated FY 2023-2025 Implementation Strategy was developed over a twelve-month period from September 2021 to September 2022. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill the MAH's need to conduct a community health needs assessment, engage the community, identify priority health issues, inventory community assets, assess impact, and develop an Implementation Strategy. However, these activities are driven primarily by MAH's dedication to its mission, its covenant to 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 2022. FY 2022 Community Benefits programming was informed by the FY 2021 CHNA and aligns with MAH's FY 2022 Implementation Strategy. The following is a summary description of the FY 2022 CHNA approach, methods, and key findings.

Approach and Methods
The FY 2022 assessment and planning process was conducted in three phases between September 2021 and September 2022, 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, as well as the current and historical discrimination and injustices that underlie existing disparities. 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.

Between October 2021 and February 2022, MAH conducted 18 one-on-one interviews with key collaborators in the community, facilitated 3 focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 260 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 300 community residents, clinical and social service providers and other 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 MAH's Implementation Strategy that is adopted by MAH's Board of Trustees.

Summary of FY 2022 CHNA Key Health-Related Findings

Equitable Access to Care

- Individuals 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 stem from the way in which the system does or does not function. System level issues included providers not accepting new patients, long wait lists, and an inherently complicated healthcare system that is 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 economic insecurity, education, food insecurity, access to care/navigation issues, and other important social factors.

- There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, survey, and listening sessions suggested 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, and economic stability.

Mental Health and Substance Use

- Anxiety, chronic stress, depression, and social isolation were leading community health concerns. The assessment identified specific concerns about the impact of mental health issues for youth and young adults, the mental health impacts of racism, discrimination, and trauma, and social isolation among older adults. These difficulties were exacerbated by COVID-19.
- In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services.
- Substance use continued to have a major impact on the CBSA; the opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities, including mental health, housing, and homelessness. Individuals engaged in the assessment identified stigma as a barrier to treatment and reported a need for programs that address common co-occurring issues (e.g., mental health issues, homelessness).

Complex and Chronic Conditions

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

Racial Equity

- Racial equity is the condition where one's racial identity has no influence on how one fares in society. Racism and discrimination influence the social, economic, and physical development among Black, Indigenous, and People of Color (BIPOC), resulting in poorer social and physical conditions in those communities today. Race and racial health

differences are not biological in nature. However, generations of inequity create consequences and differential health outcomes because of structural environments and unequal distribution of resources.

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

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

For more detailed information, see the full FY 2022 MAH Community Health Needs Assessment and Implementation Plan Report on the hospital's website.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Access to Care and Community Navigation **Program Name: Africano Holistic Health Program** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	This Program supports a social worker who sets up needed systems, monitors families, and provides referrals and follow-up with clients regarding referrals to outside resources. These referrals include outside resources for hunger relief, mental health support, medical, housing, and legal services. The social worker is a central point of contact and is essential to address the needs of immigrants who are often very low income, lack skills in self-advocating, have limited English proficiency, may be undocumented, and are likely overwhelmed with multiple stressors.
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	Develop and implement an intake process for all members of the center.
Goal 1 Status	Social worker was able to develop and implement the intake process using the Upmetrics program.
Time Frame Year: Year 1	**Time Frame Duration: Year 2** / **Goal Type: Process Goal**
Program Goal 2	Meet various social service agency partners in Waltham and neighboring towns and discuss opportunities and challenges and develop new partnerships.

Goal 2 Status	We have four confirmed partnerships that are going well and we are able to refer members to for various services. This is an area we have to work very slowly on because choosing the right partner seems harder than we had thought.		
Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**	
Program Goal 3	Conduct ten calls with African immigrant families weekly to support them with referrals and monitor progress.		
Goal 3 Status	Because of the challenging needs that families have, we had to reduce this goal to six families weekly. Families have multiple needs going on at the same time. We are making referrals for these families on a regular basis.		
Time Frame Year: Year 1	**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 Groups for community members.
Goal 1 Status	Two eight week long sessions were completed and thirty community members attended.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	Over 80% of participants will report that they were satisfied with this program.
Goal 2 Status	92% of participants reported being satisfied or very satisfied with this program.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal**
Program Goal 3	Over 80% of participants will report that they felt respected while participating in the group.
Goal 3 Status	100% of participants reported feeling respected while participating in the group.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal**

Program Goal 4	Over 80% of participants report that they were satisfied with the support they received from the facilitator.
Goal 4 Status	100% of participants responding reported they were satisfied or very satisfied with the support they received from the facilitator.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Program Goal 5	Over 80% of participants report gaining some new knowledge that will help them move forward in the grieving process as a result of the group.
Goal 5 Status	92% of participants responding reported gaining some new knowledge that will help them move forward in the grieving process as a result of the group.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Program Goal 6	Over 80% of participants agreed that they were given the opportunity to express their feelings in the group.
Goal 6 Status	100% of participants responding agreed or strongly agreed that they were given the opportunity to express their feelings in the group.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Access to Care and Community Navigation **Program Name: Breast Feeding Education and Support Program** **Health Issue: Access to Care**	
Brief Description or Objective	This program aims to improve rates of breastfeeding for Latina women. The goal of this project was to look into various supports and educational materials to help aid in breaking down the barriers to breast feeding. Some outcomes of the project included development of educational materials, providing breast feeding counseling during maternity stay and connecting Latina women to a Latina community outreach worker who is available during their stay and for postnatal support. Evidence shows that exclusively breast feeding for up to the first 6 months of the babies life has a host of benefits for both baby and new mom.
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	Create a working group to research supports and educational materials in order to break down barriers for breast feeding for Spanish speaking mothers.
Goal 1 Status	Workgroup was created in October of 2021.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	Develop breast feeding educational materials for Spanish speaking pregnant people.
Goal 2 Status	Complete: Created a comprehensive education guide for the purpose of reviewing with pregnant person before birth and available for outpatient and inpatient staff to review with patient.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 3	Create a system to connect Latina pregnant persons to a Latina outreach worker during their stay and for postnatal support after discharge.
Goal 3 Status	Complete: A Latina outreach worker is available to visit patients during their stay and for postnatal support after discharge.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**

Program Goal 4	Increase access to breast pumps for postnatal persons who wish to utilize breast pump at home.
Goal 4 Status	Complete: New moms are now connected to breast pump access before coming in for delivery in order to increase their access to a breast pump upon discharge.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Caregiver Support Group** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	This support group allows those who care for a loved one suffering from Alzheimer's' Disease or dementia to connect with others who understand their challenges in a safe, supportive, and engaging environment. This safe supportive an engaging environment also helps support the mental health of the participants.
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 an on going support group for caregivers.
Goal 1 Status	An ongoing support group was provided two times per week for caregivers.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	Provide support for at least twelve caregivers.
Goal 2 Status	Twelve caregivers attended at least one or more caregiver support group sessions.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **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	Partner with Metro Housing Boston (MHB) to assist patients in need of housing stability resources.
Goal 1 Status	MHB provided a dedicated case worker who met with patients and community members and provided assistance and referrals to community programs and governmental assistance programs.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	The dedicated case worker will make referrals for individuals needing support services or information in addition to housing support.
Goal 2 Status	30% of total referrals were for non-housing related services in the community.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 3	The dedicated case worker will provide a consultation service or interaction with at least thirty individuals.
Goal 3 Status	Thirty-one individuals received a service or interaction which included increased knowledge of eviction prevention, housing search strategies and or financial assistance programs.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Outcomes 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. MAH also subsidizes inpatient and outpatient psychiatric services for those most in need by providing compassionate and evidence-based treatment to patients who present as a threat to themselves or others, or who are unable to care for themselves due to mental illness.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To increase access to behavioral health services.
Goal Status	Provided behavioral health services to 1,751 patients across seven sites.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** | **Goal Type: Process Goal**

Priority Health Need: Access to Care and Community Navigation **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 our 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	MAH staff attended 50 community coalition and or community task force meetings in its service area.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	Build capacity of community-based organizations (CBOs).
Goal 2 Status	MAH provided technical assistance and shared information in order to aid in helping community organizations and residents navigate the health care system; BILH provided evaluation and facilitation trainings to CBOs.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**

Priority Health Need: Access to Care and Community Navigation **Program Name: Community and Professional Education for Emergency Care** **Health Issue: Access to Care**	
Brief Description or Objective	MAH Emergency Room physicians work with Arlington, Belmont, Cambridge, Watertown, Lexington Fire and Police departments, and privately owned Professional EMS to increase their capacity to serve community members in need of emergent care. MAH provides an EMS medical director who works with affiliated EMS services to provide credentialing, continuous review/quality assurance, and education for affiliated community EMTs and paramedics. This involves protocol reviews, medical control, monthly education sessions, and other educational opportunities.
Program 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 Physicians will serve as EMS Medical Directors to local organizations.
Goal 1 Status	MAH Physicians served as EMS Medical Directors to MIT EMS, Harvard University EMS and Pro Ambulance EMS.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	MAH ED Physicians will meet with Belmont, Watertown, Cambridge, and Lexington Fire Department pre-hospital providers as well as Pro EMS providers to review cases and discuss best practices and processes for treatment improvement.
Goal 2 Status	Monthly peer review sessions were provided by MAH ED Physicians.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**

Program Goal 3	Provide medical direction, planning and support as well as ongoing education for Arlington, Belmont, Watertown, and Cambridge Fire Departments, Pro Ambulance EMS, MIT EMS, and Harvard University EMS. Reach at least twenty staff with education medical direction and support monthly.
Goal 3 Status	As medical directors, the Emergency Department provided monthly education sessions to Cambridge, Arlington, Belmont Watertown Fire departments. An average of twenty-five staff were in attendance each month (all towns).

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Program Goal 4	Create an Emergency Preparedness Community Class to teach community members skills and information on what to do in the first minutes of a medical emergency to possibly save a life in an emergency situation at work, home, school or on the street.
Goal 4 Status	MAH Emergency Department staff created a What to do: Life Threatening Emergency Class presentation to educate community members on the importance of acting fast and teaching what to do in the first minutes of a medical emergency to save a life.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Program Goal 5	MAH Emergency Physicians will provide at least two "Life Threatening Emergency - what to do" classes to community organizations who are requesting training.
Goal 5 Status	MAH Emergency Physicians provided three classes in the community and trained seventy people in "Life Threatening Emergencies - what to do".

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: All Health Needs **Program Name: Community Health Grant Program** **Health Issue: Additional Health Needs**	
Brief Description or Objective	To address the priority health needs that were identified by community members through our most recent CHNA, MAH awards grant funding to local community based organizations, municipalities and/or other non-profit status organizations. This program supports a variety of programs which positively impact populations in our service area that face health disparities and inequities.
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 grant funding opportunities to community based organizations, municipalities and other non-profit organizations.
Goal 1 Status	Provided a total of eight organizations funding to work on identified projects which reflect the health priorities identified in our most recent Community Health Needs Assessment.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** | **Goal Type: Process Goal**

Priority Health Need: Access to Care and Community Navigation **Program Name: Culturally Informed Psychological Care** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	DeNovo 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. All clients will report a reduction in persistence of symptoms and improve their daily function.
Goal 1 Status	In FY22, DeNovo provided 148 clients with free or low-cost mental health services.
Time Frame Year: Year 1	**Time Frame Duration: Year 2** / **Goal Type: Outcomes Goal**
Program Goal 2	Support sixty clients with case management, such as safety planning, food or clothing assistance, housing navigation, and accompaniment to court hearings, among other services.
Goal 2 Status	In FY22, De Novo supported seventy-one clients with case management.
Time Frame Year: Year 1	**Time Frame Duration: Year 2** / **Goal Type: Outcomes Goal**

Program Goal 3	Assist sixty survivors of torture, gender-based violence, war crimes or other human rights violations with specialized services through the Torture Treatment Program.
Goal 3 Status	In FY22, De Novo assisted eighty survivors through the Torture Treatment Program.

Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**Goal Type: Outcomes Goal**

Priority Health Need: Access to Care and Community Navigation **Program Name: Doula Program** **Health Issue: Access to Care**	
Brief Description or Objective	MAH offers certified Doulas for Charles River Community Health patients who deliver their baby at MAH. Doulas provide continuous physical, emotional and informational support to a mother before, during and shortly after childbirth.
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 underserved persons at the time of delivery in person.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	Provide Doula support for at least twenty deliveries for those who qualify and request this support.
Goal 2 Status	A doula was provided for five births. We were not able to meet this goal due to staffing shortages and the effects of the pandemic.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Outcomes 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 our 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 healthy food and fresh produce to local food distribution locations to support those most affected by the pandemic and food insecure families and individuals.
Goal 1 Status	5,060 pounds of food delivered and distributed, consisting of a total of 1,086 dozen eggs, 1,134 loaves of whole grain bread, 60 cartons of orange juice, 672 jars of peanut butter, and 504 cans of beans distributed to food insecure families and individual.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Fresh Bucks Program** **Health Issue: Food Insecurity**	
Brief Description or Objective	The Fresh Bucks farmer's market voucher program in Arlington provides vouchers to clients who may not otherwise have the ability to pay for fresh, healthy food at the Farmers Market. This program supports people to increase their purchasing power at the local farmer's markets, and allows Arlington EATS to continue increasing access to fresh local food to community 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	Connect people experiencing food insecurity to the Arlington Eats Market; increase the number of new Arlington households (by 30%).
Goal 1 Status	In FY22, 278 Arlington households (38%) were new additions to the Arlington EATS program.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal**
Program Goal 2	Individuals who are Supplemental Nutrition Assistance Program (SNAP) card holders will be given access to fresh food at the Arlington Farmer's Market in order to increase the number of SNAP vouchers given out.
Goal 2 Status	There was a 130% increase in the number of SNAP vouchers given out in 2022 compared to the 2021 season. There was a 140% increase in the number of unique individuals served.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal**

Priority Health Need: Access to Care and Community Navigation **Program Name: Health Coverage and Public Assistance Enrollment** **Health Issue: Access to Care**	
Brief Description or Objective	MAH recognizes that navigating applications for health insurance can be overwhelming and cumbersome. To address access to health care, MAH provides Certified Application Counselors (CACS) to assist patients and community members in applying for public assistance programs. MAH provides staffing of CACSs to work directly at Charles River Community Health which is a Federally Qualified Health Center to augment their enrollment staff to help with health coverage and public assistance enrollment.
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 health care by providing CACS to work on site at Charles River Community Health in Waltham.
Goal 1 Status	1.01 MAH full time equivalents (FTE) are provided to Charles River Community Health Center to provide these services. These staff are CACs.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	Support community members through the process of enrollment for health insurance and public assistance programs.
Goal 2 Status	3.28 FTE's provide support and enrollment services, at both MAH and Charles River Community Health Center. These staff are CACs.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 3	Support patients and community members by assisting them with enrollment for health insurance and public assistance programs and referring them to government programs.
Goal 3 Status	MAH financial counselors referred 148 individuals with government application forms including help with health insurance applications.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Outcomes 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. Topics included breast cancer education and prevention, nutrition and healthy living education and how to reduce the risk of cancer.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goa 1	Provide at least two health literacy education programs for those who are English language learners.
Goal 1 Status	In FY22, MAH provided three health literacy education programs at two different English language learning community programs. A total of seventy people attended these programs.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	75% of participants in the program will increase their knowledge of ways to find a lump early (breast cancer screening).
Goal 2 Status	In FY22, 79% of participants in the program reported an increase in knowledge of screening methods for breast cancer and reported an increase in how to find a lump early.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal**
Program Goal 3	Over 75% of participants in the program will report an increase in their own knowledge of their risk factors for breast cancer.

Goal 3 Status	In FY22, 79% of participants reported increasing their knowledge of their own risks for breast cancer after the program.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Program Goal 4	75% of participants of the program will report gaining new knowledge about ways to reduce their risk of cancer.
Goal 4 Status	In FY22, 100% of participants surveyed reported they gained new knowledge about ways they can reduce their risk of cancer.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Program Goal 5	75% of participants of the program report they gained new knowledge about the healthy eating plate.
Goal 5 Status	100% of participants surveyed reported gaining new knowledge about the healthy eating plate that will help them make better food choices.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes 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 and the Aging Services Access Points (ASAP) within the hospitals service area.
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 over a zoom platform with a total of 149 older adults in attendance (all four sessions). Presentation topics included: Honoring Choices, Nutrition as We Age, Heart Health Advice from the Doctor, Mindfulness Practice.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	Record the healthy aging presentations to increase access for those unable to participate live and post recording on our website for community viewing.
Goal 2 Status	Increased access to all presentations by posting presentation recordings on the hospital website to allow for community viewing.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**

Program Goal 3	80% of participants who attended a presentation report that they learned strategies or information to help them make choices that could positively impact their overall health.
Goal 3 Status	92% of participants surveyed reported that they learned strategies or information to help them make choices that could positively impact their overall health.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Program Goal 4	Advanced Care Planning Presentation: 80% of participants report after the presentation that they would be able to take what they learned and change or improve their own advance care planning.
Goal 4 Status	100% of those surveyed reported after the presentation that they would be able to take what they learned and change or improve their own advance care planning.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Program Goal 5	Heart Health Advice from the Doctor Presentation: 80% of participants report that after the heart health presentation they were more likely to change their behaviors to improve their overall health.
Goal 5 Status	83% of participants surveyed reported that after the heart health presentation they were more likely to change their behaviors to improve their overall health.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Program Goal 6	Heart Health Advice from the Doctor Presentation: 80% of participants will report that they were more likely to change their behaviors to improve their overall health because of what they learned in the presentation.
Goal 6 Status	83% of participants who took the survey reported that they were more likely to change their behaviors to improve their overall health because of what they learned in the presentation.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Program Goal 7	Mindfulness Program: 80% of participants will report that by participating in the mindfulness presentation they learned strategies or information to help them make choices that could positively impact their overall health.
Goal 7 Status	85% of participants surveyed reported that by participating in the mindfulness presentation they learned strategies or information to help them make choices that could positively impact their overall health.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Program Goal 8	Nutrition as We Age Presentation: 80% of participants will report that they learned new information about plant based foods.
Goal 8 Status	86% of participants surveyed reported that they learned new information about plant based foods.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Access to Care and Community Navigation **Program Name: Infrastructure to support Community Benefits Collaborations across BILH Hospitals** **Health Issue: Access to Care**	
Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital have worked together to plan, implement, and evaluate Community Benefits programs. Staff have worked together to plan the FY22 Community Health Needs Assessment, understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH, in partnership with Mass General Brigham (MGB), has developed a Community Benefits (CB) database. This database is part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.
Program 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 September 30, 2022, in partnership with MGB, create and implement a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits data to more accurately capture and quantify CB/CR activities and expenditures.
Goal 1 Status	All FY22 regulatory reporting data were entered into the Community Benefits Database.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	By September 30, 2022, plan and implement the Community Health Needs Assessment and create the Implementation Strategy to address the priorities that is approved by the hospital Board of Trustees.
Goal 2 Status	All ten BILH Community Benefits hospitals received Board of Trustee approval on their Community Health Needs Assessment and Implementation Plan.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**

Priority Health Need: Access to Care and Community Navigation **Program Name: Lifeline** **Health Issue: Access to Care**	
Brief Description or Objective	This program provides personal emergency response services (Lifeline) to underserved elders and disabled adults. MAH works closely with local Aging Services Access Point Agencies and provides the emergency response services below cost to community members who are 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	Work with local Aging Services Access Points to provide personal emergency response systems at low cost to at least 850 lower-income older and disabled adults.
Goal 1 Status	Over 850 eligible elders and or disabled adults received a personal emergency response system installed at below cost. A service discount is also provided on a monthly basis.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health **Program Name: Medical Interpreter Services (IS)** **Health Issue: Additional Health Need**	
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 speaker phone 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	Provided 18,455 individual encounters either face to face, video, or telephonic.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Mental Health and Substance Use Disorder **Program Name: Mental Health Counseling Initiative with Massachusetts Alliance of Portuguese Speakers (MAPS)** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	This program benefits those who speak little to no English and find it difficult to access critical mental health services due to economic, language, cultural, and/or other barriers such as immigration status. This program utilizes six experienced, bilingual/bicultural Portuguese-speaking counselors, three from within MAPS outside their regular program hours, and three consultants from the community who have worked with MAPS for many years. This program aims to increase access to mental health counseling and services for those who experience significant barriers to these 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	Provide at least twenty-five free Mental Health counseling sessions to people who were in need and requested mental health counseling. These sessions are geared towards individuals identifying as BIPOC.
Goal 1 Status	Twenty-nine free Mental Health counseling sessions were provided for people who were in need of short-term mental health counseling.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** | **Goal Type: Outcomes Goal**
Program Goal 2	Fifteen members of the service community will have their short-term behavioral health issues addressed through remote counseling sessions.
Goal 2 Status	A total of seven community members had their short-term issues addressed by the counseling sessions.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** | **Goal Type: Outcomes Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Mindfulness Based Stress Reduction Class (MBSR)** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	This year the hospital was able to offer a free MBSR © class to community members. MBSR © is an eight week evidenced based program and has been shown to complement traditional medical and psychological treatments and general wellness. This class was facilitated by a certified MBSR© teacher.
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	Offer a free MBSR class to community members.
Goal 1 Status	This eight week class ran in the fall of 2021 and there were eight people who completed the class.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	80% of those who took the class will report that they would be able to take what they learned and use it to improve their own health and wellbeing.
Goal 2 Status	100% of those who took the class reported that they would be able to take what they learned and use it to improve their own health and wellbeing.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal**

Program Goal 3	80% of those who took the class will report they had some or a great deal of positive change when it came to their ability to handle stressful situations appropriately.
Goal 3 Status	100% of those who took the class reported they had some or a great deal of positive change when it came to their ability to handle stressful situations appropriately.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Access to Care and Community Navigation **Program Name: Patient Clothing Closet** **Health Issue: Social Determinants of Health**	
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 1	**Time Frame Duration: Year 1** | **Goal Type: Process Goal**
Program Goal 2	Provide an opportunity for hospital staff to donate to the patient clothing closet in order to restock items that will benefit community residents upon discharge.
Goal 2 Status	Hospital staff 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 1	**Time Frame Duration: Year 1** | **Goal Type: Process Goal**

Priority Health Need: Access to Care and Community Navigation **Program Name: Pharmacy Benefit** **Health Issue: Access to Care**	
Brief Description or Objective	MAH partners with a local pharmacy to provide free, one-time prescriptions to help those who would otherwise not be able to afford or have access to medicine. The social work department then works with these patients to help them transition to 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 24 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.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Access to Care and Community Navigation **Program Name: Prenatal/Post Partum Bilingual Outreach Program** **Health Issue: Social Determinants of Health**	
Brief Description or Objective	This program provides a prenatal community outreach worker at the Charles River Community Health Center. 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.
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 an outreach worker to support Latina women through pregnancy, birth and post partum issues to help them navigate the system and support them for their own health and wellbeing.
Goal 1 Status	A Latina community outreach worker available to provide accessibility help with resources and to provide emotional support.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	Provide community navigational support through a community health worker for at least 150 encounters where navigating the system is a barrier to care.
Goal 2 Status	Provided over 200 encounters which provided navigational and emotional support as well as referrals to community resources. This included helping with governmental assistance programs, birth certificates, SSI office visits, immigration status, babies first appointments, billing issues and helping to prepare moms for appointments and hospital follow-up visits.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal**

Program Goal 3	Provide infant car seats to women who are in need of transporting their newborn home after delivery.
Goal 3 Status	Provided fifteen women with a new infant car seat to assist in transporting their newborn safely home.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Chronic or Complex Conditions **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 medically at risk households weekly for twenty weeks from mid-June to mid-October.
Goal 1 Status	CSA shares were provided to sixteen households in FY22. Thirty households would have been if the program was fully funded, which it was not by the time of the program commencement. Funding from MAH supported thirteen households.
Time Frame Year: Year 1	**Time Frame Duration: Year 2** / **Goal Type: Outcomes Goal**
Program Goal 2	Purchase and provide additional food staples on a weekly basis for the Community Supported Agriculture program at Waltham Fields Community Farms.
Goal 2 Status	Provided 144 bags of lentils, 144 bags of beans, 84 jars of juice and 194 jars of peanut butter to be included with the fresh produce.
Time Frame Year: Year 1	**Time Frame Duration: Year 2** / **Goal Type: Process Goal**

Priority Health Need: Racial Equity **Program Name: Racial Equity and Mental Health, Collaborations with CHNA 17 (Community Health Network Area 17)** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	MAH collaborates with Community Health Network Area (CHNA) 17 to help support and fulfill its mission. MAH provides funding, technical assistance and active steering committee membership. The focus of CHNA 17's work is racial equity as it intersects with mental health.
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 CHNA 17 to support racial equity and mental health.
Goal 1 Status	MAH Community Benefits Director is an active participant in the CHNA 17 Steering Committee.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	85% of coalition members have access to networking opportunities through the coalition.
Goal 2 Status	75% of CHNA 17 members say that the coalition has provided them with networking opportunities.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal**
Program Goal 3	85% of coalition members feel they have access to peer supports in their work to improve racial equity in mental health.

Goal 3 Status	91% of CHNA 17 members consider CHNA 17 to be a source of peer support in improving racial equity in mental health.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Program Goal 4	50% of training participants will improve their skills to incorporate racially explicit programming, policy, or organizational changes.
Goal 4 Status	53% of training participants improved their skills to incorporate racially explicit programming, policy, or organizational changes.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Access to Care and Community Navigation **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 men, women and people of all genders and their dependents who are victims of domestic violence.
Goal 1 Status	Provided a safe bed for persons of all genders and their dependents who were victims of domestic violence and were not able to go home because of an unsafe situation.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: SNAP Match Program at the Farmers Markets** **Health Issue: Food Insecurity**	
Brief Description or Objective	The SNAP Match Program, provides eligible (SNAP enrolled) customers a match of up to $15 in free market dollars every week at the farmers market. The Healthy Incentive Program (HIP), an affiliated benefit for all enrolled in SNAP, HIP is an instant rebate, which can only be used to access produce items at a farmers market or CSA, through HIP certified vendors. This funding supports both Watertown and Belmont's farmer's markets to help grow their SNAP Match Programs and affiliated HIP programs. It also supports the efforts to increase enrollment with outreach and education about the market's food assistance programs. This year MAH worked with the Belmont Food Collaborative and the City of Watertown to increase their capacity to provide residents with increased access to healthy foods.
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 the number of SNAP Match shoppers at the Watertown Farmer's Market.
Goal 1 Status	SNAP Match customers increased by 35% this year at the Watertown Farmers Market from the previous year. This represented an increase of about 200 people.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal**
Program Goal 2	Increase the number of SNAP Match shoppers at the Belmont Farmers' Market.
Goal 2 Status	Total SNAP Match shoppers at this year's farmers market was 234 individuals, an increase of 54% from the previous year.

Time Frame Year: Year 1	Time Frame Duration: Year 1	Goal Type: Outcomes Goal
Program Goal 3	Collaborate with local SNAP Match Programs to help support access to fresh produce for those who are low resourced.	
Goal 3 Status	Collaborated and supported both Belmont and Watertown SNAP Match programs with their local farmers markets in order to increase access to fresh produce for those who are low resourced.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Social Determinants of Health Screening Program** **Health Issue: Social Determinants of Health**	
Brief Description or Objective	The social determinants of health are the conditions in which people are born, grow, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These conditions have a huge impact on the health of all people especially those who face the greatest inequities and health disparities. MAH worked extensively this year to determine how best to identify patients who are most affected by social determinants of health and develop a system to refer patients to community 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	Create a work group to plan and implement a screening program for providers to identify patients who experience food, housing, transportation and/or financial insecurity.
Goal 1 Status	Work group was created and worked towards goals of project.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	Develop a system to identify patients who can benefit from community resources through the screening process.
Goal 2 Status	A system has now been developed to identify patients who can benefit from community resources through the screening process.

Time Frame Year: Year 1	Time Frame Duration: Year 1	Goal Type: Process Goal
Program Goal 3	Build a Social Determinants of Health screening process for social work and case workers to be able to identify patients who can be referred to outside community resources.	
Goal 3 Status	A system has now been developed for social work and case workers to be able to identify patients who can be referred to outside community resources.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Social Work Community Support** **Health Issue: Social Determinants of Health**			
Brief Description or Objective	MAH social workers attend community meetings to share best practices, identify opportunities to improve collaborations, and address challenges to optimizing health for our most underserved community members including older adults and people experiencing homelessness.		
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	Social workers to attend community meetings and facilitate bidirectional communication between community based organizations, local agencies and hospital staff.		
Goal 1 Status	Designated social workers attend a variety of community meetings as a representative of MAH to facilitate bidirectional communication and support for transitional care.		
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**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 225 patients and their family members by the stroke nurse coordinator.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Program Goal 2	Create a Stroke awareness campaign during the month of May 2022 which is Stroke Awareness Month.
Goal 2 Status	Created a stroke awareness campaign including developing and distributing stroke education and “Act Fast” materials for community members.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Program Goal 3	Distribute over 1,500 pieces of stroke education in multiple languages through the local Meals on Wheels programs and other community organizations hosting food pantries or delivering food to homebound individuals.
Goal 3 Status	Distributed over 2,000 stroke educational pieces in six different languages in addition to English to various community organizations for distribution to community members and for posting in common areas.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Program Goal 4	Provide over 1,000 stroke education materials in multiple language to our local Visiting Nurse Association service for distribution to residents when conducting home visits.
Goal 4 Status	Provided over 1,000 stroke education materials to our local Visiting Nurse Association in six different languages in addition to English, which were distributed to residents when conducting home visits.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use Disorder **Program Name: Substance Use Navigation and Support** **Health Issue: Substance Use Disorders**	
Brief Description or Objective	This program provides a social work navigator in the MAH ED. The navigator provides support, screening and referrals to the Substance Treatment and Referral Team (START). This team collaborates with the department of psychiatry to help with continuity of 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 a substance use navigator to provide support and care to those patients in the ED who show signs of substance use disorder and to help with continuity of care.
Goal 1 Status	Provided a substance use navigator in the ED to provide support and care to those patients in the ED who show signs of substance use disorder and to help with continuity of care.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	Refer patients who are diagnosed with substance use disorder to the START Program (Substance Treatment and Referral Team), and give them an opportunity to have a consult with the team.
Goal 2 Status	Referred 517 individuals to the START program and 423 individuals received an assessment and met with the team.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process 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 ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
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 wellbeing.
Goal 1 Status	Survivorship Day Event completed (virtual event) in June 2022 with 65 people participating.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Program Goal 2	90% of those who participated in survivorship day will report they will be able to take what they learned or a skill they practiced during the event and use it to improve their own health and wellbeing.
Goal 2 Status	100% of those surveyed reported they will be able to take what they learned or a skill they practiced during the event and use it to improve their own health and wellbeing.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Program Goal 3	90% of those who participated in survivorship day will report they learned something of lasting value by participating._
Goal 3 Status	94% of those surveyed reported they learned something of lasting value by participating.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes 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.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Access to Care and Community Support **Program Name: Transportation as a Barrier to Medical Care** **Health Issue: Access to Care**	
Brief Description or Objective	MAH in partnership with SCM Transportation provides transportation to medical appointments to community members in need. Metro Cab vouchers and Charlie Cab cards are also available for those who qualify for transportation support.
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	Over 2,318 rides provided free of charge to those where transportation is a barrier to medical care. Transportation is provided via SCM Transportation, Metro Cab vouchers and Charlie Cards distributed as determined by the social work staff.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal**
Program Goal 2	MAH staff to participate in Cambridge Transportation Task Force and the Alewife Transportation Management Association addressing transportation 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 it pertains to transportation.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**

Priority Health Need: Racial Equity **Program Name: Trauma Informed Counselors Representing the BIPOC 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 additional counselors in the community who represent Black and POC as well as non-English speaking communities to expand the community team's counseling capacity and make counseling services more accessible to people from these 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	Mount Auburn Hospital to help support Transition House to be able to expand staffing to include three new counselors with language and cultural fluency.
Goal 1 Status	Three new counselors were hired and Transition house is now able to provide culturally appropriate counseling services in English, Haitian Creole and Spanish.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	Provide culturally appropriate counseling services within a week for those who seek to connect with a clinician.
Goal 2 Status	Culturally appropriate counseling services are provided within a week for those who seek to connect with a clinician
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Upstream Intervention Model Resource Navigator** **Health Issue: Housing Stability/Homelessness**	
Brief Description or Objective	This program helps support a resource navigator at the Somerville Homeless Coalition (SHC). The resource navigator connects families and individuals to public and private benefits to boost household income. The aim is to use this pilot program as a pivot point to move away from crisis response model to a proactive upstream intervention model. This paradigm shift allows for more critical time and opportunity to introduce clientele to a greater range of services and support. The goal is to help families access resources, which they have found previously unobtainable, to increase household income (e.g., access to job programs) and decrease household expenditures (e.g., securing benefits), thereby fostering a more stabilized lifestyle.
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 low-income and food insecure households (including children) services and or referrals in their primary language.
Goal 1 Status	Fifty low-income and food insecure households (includes families) have received services in their primary language.
Time Frame Year: Year 1	**Time Frame Duration: Year 2** / **Goal Type: Outcomes Goal**
Program Goal 2	Sixty low-income and food insecure households will be enrolled into the SNAP program.
Goal 2 Status	Sixty six households have enrolled for SNAP through SHC.
Time Frame Year: Year 1	**Time Frame Duration: Year 2** / **Goal Type: Outcomes Goal**

Program Goal 3	Forty low-income and food insecure households will have been provided with wraparound case management services at our food pantry.
Goal 3 Status	Forty low-income households have been provided with case management services.

Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**Goal Type: Outcomes Goal**

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	**$1,124,460**	**$0**
Community-Clinical Linkages	**$548,513**	**$17,833**
Total Population or Community Wide Interventions	**$421,771**	**$96,626**
Access/Coverage Supports	**$777,225**	**$10,000**
Infrastructure to Support CB Collaborations	**$42,720**	**$0**
Total Expenditures by Program Type	**$2,914,689**	**$124,459**
Leveraged Resources		
Total CB Programming	**$2,914,689**	
Net Charity Care Expenditures		
HSN Assessment	**$2,798,362**	
Free/Discounted Care		
HSN Denied Claims	**$1,822580**	
Total Net Charity Care	**$4,620,942**	
Total CB Expenditures	**$7,535,631**	

Additional Information	
Net Patient Services Revenue	**$337,357,000**
CB Expenditure as % of Net Patient Services Revenue	**2%**
Approved CB Budget for FY23 (*Excluding expenditures that cannot be projected at the time of the report)	**$7,500,000**
Bad Debt	**$3,496,536**
Bad Debt Certification	**Yes**

Comment: In addition to the above amounts, Beth Israel Lahey Health contributed $1 million to The Latino Equity Fund and the New Commonwealth Racial Equity and Social Justice Fund in support of addressing health disparities related to hypertension, diabetes and obesity and further integration and alignment, particularly regarding stakeholder engagement and convening with the Health Equity Compact.

SECTION VI: CONTACT INFORMATION

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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Form – Year 1

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

I. Community Benefits Process:

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

     MAH is a member of Beth Israel Lahey Health (BILH). While MAH oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure ensures that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with 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.**

2. Community Benefits Advisory Committee (CBAC)
   - Members (and titles):
     Mary DeCourcey, Director of Community Benefits and Chair of MAH CBAC, MAH; Carla Beaudoin, Director of Development, Metro Housing Boston; Christine Bongiourno, Director, Arlington Health and Human Services; Diane Bono, Vice President of Human Resources, MAH: Elizabeth Browne, CEO, Charles River Community Health; Renee Cammarata Hamilton, Director of Community Health Improvement Team, Cambridge Health Alliance; Stacy Carruth, Planning Director, CHNA 17; Yvonne Cheung, MD, Chair of Quality and Safety, MAH; Patty Contente, Director, Community Outreach, Help and Recovery, Somerville Police Department; Lisa Cook, Executive Director, Somerville Center for Adult Learning Experiences, (SCALE); Heather Gibbons-Perez, Director of Performance Improvement and Regulatory Affairs, MAH; Rich Guarino, Chief Operating Officer, MAH; Nancy Bacci, Acting Director, Somerville Health and Human Services; Laura Kurman, Senior Program Director, Wayside Youth and Family Support Network; Mike Libby, Executive Director, Somerville Homeless Coalition; Julia Londergan, Esq., Director of Development, CASPAR Inc. Marie McCune, RN Stroke Nurse Coordinator, MAH; Myriam Michel, Executive Director, Health Waltham; Colleen Morrissey, Director of Volunteers and Special Projects, Somerville Cambridge Elder Services; Nava

Niv-Vogel, Director, Belmont Council on Aging; Larry Ramdin, Director, Watertown Public Health Department; Robert Torres, Boston Regional Manager, Community Benefits, BILH; Stephanie Venizelos, Community Wellness Program Manager, Town of Watertown; Jose Wendel, Director, Population Health Initiatives, Cambridge Health Department, Dr. Elissa Stecker, Mount Auburn Professional Services Director, Kathy Howard, Director of Social Work and Interpreter Services, MAH

- Leadership:
  Chad Wable, President (2022), Diane Bono, VP of Human Resources; Rich Guarino, Chief Operating Officer (2022); Yvonne Cheung, MD, Chair of Quality and Safety (2022); Mary DeCourcey, Director of Community Benefits; Health Gibbons-Perez, Director of Performance Improvement and Regulatory Affairs; Kathy Howard, Director of Social Work and Interpreter Services; Marie McCune, Stroke Nurse Coordinator

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- Frequency of meetings:

The MAH Community Benefits Advisory Committee (CBAB) met quarterly during FY 2022 and also attended the hospital's annual Community Benefits public meeting. Meeting Dates: December 16, 2021, March 24, 2022, May 19, 2022, June 16, 2022 and September 8, 2022.

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

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

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

At BILH and Mount Auburn Hospital our belief that everyone deserves high-quality, affordable health care is at the heart of who we are and what drives our work with our community partners. The organizations that are now part of BILH have always been deeply committed to serving their communities. Working collaboratively with our

community partners, our Community Benefits Advisory Committee and the Community Benefits team, such commitment is shared by staff at all levels within MAH:

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

Senior Leadership Team – provided input and reviewed the CHNA and adopted the Implementation Strategy; was informed of process for the CHNA and Implementation Strategy. Members of the senior leadership team include:
Chad Wable, President and CEO
Rich Guarino, COO
Bill Sullivan, CFO
Deb Baker, RN, VP of Patient Care Services
Yvonne Cheung, MD, Chief Quality Officer
Chris Fischer, MD, Chair Department of Emergency Medicine
Ed Huang, MD, Chair Department of OB/GYN

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

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

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 assessments. The assessment was supported by MAH's Community Benefits Advisory Committee. The Community Benefits Advisory Committee is comprised of community members,

service providers, and other stakeholders that either live in 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: healthy eating and active living opportunities, housing affordability and home ownership, workforce development and the creation of employment opportunities.

- 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, required focused and ongoing societal efforts to address avoidable inequalities, socioeconomic barriers to care, and both historical and contemporary injustices. Throughout MAH's assessment process, MAH worked to understand the needs of populations that are often disadvantaged, face disparities in health-related outcomes, and are deemed most vulnerable. MAH's IS is rooted in health equity and was developed with a focus on reaching the geographic, demographic and socioeconomic segments of populations most at risk, as well as those with physical and behavioral health needs in the hospital's CBSA.

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

  The MAH's IS includes a diverse range of programs and resources to addresses the prioritized needs within the MAH's Community Benefits Service Area. The majority of MAH's community benefits initiatives are focused on cohorts and sub-populations due to identified disparities or needs. MAH's strategies include increasing access to healthy foods through support of Healthy Waltham and its initiatives as well as supporting SNAP Match programs in the hospital's service area. MAH partners closely with Community Health Network Area 17, a local coalition working on racial justice. Additionally, MAH collaborates with many community partners to own, catalyze and/or support total population and community-wide interventions including Somerville Homeless Coalition, Waltham Fields Community Farm, De Novo Center for Justice and Healing and Charles River Community Health.

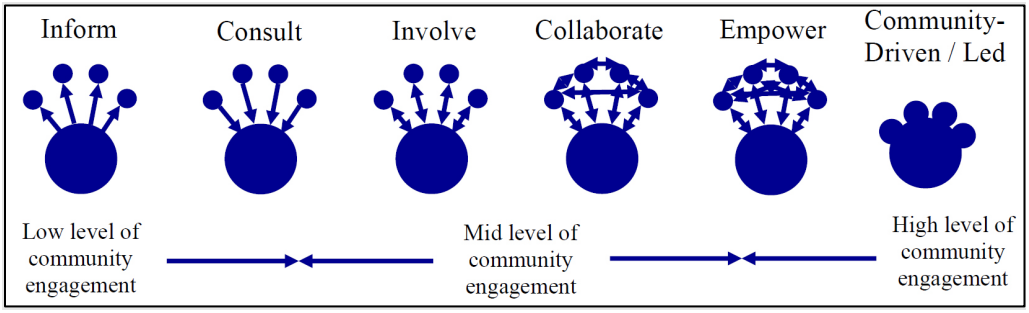
II. Community Engagement

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

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
CHNA 17	Stacy Carruth, Planning Director	Local health community organizations (CHNAs)	CHNA 17 is an active member on MAH's CBAC. They were heavily involved in the prioritization and strategy process. CHNA 17 consulted on the community engagement process and helped recruit survey and focus group participants.
Healthy Waltham	Miriam Michel, Executive Director	Local health community organizations (CHNAs)	Healthy Waltham participated as a member of our CBAC. Participated MAH's prioritization and strategy process. They were interviewed as a key informant for the CHNA and guided the process.
SCALE in Somerville	Lisa Cook, Director	Schools	SCALE provides English classes and GED education to adult learners. They organized a focus group for MAH to engage English Language Learners to inform our CHNA and elevate voices not always heard in health assessments.
Charles River Community Health	Amy Knudsen, Grants Manager	Community health centers	MAH engages with CRCH on a number of different programs. CRCH participates on the MAH CBAC and consulted on their community engagement process. CRCH also conducted its own health assessment during the same time MAH was conducting theirs. Both MAH and CRCH

			were able to share information, leverage resources and chose complimentary strategies when possible.
Local Health Departments	Directors of the six local health departments of in MAH Service area	Local Health Departments	Participated as members of the CBAC; provided input on community engagement and prioritization of health priorities and strategies.

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



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

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

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in assessing community health needs	Empower	Goal was met.	Collaborate
Collecting data	Empower	Goal was met – MAH built capacity for community residents to co-facilitate/facilitate focus groups and breakout sessions during listening sessions.	Collaborate

[1]

Defining the community to be served	Collaborate	Starting several months before launching the CHNA, MAH worked with its CBAC to identify the community, those to be engaged and ways to engage them.	Collaborate
Establishing priorities	Empower	Working with BILH, MAH actively engaged with the CBAC and the community to identify and select priorities.	Collaborate

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

  BILH and MAH are committed to continuing to build our capacity to engage with the community and to foster community member capacity for facilitation and evaluation.

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 met – community listening sessions with breakout sessions facilitated by community members, with active CBAC engagement in prioritization discussions and decisions.	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Collaborate	Goal met – FY 2022 was the last year of MAH's previous Implementation Strategy (IS) and its CBAC was informed regarding how CB resources were allocated. MAH will collaborate with its CBAC to select programs to invest its resources in for the FY 2023 – 2025 IS.	Collaborate
Implementing Community Benefits programs	Collaborate	Goal met – FY 2022 was the last year of MAH's previous Implementation Strategy (IS). MAH will be collaborating with the community on new and existing programs for its FY 2023-2025 IS.	Collaborate
Evaluating progress in executing Implementation Strategy	Involve	Goal met - BILH and MAH held multiple evaluation workshops to build evaluation and data capacity of community organizations, CBAC members and community residents.	Collaborate

Updating Implementation Strategy annually	Inform	Goal met – FY 2022 was the last year of the current FY22 IS. BILH and MAH are working to develop, track and share data on a routine basis with the CBAC.	Collaborate

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

  BILH and MAH are committed to continuing to build our capacity to engage with the community and to foster community member capacity for facilitation and evaluation.

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.

   Yes
   June 16, 2022 – Virtual meeting on Zoom platform

   MAH has a comprehensive Implementation Strategy (IS) to respond to identified community health priorities. MAH engaged with the leadership team and the community to identify and select priorities for the new (FY2023-2025) IS. The IS was shared with the CBAC, the leadership team, adopted by the Board of Trustees and widely distributed.

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 their collaboration with these and other organizations that allowed MAH to engage with hard-to-reach cohorts. MAH is particularly proud of how it was able to reach community members who had not previously been engaged.
   - What lessons have you learned from your community engagement experience? (150-word limit)

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

III. Regional Collaboration

1. Is the hospital part of a larger community health improvement planning process?

   ☒Yes ☐No

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

  For its FY 2022 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 10 licensed hospitals, including MAH, encompassing 49 municipalities and six Boston neighborhoods. While MAH focuses its Community Benefits resources on improving the health status of those in its CBSA experiencing the significant health disparities and 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.

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:
  MAH worked collaboratively with each of the 9 other hospitals in the BILH system to design and implement a system-wide, highly coordinated CHNA and prioritization process across each of the system's 10 licensed hospitals.

  MAH also collaborated with Cambridge Health Alliance (CHA). CHA was also conducting their Regional Wellbeing Assessment at the same time as MAH was conducting its CHNA.

- Institutions involved with the BILH Collaboration:
  - Anna Jaques Hospital
  - Beth Israel Deaconess Hospital - Milton
  - Beth Israel Deaconess Hospital - Needham

- Beth Israel Deaconess Hospital - Plymouth
- Beth Israel Deaconess Medical Center
- Beverly and Addison Gilbert Hospitals
- Lahey Hospital and Medical Center
- Mount Auburn Hospital
- New England Baptist Hospital
- Winchester Hospital

- Institutions involved with regional collaboration
  - Cambridge Health Alliance

- Brief description of goals of the collaboration:
  MAH collaborated with the other 9 hospitals in the BILH system to add rigor to the hospitals' assessments and planning processes, promoting alignment across hospital efforts and strengthening relationships between and among BILH hospitals, community partners and the community-at-large.

  MAH collaborated with CHA during the FY 22 CHNA and IS process. Our goal was to share data and information about the communities we serve to enhance our experiences and to reach more people. During MAH's CHNA we collaborated with CHA to reach our overlapping communities more deeply. We worked together to create shared survey questions and shared distribution avenues in order to reach as many community members as possible, with a focus on populations that experience the greatest health inequities. We worked together to make sure we were not overburdening certain cohorts in our shared service areas when carrying out our community engagement plans. We also shared focus group data and other qualitative and quantitative data in order to enhance our knowledge of the needs of those living in our service areas.

- Key communities engaged through collaboration:
  MAH collaborated with the other 9 hospitals in the BILH system to engage the 49 municipalities and six Boston neighborhoods who were part of the individual Community Benefits Service Areas from each of the licensed hospitals.

  MAH and CHA shared service area includes Cambridge and Somerville.
- If you did not participate in a collaboration, please explain why not:
  Click or tap here to enter text.