Community Benefits Report

Fiscal Year 2024

Beth Israel Lahey Health
Mount Auburn Hospital

TABLE OF CONTENTS

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 *WE CARE:*

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

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

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

"Mount Auburn Hospital is steadfast in its commitment to improving the health and wellbeing of community members, through collaboration with community partners to

reduce barriers to health care and to continually strive to reduce health disparities and health inequities for those who are most vulnerable in our community. We seek to identify current and emerging health needs and address these needs through education, prevention, treatment and the promotion of healthy behaviors."

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

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

- **Implementing community health programs and services** 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) is focusing 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
The accomplishments and activities highlighted in this report are based upon priorities identified and programs contained in MAH's FY 2022 Community Health Needs Assessment (CHNA) and FY 2023-2025 Implementation Strategy (IS):

- Provided stroke education and support to over 240 patients and their family members by the stroke nurse coordinator. Through our stroke awareness program, distributed over 5,000 stroke educational materials including magnets in 5 different languages in addition to English through the local Meals on Wheels programs, farmer's markets, at libraries and other community organizations through educational tabling.
- Provided a grant opportunity to current grantees to continue their work in the community. MAH was able to fund four organizations to work on programs that helped to increase their capacity to address the top health concerns identified in MAH's most recent CHNA and in their community.
- Provided Health Education through MAH's Healthy Aging program to over 150 older adults.
- Financial Counselors assisted 3,922 people with new applications, renewals and public assistance programs including help to enroll in and receive health insurance benefits. This includes both MAH and at Charles River Community Health sites.
- Through the MAH Collaborative Care Model behavioral health services were provided to 1,395 patients across twelve sites. Direct subsidies for this service included $211,229 within MAH's CBSA and $433,069 was accounted for subsidizing these services outside of its CBSA.
- Case management and counseling services were provided to 45 low-to-moderate income individuals in order to prevent eviction, increase housing stability and economic self-sufficiency and improve overall quality of life through the Metro Housing Boston Co-Location Program.
- Supported 46 individuals and 4 children into stable housing through Somerville Homeless Coalition Support Services program.
- Reduced food insecurity by providing food for distribution to those who have been severely impacted by food insecurity. Provided and distributed 900 dozen eggs and 900 loaves of bread.
- Contributed to supporting an increase in SNAP Match enrollments and healthy food incentives for use at farmer's markets within our service area by collaborating with cities and towns to promote enrollment. There was an average increase in enrollment in these incentive programs of 35% in the collaborating cities and towns included in this program.
- Provided over 250 women with navigational and emotional support as well as referrals to community resources. This included over 2,000 encounters of support including, helping with governmental assistance programs, birth certificates, SSI office visits, immigration status, babies first appointments, billing issues and helping to prepare moms for appointment and hospital follow-up visits.

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 four 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's FY 2023 - 2025 IS, it should work with its community partners to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, 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 continue to provide effective and high-quality interpreter services for patients who request this service in order to improve access to care.

- **Social Determinants of Health**

  - MAH will continue to use its purchasing power to acquire food for distribution through its partnership with Healthy Waltham.
  - MAH will continue to partner with More Than Words to help support youth job training, youth development, intense case management, education and employment coaching for high-risk teens through their Social Enterprise Youth Development Program.

- **Mental Health and Substance Use**
  - MAH will continue to collaborate with De Novo Center for Justice and Healing to help support its Culturally Informed Counseling Program.
  - MAH will continue to connect people to behavioral health services through its Collaborative Care model.
- **Complex and Chronic Conditions**
  - MAH will continue its healthy aging program which partners with local Councils on Aging and provides a venue for older adults to learn about preventing and or managing chronic conditions as well as healthy aging.
  - MAH will continue to partner with many area agencies to promote stroke prevention and how to recognize the signs of stroke for early intervention to save lives.
- **Racial Equity**
  - MAH will continue to work with CORE MH to support their work in promoting racial equity with a focus on increasing access to mental health for those who identify as BIPOC.
  - MAH will continue to partner with Africano Waltham to help support its efforts to increase mental health support through its Holistic Health Program.

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). The MAH Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members and asked them to submit the form to the AGO website.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team
MAH's Board of Trustees along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its CBSA and beyond. World-class clinical expertise, education and research along with an underlying commitment to health equity are the primary tenets of its mission. 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 MAH's Implementation Strategy, ensuring that hospital policies and resources are allocated to support planned activities.

It is not only 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 *WE CARE:*

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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 MAH's 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 14, 2023
March 21, 2024
June 20, 2024
September 19, 2024

Community Partners

MAH recognizes its role as a tertiary/academic resource in a larger health system and knows that to be successful it needs to collaborate with its community partners and those it serves. MAH's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy (IS) were completed in close collaboration with MAH'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 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 with Charles River Community Health (CRCH) in Waltham. This relationship includes providing a strong OB/GYN and Midwifery program there, particularly supporting Massachusetts Department of Mental Health which continues to partner with us. This year we are working on streamlining our data collection tools and have partnered with Salesforce to help support and consult with us to improve our database. We also support Latinas, through pre- and post-natal care which includes outreach and home visits. Other support to CRCH includes providing financial counselors.

The following is a comprehensive listing of the community partners with which MAH joins in assessing community need as well as planning, implementing, and overseeing its Community Benefits Implementation Strategy. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment (Section VII, page 70).

Africano Waltham	Massachusetts Alliance of Portuguese Speakers
American Cancer Society	Mass. Institute of Technology EMS
Arlington Council on Aging	MassHire MNW
Arlington Eats	Metro Cab of Boston
Arlington Fire Department	Metro Housing Boston
Arlington Health and Human Services	More Than Words
Arlington Housing Authority	Paine Senior Services
Arlington Police Department	Professional Ambulance EMS
Arlington Youth Counseling Center	Rainbow Commission in Arlington
Belmont Council on Aging	SCM Community Transportation
Belmont Department of Public Health	Somerville Cambridge Elder Services
Belmont Fire Department	Somerville Council on Aging
Belmont Police Department	Somerville Health and Human Services
Cambridge Community Foundation	Somerville Homeless Coalition
Cambridge Community Learning Center	Somerville Police Department
Cambridge Council on Aging	Somerville Stakeholders Coalition
Cambridge Department of Public Health	Springwell Elder Services
Cambridge Fire Department	Transition House
Cambridge Heart	Town of Arlington
Cambridge Health Alliance	Town of Belmont
Cambridge Police Department	Waltham Connections
Charles River Community Health	Waltham Council on Aging
City of Cambridge	Waltham Family School
City of Somerville	Waltham Fields Community Farm
City of Waltham	Waltham Health Department
City of Watertown	Waltham Interagency Group
CORE Mental Health	Waltham Partnership for Youth
DeNovo Center for Justice and Healing	Waltham Police Department
First Source	Watertown Cares
Harvard University EMS	Watertown Council on Aging
Healthy Waltham	Watertown Fire Department
Housing Corp. of Arlington	Watertown Health Department
Kingdom Empowerment Center	Watertown Housing Authority
Lamplight Women's Literacy Center	Watertown Police Department
Lexington Fire Department	Wayside Youth and Family Services
Live Well Watertown	Y2Y Network

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 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: Racial Equity **Program Name: Africano Waltham 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	Enter family data into the Upmetrics intake tracking system.
Goal 1 Status	In FY24, the social worker entered at least 50 new families into the Upmetrics tracking system.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** / **Goal Type: Process Goal**
Program Goal 2	Create at least 2 new partnerships this year.
Goal 2 Status	7 new partnerships were created this year. This included coordinating a new community coalition which meets regularly to share information and increase referral resources.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** / **Goal Type: Process Goal**
Program Goal 3	Serve at least ten families with in depth services and counseling, resulting in improved wellness.
Goal 3 Status	In FY24, 5 new families successfully served with in-depth services and counseling which improved wellness for these families. There are 20 families total who have utilized this service within the past 2 years.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** / **Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Behavioral Health Crisis Consultation** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	To provide 24/7/365 behavioral health crisis evaluation in the emergency department (ED) and throughout other hospital units for individuals experiencing mental health and substance use related crisis. Services are payer agnostic and provided via in-person or telehealth by a multidisciplinary team of qualified professionals, including Psychiatrists, independently licensed and Master level clinicians, Nurse Practitioners, Registered Nurses, Certified Peer Specialists, and Family Partners. The services include initial assessments for risks, clinical stabilization, treatment initiation, care coordination, and ongoing evaluation to ensure appropriate level of care placement.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Increase access to clinical and non-clinical support services for those with mental health and substance use issues, by providing behavioral health services in the hospital.	
Goal 1 Status	A multidisciplinary team, comprised of qualified behavioral health providers, psychiatry, family partners, and peer specialists, is employed to provide behavioral health crisis consultations in the Emergency Department or medical floors of the hospital. In FY24 between the months of August and September, the team provided a total of 25 screenings.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**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	Three eight-week long sessions were completed and 26 community members attended.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: BILH Workforce Development** **Health Issue: Additional Health Needs Identified by the Community**	
Brief Description or Objective	BILH is strongly committed to workforce development programs that enhance the skills of its diverse employees and provide career advancement opportunities. BILH offers incumbent employees pipeline programs to train for professions such as Patient Care Technician, Central Processing Technician and Associate Degree Nurse Resident. BILH Employee Career Initiative provides career and academic counseling, academic assessment, and pre-college and college-level science courses to employees at no charge, along with tuition reimbursement, competitive scholarships and English for Speakers of Other Languages (ESOL) classes. BILH is also committed to making employment opportunities available to qualified community residents through training internships conducted in partnership with community agencies and hiring candidates referred by community programs.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	In FY24, MAH will offer career development and health care training information to college level students in the community.
Goal 1 Status	In FY24, MAH provided career development and health care training information to 225 college level students.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**
Program Goal 2	In FY24 MAH will offer career development and health care field training information to high school students in the community.
Goal 2 Status	In FY24, MAH provided career development and health care field training information to 40 high school students.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**
Program Goal 3	In FY24, Workforce Development will attend events and give presentations about employment opportunities to community partners.
Goal 3 Status	In FY24, 33 events and presentations were conducted with community partners across the BILH service area.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**
Program Goal 4	In FY24, Workforce Development will continue to encourage community referrals and hires.

Program Status 4	In FY24, 412 job seekers were referred to BILH and 111 were hired across BILH hospitals.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 5	In FY24, Workforce Development will hire interns hired after internships and place in BILH hospitals.
Program Status 5	In FY24, 37 interns were hired permanently in BILH hospitals. MAH participated in these hirings.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 6	In FY24, Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees.
Program Status 6	In FY24, 14 BILH employees attended citizenship classes, 15 BILH employees attended career development workshops and 207 BILH employees attended financial literacy classes. Mount Auburn employees participated in these offerings.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 7	In FY24, Workforce Development will offer employees career development services.
Program Status 7	In FY24, 1,044 BILH employees received career development services.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 8	In FY24, Workforce Development will offer English for Speakers of Other Languages (ESOL) classes to BILH employees.
Program Status 8	In FY24, 82 employees across BILH were enrolled in ESOL classes. MAH employees participated in these classes.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 9	In FY24, Workforce Development will offer internships in BILH hospitals to community members over the age of 18.
Program Status 9	In FY24, 107 community members placed in internships across BILH hospitals to learn valuable skills. MAH participated in offering these internships.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal 10	In FY24, Workforce Development will offer paid trainings for community members across BILH.
Program Status 10	In FY24, BILH trained total of 99 community members to Patient Care Technician or Nursing Assistant (41), Pharmacy Tech (22), Medical Assistant (29), Behavioral Health

	roles (3) or into the Associate Degree Nursing Residency program (4). MAH participated in offering these trainings.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Racial Equity **Program Name: BILH Diversity, Equity and Inclusion Office** **Health Issue: Additional Health Needs Identified by the Community**	
Brief Description or Objective	BILH's Diversity, Equity, and Inclusion (DEI) office develops and advocates for policies, processes and business practices that benefit the communities and our workforce. The DEI vision is to transform care delivery by dismantling barriers to equitable health outcomes and become the premier health system to attract, retain and develop diverse talent.
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	Across BILH, increase BIPOC representation among new leadership (directors and above) and clinical (physicians and nurses) hires with an aim of at least 25% representation.
Goal 1 Status	Across BILH there was a 18% increase in BIPOC leadership (directors and above) and clinical (physicians and nurses) hires.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal**
Program Goal 2	Increase spend with diverse businesses by 25% over the previous fiscal year across the system.
Goal 2 Status	More than $70 million was contracted to Women and Minority-owned Business Enterprises (WMBE) in FY23. This is a 28% increase over FY23.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal**
Program Goal 3	Provide an opportunity for staff to work together to promote Diversity, Equity and Inclusion and to guide the hospital's efforts to nurture and sustain a diverse, equitable and inclusive organizational culture and to make meaningful and lasting change for our patients, our employees and our communities.
Goal 3 Status	Mount Auburn Hospital continues to support its Diversity, Equity and Inclusion Council to guide the hospital's efforts to nurture and sustain a diverse, equitable and inclusive organizational culture and to make meaningful and lasting change for our patients, our employees and our communities.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** | **Goal Type: Process Goal**

Program Goal 4	Support creation or expansion of local DEI committees/resource groups.
Goal 4 Status	MAH created a Diversity, Equity and Inclusion Council to guide the hospital's efforts to nurture and sustain a diverse, equitable and inclusive organizational culture and to make meaningful and lasting change for our patients, our employees and our communities.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **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 Latinas 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 a baby's life has a host of benefits for both the baby and the 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	Provide breast feeding education materials to promote breast feeding during 3 touch points of pregnancy, in the first trimester, in the second trimester and at 36 weeks of gestation.
Goal 1 Status	Complete: 3 informational documents are provided to patients during their pre-natal visits and all materials are translated into Spanish.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: BILH Behavioral Health Access Initiative** **Health Issue: Mental Health/Mental Illness**			
Brief Description or Objective	To support increased access to mental health and substance use services and supports, MAH participated with other BILH hospitals to pilot Behavioral Health Navigator grant programs, offer Mental Health First Aid (MHFA) trainings, provide behavioral health navigation and digital literacy trainings to BILH physical health navigators and amplify anti-stigma messaging, resources and supports.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	Offer Mental Health First Aid (MHFA) trainings to community residents and BILH staff across the BILH Community Benefits Service Area (CBSA).		
Goal 1 Status	More than 350 community residents and BILH staff attended one of 21 MHFA trainings provided across the BILH CBSA, of which 75% (274) completed all pre- and post-training requirements to receive Mental Health First Aid certification.		
Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**	
Program Goal 2	Increase knowledge and awareness of available behavioral health services and supports among clinical and non-clinical staff who provide patients/clients with physical and/or social determinants of health navigation services. Offer Mental Health First Aid (MHFA) trainings to community residents and BILH staff across the BILH Community Benefits Service Area (CBSA).		
Goal 2 Status	28 BILH, Community Health Center and Community Behavioral Health Center staff were trained. Trainees reported a 35% increase in identifying the essential elements of the behavioral health treatment systems of care; a 49% increase in feeling confident they can navigate patients to the appropriate level of behavioral health care, including outpatient, self -help, hotlines, and helplines; a 26%increase in feeling comfortable using different ways to promote patient engagement and activation; and a 37% increase in explaining the process of referrals to agencies.		
Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**	
Program Goal 3	Offer 2 Mental Health First Aid (MHFA) trainings to MAH staff and community residents in the MAH community benefits service area.		

Goal 3 Status	Complete. MAH offered 2 MHFA trainings within its service area and 21 people (including MAH staff) completed all pre- and post-training requirements to receive Mental Health First Aid certification.

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

Priority Health Need: Equitable Access to Care **Program Name: Birthing Center Program** **Health Issue: Access to Care**	
Brief Description or Objective	BILH supports the Cambridge Health Alliance (CHA) birthing center through funding that focuses on and supports low-resourced and diverse patients. This program provided funding for the CHA birthing center to re-open.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Increase access to outpatient birthing centers for low resourced and diverse community members.
Goal 1 Status	Provided a grant opportunity to reopen the CHA birthing center. CHA has completed renovations and is working towards accreditation compliance.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Co-Location Program** **Health Issue: Housing Stability/Homelessness**	
Brief Description or Objective	This program is a partnership with Metro Housing Boston (MHB). MAH collaborates with MHB to improve access for patients and community members. This program connects patients to community resources and supports a case manager for people experiencing housing instability. The Co-Location program provides free counseling services to individuals and families to help access housing stability and economic mobility resources with the aim of improving their health and quality of life.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	In FY24, Metro Housing will serve at least 50 participants who present with a housing concern or crisis.
Goal 1 Status	In FY24, Metro Housing served 45 participants who presented a housing concern or crisis.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal**
Program Goal 2	In FY24, at least 50% of participants who received services through this program will stabilize their housing situation.
Goal 2 Status	In FY24, over 60% of participants who received services were able to stabilize their housing situation and reported an increased knowledge of the housing search process.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health **Program Name: Coalition Building** **Health Issue: Access to Care**	
Brief Description or Objective	To address the social determinants of health, healthy aging, prevention and self-management of chronic illness, mental health and substance use disorders, MAH continues to support a wide range of community groups by supporting them through technical assistance and participation at regular meetings. At these meetings, stakeholders share experiences, ideas and best practices. This gives MAH an opportunity to listen to concerns of the community in order to help strategize community benefits work. This work also helps to inform 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 43 community coalition, community building or task force meetings in MAH's service area.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use Disorder **Program Name: Collaborative Care Model** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	To increase access to mental health services, MAH has implemented the Collaborative Care model, a nationally recognized primary care led program that specializes in providing behavioral health services in the primary care setting. The services, provided by a BILH licensed behavioral health clinician, include counseling sessions, phone consultations with a psychiatrist, and coordination and follow-up care. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treat a variety of medical and mental health conditions.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	To increase access to behavioral health services through the Collaborative Care model.
Goal 1 Status	Provided behavioral health services to 1,395 patients across 12 sites.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal**

Priority Health Need: Equitable Access to Care **Program Name: Community and Professional Education for Emergency Care** **Health Issue: Access to Care**	
Brief Description or Objective	MAH Emergency Department (ED) physicians work with Arlington, Belmont, Cambridge, Watertown, Lexington Fire and Police departments, and privately owned Professional EMS to increase their capacity to serve community members in need of emergent care. MAH provides an EMS medical director who works with affiliated EMS services to provide credentialing, continuous review/quality assurance, and education for affiliated community EMTs and paramedics. This involves protocol reviews, medical control, monthly education sessions, and other educational opportunities.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	MAH ED physicians will meet with Belmont, Watertown, Cambridge, and Lexington Fire Department pre-hospital responders as well as Pro EMS and MIT EMS responders to review cases and discuss best practices and processes for treatment and outcome improvement.
Goal 1 Status	Six peer review sessions were provided by MAH ED Physicians for Belmont, Watertown, Cambridge and Lexington Fire Departments and Pro Ambulance EMS service. Arlington's education is done once per year and MIT EMS and Harvard EMS twice per year.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**
Program Goal 2	MAH Emergency Physicians will provide at least 2 "Life Threatening Emergency - what to do" classes to community organizations who are requesting training
Goal 2 Status	6 sessions of "Life Threatening Emergency - What to do" were provided to community organizations and municipal staff. Approximately 165 people were trained.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**
Program Goal 3	MAH Physicians will serve as EMS Medical Directors to local municipalities and organizations.
Goal 3 Status	MAH Physicians served as EMS Medical Directors to Arlington, Belmont, Cambridge and Watertown as well as MIT EMS, Harvard University EMS and Pro Ambulance EMS.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Community Benefits Administration and Infrastructure** **Health Issue: Additional Health Needs Identified by the Community**	
Brief Description or Objective	Community Benefits and Community Relations staff implement programs and services in our Community Benefits Services Area, encourage collaborative relationships with other providers and government entities to support and enhance community health initiatives, conduct Community Health Needs Assessments and address priority needs and ensure regulatory compliance and reporting. Additionally, Community Benefits and Community Relations staff at BILH hospitals work together and across institutions to plan, implement, and evaluate Community Benefits programs. In FY24, the staff worked collaboratively to begin the Community Health Needs Assessment, sharing community outreach ideas and support, and help to distribute the community survey and identify key community residents for interviews and focus groups.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits
Program Goal 1	Implement effective and efficient programs that support the community health needs of the Community Benefits Service Area.
Goal 1 Status	MAH supported and implemented 39 programs and granted $131,626 to local organizations.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**
Program Goal 2	Offer evaluation capacity workshops to partner organizations and grantees to better understand impact.
Goal 2 Status	BILH offered two evaluation workshops to 30 organizations and grantees. 100% of organizations and grantees who attended were Satisfied or Very Satisfied with the workshops and 90% stated it was directly relevant to their role at their organization.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal**

Priority Health Need: Equitable Access to Care **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	Assist 50-60 survivors of torture, gender-based violence, war crimes or other human rights violations with specialized services through our Torture Treatment Program, including forensic psychological evaluations.
Goal 1 Status	In FY24, 117 survivors of torture, gender-based violence, war crimes or other human rights violations received specialized services through our Torture Treatment Program. (Note: this is a Program-wide number for De Novoâ€™s entire service area) and 32 clients received forensic psychological evaluations, and in-court testimony as needed, to support their humanitarian relief applications.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**
Program Goal 2	Support 50-60 clients with case management services, such as safety planning, food or clothing assistance, housing navigation, technology assistance, help completing paperwork, referral for legal or medical services, and accompaniment to court hearings, among other services.
Goal 2 Status	In FY24, 62 clients received case management supports, such as safety planning, food or clothing assistance, housing navigation, technology assistance, help completing paperwork, referral for legal or medical services, and accompaniment to court hearings, among other services. In FY23 De Novo assisted ninety survivors through the Torture Treatment Program.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**
Program Goal 3	Provide access to healing to 125-150 adults by delivering free or low-cost mental health services, including long-term individual therapy, group counseling, assessments and referrals.

Goal 3 Status	In FY24, 189 adults received free or low-cost individual counseling services, including 64 residing in Arlington, Cambridge, Waltham, Watertown or Somerville. Of these, 57 percent received services in Spanish, French, Farsi/Dari or Portuguese.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Program Goal 4	Launch a weekly peer support groups, including a Trauma Skills Group for Spanish-speakers, a Domestic Violence Peer Support Group, and a Mutual-Aid Group for LGBTQ+ Asylum Seekers.
Goal 4 Status	In FY 24, launched weekly peer support groups, including a Trauma Skills Group for Spanish-speakers, a Domestic Violence Peer Support Group, and a Mutual-Aid Group for LGBTQ+ Asylum Seekers.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Doula Program** **Health Issue: Mental Health/Mental Illness**	
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 2	**Time Frame Duration: Year 3** / **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 14 births.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health **Program Name: Eviction Homelessness Prevention Program** **Housing Corporation of Arlington** **Health Issue: Housing Stability/Homelessness**	
Brief Description or Objective	This program supports an integrated set of social services that provide eviction and homelessness prevention, connecting families to vital resources. In addition, low resourced individuals will have an opportunity to develop as leaders so that they may advocate for themselves and their community. These social services will help to resolve urgent financial, housing, and employment issues through the provision of direct social services and referrals to partner agencies.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	In FY24, prevent homelessness and create more stable tenancies for at least 45 families by providing homelessness prevention grants, funded by an appeal to HCA donor base. See at least 80% of grantees remain stable in their homes for at least 18 months after receiving assistance.
Goal 1 Status	In FY24, HCA supported 48 households with eviction prevention grants that supported back rent, security deposit or moving expenses to help very low-income families at risk of losing housing remain stable and housed. 80% of these grantees remained stable.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** / **Goal Type: Outcomes Goal**
Program Goal 2	Support at least 75 families in resolving urgent financial, housing, employment, or other issues through the provision of direct social services and referrals to partner agencies as needed.
Goal 2 Status	In FY24 HCA Has supported 90 households in resolving urgent financial, housing, employment, or other issues through the provision of direct social services and referrals to partner agencies as needed.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** / **Goal Type: Outcomes Goal**
Program Goal 3	Expand tenant voice. Establish Tenant Councils throughout HCA's housing. Train at least 12 HCA tenants as leaders to facilitate Councils. See at least 80

	HCA tenant households participate in Tenant Councils each year. See at least 2 HCA tenants newly join the HCA Board over the next 2 years. Engage at least 25 HCA tenants and/or social service clients in housing or other relevant local advocacy over the next 2 years.
Goal 3 Status	In FY24 over 25 tenants or social service clients were engaged in advocacy. Examples of engagement include tenants in advocating for several housing related bills at the state level including Tenant Opportunity to Purchase Act (TOPA), and the Zero Carbon Renovation Fund. In FY24 2 HCA tenants joined the HCA Board. The total number of HCA Tenants in FY24 on the HCA Board is six out of 14 total Board members.

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

Priority Health Need: Equitable Access to Care **Program Name: Facilitating Primary Care Access** **Health Issue: Additional Health Needs Identified by the Community**		
Brief Description or Objective	Throughout MAH's Community Benefits Service Area, MAH supports Primary Care services provided by BILH Primary 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 access to primary care for uninsured and underinsured patients.	
Goal 1 Status	In FY24, MAH provided access to primary care in it's CBSA.	
Time Frame Year: Year 1	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Food Insecurity** **Health Issue: Food Insecurity**	
Brief Description or Objective	Using our purchasing power, MAH purchases healthy foods and fresh produce and delivers to local distribution markets in MAH's service area which provide free food to community members in need.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Provide eggs and bread to local food distribution locations to support food insecure families and individuals.
Goal 1 Status	Provided nine deliveries of food which included 900 dozen eggs and 900 loaves of whole grain bread which was distributed to food insecure families and individuals in the city of Waltham.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Farmers Market Incentive Program** **Health Issue: Food Insecurity**	
Brief Description or Objective	MAH supports a number of local farmers market programs to increase their capacity to provide low resourced residents with increased access to healthy foods. This program helps support through funding the Supplemental Nutrition Assistance Programs (SNAP), Healthy Incentives Programs (HIP) and farmers market voucher programs. This funding supports Arlington, Belmont, Watertown and Somerville programs. It also supports the efforts to increase enrollment with outreach and education about the various market's food assistance programs.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Provide support and funding to the Somerville Winter Farmers Market (SWFM) hosted and managed by The Center for the Arts at the Armory (CAA). This funding is to support their farmer's market incentive programs for low resourced families and individuals.
Goal 1 Status	In FY24 MAH supported through funding the SWFM to support incentive programs at their winter market.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**
Program Goal 2	Increase SNAP Match usage at the Watertown Farmers Market.
Goal 2 Status	In FY24 SNAP Match usage increased by 15% this year at the Watertown Farmers Market from the previous year.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**
Program Goal 3	Collaborate with local Farmers Markets to help support access to fresh produce for those who are low resourced.
Goal 3 Status	Collaborated and supported Arlington, Belmont and Watertown farmer's markets incentive programs in order to increase access to fresh produce for those who are low resourced.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**
Program Goal 4	Increase the number of SNAP Match shoppers at the Belmont Farmers Market by promoting the program and educational awareness.

Goal 4 Status	In FY24, 48% of the SNAP shoppers were either new to the market or were people who had gone off the program and then returned by signing up again.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Program Goal 5	Fresh Bucks is a program through Arlington Eats to provide food vouchers at the farmers market to those who qualify. This year one goal was to increase the number of households using Fresh Bucks.
Goal 5 Status	In FY24, 43% of those using the vouchers were new to the program.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Equitable Access to Care **Program Name: Financial Assistance Counselors** **Health Issue: Access to Care**			
Brief Description or Objective	Significant segments of the community population living within the hospital's CBSA, particularly low-resourced and BIPOC populations, face significant barriers to care. The hospital's Financial Assistance Program offers emergency and other medically necessary services at low or no cost to qualified patients (when qualifying family income is at or below 400% of the Federal Poverty Level). The hospital's Certified Application Counselors (CAC's) screen people and assist them in applying for all eligible financial assistance programs.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	To assist patients throughout the BILH Systems who are uninsured and under insured to obtain eligibility for and align them with state financial assistance and hospital-based financial assistance programs. This include MassHealth, MassHealth ACO's, Health Connector, Pharmacy Programs and Hospital Charity programs.		
Goal 1 Status	In FY24, Charles River screened 2095 patients and enrolled them in Masshealth plans. Mount Auburn screened 1827 patients and enrolled in Masshealth or reenrollment programs.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**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	4.0 full time equivalents (FTE's) provide support and enrollment services, at both MAH and Charles River Community Health Center. These staff are Certified Application Counselors (CACs).		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal 3	Facilitate connection to health care by providing CACS to work on site at Charles River Community Health in Waltham.		
Goal 3 Status	2.0 MAH full time equivalents are provided to Charles River Community Health Center to provide these services.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Social Determinants of Health **Program Name: Health Literacy Education Program** **Health Issue: Social Determinants of Health**	
Brief Description or Objective	MAH provides presentations to local English Language Learners programs in the hospital's service area. Topics of presentations are on a variety of health issues and include tips on how to navigate the health system. The goal is to provide an educational forum that will uplift people who historically experience health disparities and help to improve access to care. An interpreter is provided when requested or needed to aid in the learning experience.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Provide at least 4 health literacy education programs for those who are English language learners.
Goal 1 Status	In FY24 MAH provided 7 health literacy education programs in the community and 172 people attended these programs.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**
Program Goal 2	Breast Health and Cancer Prevention Education: At least 80% of participants who take the survey report they learned new information about what their risks are for breast cancer.
Goal 2 Status	100% of participants reported learning some new information about what their risks are for breast cancer.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**
Program Goal 3	Breast Health and Cancer Prevention Education: At least 80% of participants who took the survey report learning some new information about breast cancer screening.
Goal 3 Status	100% of participants reported learning some new information about breast cancer screening.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**
Program Goal 4	Navigating the Health Care System Education: At least 80% of those participating who took the survey report they increased their knowledge on how to prepare for their doctors appointment.

Goal 4 Status	96% reported they increased their knowledge on how to prepare for their doctors appointment.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 5	Navigating the Health Care System Education: At least 80% of participants who take the survey report increasing their knowledge about navigating our health care system.
Goal 5 Status	96% of participants reported increasing their knowledge about navigating our health care system.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 6	Lyme Disease Presentation: At least 80% of participants who took the survey report increasing their knowledge about protecting themselves and their families against Lyme disease.
Goal 6 Status	84% of participants reported increasing their knowledge about protecting themselves and their families against Lyme disease.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 7	Skin Cancer Presentation: At least 80% of participants who took the survey report increasing their knowledge about how to protect themselves and their family from skin cancer.
Goal 7 Status	80% of participants reported increasing their knowledge about how to protect themselves and their family from skin cancer.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 8	Fall Prevention Education: At least 80% of participants who took the survey report they increased their knowledge on how to prevent falls.
Goal 8 Status	100% of those who took the survey reported they increased their knowledge on how to prevent falls.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 9	Heart Health Education: At least 80% of participants who take the survey report they learned new information about what their risks are for heart disease.
Goal 9 Status	70% of participants reported learning some new information about what their risks are for heart disease.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 10	Heart Health Education: At least 80% of participants who take the survey report they learned new information about the signs and symptoms of heart disease.

Goal 10 Status	75% of participants reported increasing their knowledge of the signs and symptoms of heart disease.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**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, Aging Services Access Points (ASAP), as well other agencies or municipal departments looking to support older adults with healthy aging.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Provide at least 4 health education presentations geared towards older adults in order to increase knowledge and reduce the feeling of isolation.
Goal 1 Status	9 presentations were coordinated and presented with a total of 179 older adults in attendance. Presentation topics included: Fall Prevention, Healthy Eating/Healthy Aging, and Heart Health including stroke awareness.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**
Program Goal 2	Heart Health: At least 80% of participants will report they increased their knowledge of the risks of heart disease.
Goal 2 Status	94% of participants reported they increased their knowledge of the risks of heart disease.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**
Program Goal 3	Heart Health: At least 80% of participants will report they increased their knowledge of the signs and symptoms of heart disease.
Goal 3 Status	94% of participants reported increasing their knowledge of the signs and symptoms of heart disease.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**
Program Goal 4	Healthy Eating/Healthy Aging: At least 80% of participants will report learning new tips or ideas about how to substitute foods in their diet with healthier foods.
Goal 4 Status	80% of participants reported learning new tips or ideas about how to substitute foods in their diet with healthier foods.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**

Program Goal 5	Healthy Eating/Healthy Aging: At least 80% of participants will report they learned some new healthy tips or ideas they will use when they go grocery shopping.
Goal 5 Status	87% of participants reported learning some new healthy tips and ideas they will use when they go grocery shopping.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Program Goal 6	Fall Prevention: At least 80% of participants will report they would be able to take what they learned and use it to improve their own health and well-being.
Goal 6 Status	98% of participants reported they would be able to take what they learned and use it to improve their own health and well-being.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Program Goal 7	Fall Prevention: At least 80% of participants will report they learned some knew information on how to prevent falls.
Goal 7 Status	94% of participants reported they learned some knew information on how to prevent falls.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health **Program Name: Medical Interpreter Services (IS)** **Health Issue: Additional Health Needs Identified by the Community**	
Brief Description or Objective	An extensive body of research illustrates the health disparities and differences in health care access and utilization that exist for diverse individuals/cohorts and foreign-born populations. Language barriers pose significant challenges to providing effective and high-quality health and social services. To address this need, and in recognition that language and cultural barriers are major difficulties to accessing health and social services and navigating the health system. MAH offers free interpreter services for 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 video-based remote interpreter service using a computer to connect patients with an interpreter. Professional interpretation services in hundreds of languages are available 24/7.
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 23,490 individual encounters either face-to-face, video, or telephonic including ASL.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal**

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

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Pharmacy Benefit** **Health Issue: Access to Care**	
Brief Description or Objective	MAH provides free, one-time prescriptions to help those who would otherwise not be able to afford or have access to medicine. The social work department works with these patients to help them transition to an affordable health insurance plan or connect them to other resources.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Provide free medications for our most under-resourced populations who otherwise would not be able to pay for or have access to medication when being discharged from the hospital.
Goal 1 Status	Provided and filled 225 free medication prescriptions for our most under-resourced populations who otherwise would not be able to pay for or have access to medication when being discharged from the hospital.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Postpartum Support Group** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	The Postpartum Support Group is a free virtual group that meets weekly. This group has been an important resource for parents to connect with each other. Open to all parents who are in the early postpartum period or who are struggling with perinatal mental health issues preventing them from leaving the house. This group offers a safe space for parents to be together. It also provides resources and information, which supports new parents.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Increase access to our postpartum support group meetings by offering one virtual and one in person each week for community members.
Goal 1 Status	The postpartum support group increased access from last year by offering two weekly support group meetings (virtual and in person meetings) and at least 138 people participated.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**
Program Goal 2	At least 80% of participants report that they felt supported and it felt like a safe space for them to share their feelings and experiences.
Goal 2 Status	100% percent of participants reported that they felt supported and it felt like a safe space for them to share their feelings and experiences.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**
Program Goal 3	At least 80% of participants report that they gained confidence in caring for themselves and their baby because of their participation in the postpartum support group.
Goal 3 Status	100% of participants report that they gained confidence in caring for themselves and their baby because of their participation in the postpartum support group.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**

Priority Health Need: Equitable Access to Care **Program Name: Prenatal/Postpartum Bilingual Outreach Program** **Health Issue: 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 postpartum 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 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal 2	Provide community navigational support through a community health worker for at least 150 encounters where navigating the system is a barrier to care.	
Goal 2 Status	Provided over 250 women with navigational and emotional support as well as referrals to community resources. This included over 2,000 encounters of support including, helping with governmental assistance programs, birth certificates, SSI office visits, immigration status, baby's first appointments, billing issues and helping to prepare moms for appointment and hospital follow-up visits.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**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 40 parents with a new infant car seat to assist in transporting their newborn safely home.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health **Program Name: Produce Prescription Program** **Health Issue: Chronic Disease**	
Brief Description or Objective	MAH supports a free Community Supported Agriculture (CSA) share program offered by Waltham Fields Community Farm. This program provides a 20-week CSA share of produce to up to thirty families and/or individual participants. Participants are chosen by their health care provider and are clinically at risk for an identifiable diet or nutrient related disease (e.g., pre-diabetic). The healthcare provider writes a vegetable prescription to the participant, who may be a child, in which case their parent/guardian has agreed to participate as well. The weekly share reflects what has been recently harvested and typically is ample vegetables for a family of four. The "veggie prescription" is written for a particular patient or family member but the produce is for the whole household. Change is more likely to be lasting when habits are changed at the household level and food prepared with fresh vegetables is for all to try.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Provide weekly vegetable CSA shares to up to thirty low-income households with underlying health conditions weekly for twenty weeks from mid-June to mid-October.
Goal 1 Status	CSA shares were provided to thirty households in FY24. This represented 6,561 pounds of fresh produce to low income medically identified families.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal**

Priority Health Need: Racial Equity **Program Name: Racial Equity and Mental Health, Collaborations with CORE MH** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	MAH collaborates with the Coalition of Racial Equity in Mental Health (CORE MH) to help support and fulfill its mission. MAH provides funding, technical assistance and active steering committee membership.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	To help support CORE MH to fulfill its mission to promote healthier people and communities by fostering community engagement, elevating innovative and best practices, advancing racial equity, and supporting reciprocal learning opportunities to address the needs of the most marginalized members of our communities.
Goal 1 Status	MAH provided funding, technical assistance and active steering committee membership.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** / **Goal Type: Process Goal**
Program Goal 1	In FY24, MAH will help support Black mental health graduate students through CORE's MH Graduate Fellowship Program.
Goal 1 Status	In FY24, 14 students participated in CORE's Graduate Fellowship program with funding from MAH which supported 2 of these graduate students and the associated costs.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** / **Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Safe Beds** **Health Issue: Mental Health/Mental Illness**		
Brief Description or Objective	MAH provides temporary Safe Beds for victims of domestic violence in partnership with local police departments and emergency services.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Facilitate connection to safe care for men, women and people of all gender and their dependents who are victims of domestic violence.	
Goal 1 Status	Provided a safe bed for persons of all gender 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 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Social Enterprise Youth Development Program** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	This program provides job training, youth development, intense case management, education and employment coaching for high-risk teens. The education coaching helps these teens stay in school and develop life skills that contribute toward improving high school graduation rates. The Social Enterprise Youth Development Program is run by More Than Words in Waltham.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	In FY24, MTW will provide job training, youth development programming, intensive case management, education and employment coaching, and individual advocacy to approximately 100 young people at our Waltham location.
Goal 1 Status	In FY24, MTW provided job training, youth development programming, intensive case management, education and employment coaching, and individual advocacy to 105 young people at our Waltham location.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** | **Goal Type: Outcomes Goal**
Program Goal 2	In FY24, 90% of MTW graduates will have or be on track to earn their high school diploma or HiSET certification.
Goal 2 Status	In FY24, 98% of MTW graduates either had, earned, or were on track to earn their high school diploma or HiSET certification.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** | **Goal Type: Outcomes Goal**
Program Goal 3	In FY24, 75% of MTW graduates will be productively engaged in school and/or work for at least 30 hours each week.
Goal 3 Status	In FY24, 70% of MTW graduates were productively engaged in school and/or work for at least 30 hours each week.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** | **Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health **Program Name: Somerville Homeless Coalition (SHC) Support Services** **Health Issue: Housing Stability/Homelessness**	
Brief Description or Objective	The mission of SHC is to provide homeless and near-homeless individuals and families with individualized supportive services and tailored housing solutions. The purpose of wrap around support services of this support is to help families and individuals access resources to help reduce homelessness and foster a more stabilized lifestyle. MAH collaborates with funding to support this program.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	In FY24 provide a wraparound support service to individuals experiencing homelessness to stabilize housing, medical and recovery needs.
Goal 1 Status	In FY24, supported approximately 535/6,306 visits each month/annually from people experiencing homelessness wishing to access support services.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** / **Goal Type: Outcomes Goal**
Program Goal 2	A In FY24, provide 1:1 case management for homeless individuals seeking stable housing.
Goal 2 Status	In FY24, supported 46 individuals and 4 children into stable housing.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** / **Goal Type: Outcomes Goal**

Priority Health Need: Equitable Access to Care **Program Name: Strengthening Y2Y Harvard Square's Case Management Program** **Health Issue: Housing Stability/Homelessness**	
Brief Description or Objective	Y2Y operates a youth-led shelter in Cambridge for young people experiencing homelessness. Support for this program includes strengthening the case management team with increased training in order to improve outcomes. This model includes getting young adults off the streets, providing stability and facilitating access to needed resources.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Continue to develop partnerships
Goal 1 Status	Massachusetts Department of Mental Health continues to partner with us. This year we are working on streamlining our data collection tools and have partnered with Salesforce to help support and consult with us to improve our database.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** / **Goal Type: Process Goal**
Program Goal 2	Increase Case Management utilization rates and outcomes.
Goal 2 Status	The result of increasing of case managers has improved our case management program, as evidenced by the fact that 83% of shelter guests reported having the opportunity to work with case managers at least once. 70% of all guests reported that Y2Y helped them meet their personal goals.
Time Frame Year: Year 1	**Time Frame Duration: Year 2** / **Goal Type: Process Goal**
Program Goal 3	Strengthen Y2Y's Case Management Team via improved training and practices.
Goal 3 Status	We continued to increase the number of case managers allowed for a higher level of support for staff and guests in the Y2Y community. There are 18 well-trained and supported case managers for the benefit of shelter guests which is an increase from 6 last year.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** / **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 240 patients and their family members by the stroke nurse coordinator.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**
Program Goal 2	Create a Stroke awareness campaign during Stroke Awareness Month.
Goal 2 Status	Distributed stroke education materials and conducted stroke awareness presentations for community members.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**
Program Goal 3	Distribute over 1,500 stroke education materials in multiple languages through the local Meals on Wheels programs, farmer's markets, at libraries and other community organizations through educational tabling.
Goal 3 Status	Distributed over 5,000 stroke educational materials including magnets in 5 different languages in addition to English through the local Meals on Wheels programs, farmer's markets, at libraries and other community organizations through educational tabling.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**
Program Goal 4	Provide in person stroke awareness presentations at local community-based organizations, English Language Learning organizations and Councils on Aging locations.

Goal 4 Status	Provided 9 stroke awareness presentations with 110 people in attendance.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 5	Over 80% of presentation participants report an increase in their knowledge of the risks of having a stroke.
Goal 5 Status	98% of presentation participants reported an increase in their knowledge of the risks of having a stroke.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**
Program Goal 6	Over 80% of presentation participants will report an increase of their knowledge of the signs and symptoms of stroke.
Goal 6 Status	97% of presentation participants reported an increase of their knowledge of the signs and symptoms of stroke.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes 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 2	**Time Frame Duration: Year 3**	**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	☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits ☐ Total Population or Community Wide Intervention	
Program Goal 1	Organize a survivorship day for community members with cancer to celebrate and empower those affected by cancer and to improve mental health and overall wellbeing.		
Goal 1 Status	Survivorship Day Event completed in June 2024 (in person) with 62 people attending.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	
Program Goal 2	80% of those who participated in survivorship day will report they learned something of lasting value by participating.		
Goal 2 Status	100% of those who took the survey reported they learned something of lasting value by participating in the event.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**	
Program Goal 3	80% of those who participated in survivorship day will report they will be able to take what they learned or a skill they practiced during the event and use it to improve their own health and wellbeing.		
Goal 3 Status	100% of those who took the survey reported they will be able to take what they learned or a skill they practice and use it to improve their own health and wellbeing.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**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 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Equitable Access to Care **Program Name: Transportation as a Barrier to Medical Care** **Health Issue: Access to Care**			
Brief Description or Objective	MAH in partnership with local transportation agencies provides transportation to medical appointments for community members when transportation is a barrier to care.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal 1	Facilitate the connection to health care by providing transportation connections at no cost when transportation is a barrier to medical care.		
Goal 1 Status	Approximately 897 rides provided, free of charge to those where transportation is a barrier to medical care. Transportation is provided via SCM Transportation and Metro Cab vouchers.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**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 2	**Time Frame Duration: Year 3**	**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 counselors who identify as BIPOC and people who speak languages other than English. are people of color, We aim to expand the community team's counseling capacity and make counseling services more accessible to people from historically underserved communities. Transition house is a domestic violence prevention and services agency. The Housing Continuum model at Transition House serves individuals and families displaced by domestic violence providing trauma recovery, connections to education, job training, legal assistance, etc. and access to emergency shelter, longer-term transitional housing, and permanent supported housing.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	By the end of FY24, three BIPOC identified clinicians will continue to be on staff at Transition House, doubling the counseling capacity at Transition House and at least one of them will be fluent in a language other than English that is commonly spoken in Cambridge.
Goal 1 Status	Complete: In FY24, Transition House continues to maintain and employ 3 BIPOC clinicians. One identifies as American Born Black, another is a fully bilingual Brazilian immigrant and the other is a fully bilingual Colombian American.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** / **Goal Type: Process Goal**
Program Goal 2	In FY24, 8 new Transition House clients will access counseling within 2 weeks of the request. 5 of these 8 will continue to actively engage in counseling for the past 3 sessions, aligning with our racial equity focus by promoting health access for BIPOC trauma survivors.
Goal 2 Status	In FY24, the counseling program received 16 referrals for counseling. Of those 16, 1 did not respond to direct outreach, 1 alerted her case manager that she connected with counseling elsewhere, and 1 was assessed to need a higher level of care. Of the 13 who did engage with counseling, all had a first session within 2 weeks. 10 stayed in counseling for several months, several others stayed engaged with counseling services for a year. Complete: Thirteen clients engaged in counseling during this period and ten of these clients have participated in more than three sessions of counseling.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** / **Goal Type: Process Goal**

Program Goal 3	In FY24, 75% of clients who report counseling as a service they engage in, will report being satisfied with their experience via the semi-annual client satisfaction survey.
Goal 3 Status	100% of client response reported strongly agree or agree to all the satisfaction questions.

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

Priority Health Need: Racial Equity **Program Name: WHOLE Program (We Heal Ourselves with Love and Empowerment)** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	The mission of the WHOLE program is to provide opportunities to learn and heal in order to improve the health outcomes for people of color and faith-based communities and to break down barriers to access to care. Its goal is to provide support within the Black community and reduce stigma associated with mental health. This program offers two separate group therapy programs facilitated by Black licensed clinicians. These programs seek to create a safe space and collective healing as well as removing roadblocks to receiving traditional therapy.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal 1	Partner with local clinical practitioners to offer group sessions which include a safe place and brave space to discuss the stresses, challenges, and rewards of providing care for an adult that is led by individuals with lived and/or clinical experience in caregiving.
Goal 1 Status	In FY24, WHOLE partnered with the Alzheimer's Association and Paine Senior Services to offer 2 programs creating a safe place and brave space to discuss the stresses, challenges, and rewards of providing care for an adult that is led by individuals with lived and/or clinical experience in caregiving. The two programs included "The 10 Warning Signs of Alzheimer's" and "Managing Money: A Caregiver's Guide o Managing Finances". 75 people participated in these programs.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** / **Goal Type: Process Goal**
Program Goal 2	Engage, educate and empower the BIPOC community with comprehensive health resources and events.
Goal 2 Status	In FY24 WHOLE hosted an event called "Working While Black". This included a panel discussion that featured black professionals who shared their experiences and their journeys. 48 people participated. 100% said that they learned information that was helpful and 86% said that they learned something new.
Time Frame Year: Year 2	**Time Frame Duration: Year 2** / **Goal Type: Process Goal**
Program Goal 3	Remove some of the roadblocks to receiving therapy and foster collective healing by offering a group facilitated by Black licensed clinicians.

Goal 3 Status	In FY24 Whole offered and conducted a six-week psychoeducation therapy group to Black/African American women. 15 women participated and 100% of the women who provided feedback stated that they learned skills that they felt could apply to their lives. Overall, women stated that the group allowed them to feel validated, relaxed, and lighter.

Time Frame Year: Year 2	**Time Frame Duration: Year 2**	**Goal Type: Process Goal**

SECTION V: EXPENDITURES

Item/Description	Amount
CB Expenditures by Program Type	
Direct Clinical Services	$3,096,781
Community-Clinical Linkages	$271,929
Total Population or Community Wide Interventions	$327,476
Access/Coverage Supports	$947,517
Infrastructure to Support CB Collaborations	$178,133
Total Expenditures by Program Type	$4,821,836
CB Expenditures by Health Need	
Chronic Disease	$185,947
Mental Health/Mental Illness	$2,481,043
Substance Use Disorders	$114,908
Housing Stability/Homelessness	$83,135
Additional Health Needs Identified by the Community	$1,956,803
Total by Health Need	$4,821,836
Leveraged Resources	$5,271
Total CB Programming	$4,827,107
Net Charity Care Expenditures	
HSN Assessment	$3,944,578
Free/Discounted Care	
HSN Denied Claims	$5,712,912
Total Net Charity Care	$9,657,490
Total CB Expenditures	$14,484,597

Additional Information	
Net Patient Services Revenue	$330,100,983
CB Expenditure as % of Net Patient Services Revenue	4.39%
Approved CB Budget for FY25 (*Excluding expenditures that cannot be projected at the time of the report)	$6,493,394
Bad Debt	$2,623,191
Bad Debt Certification	Yes
Optional Supplement	

Comments: In addition to the above expenses MAH spent $433,069 subsidizing behavioral health services outside of its CBSA	

SECTION VI: CONTACT INFORMATION

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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3
Note: This form is to be completed in the two Fiscal Years following the hospital's completion of its triennial Community Health Needs Assessment

I. Community Benefits Process:

- Has there been any change in the composition or leadership of the Community Benefits Advisory Committee in the past year? ☒Yes ☐No
  - If so, please list updates:

The following members have transitioned off of the MAH CBAC: Carla Beaudoin, Dana Bickelman, Christine Bongiorno, Renee Cammarata Hamilton, Amy Knudsen, Julia Londergan, Esq., Myriam Michel, Colleen Morrissey, Larry Ramdin, Jose Wendel, Kathy Howard, and Ed Huang, MD. New members for FY 24 include: Viet Van, Doug Kress, Christine Dwyer, Katherine Rafferty, BJ Osuagwu and Steven Kapfhammer COO of MAH.

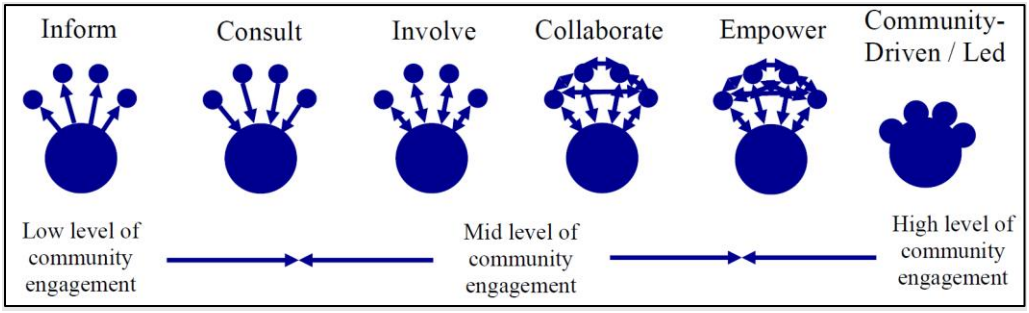
II. Community Engagement

- Organizations Engaged in CHNA and/or Implementation Strategy
  If there have been any updates to the key partners with whom the hospital collaborates, please indicate in the table below. 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)
CORE MH	Pietra Check, Interim Planning Director	Behavioral health and mental health organizations	MAH is an active member on the steering committee. Particpates as a member of the CBAC. Involved in the prioritization and strategy process. Consulted on our community engagement process.
Healthy Waltham	BJ Osuagwu	Social service organizations	Participates as a member of our CBAC. Participated on prioritization and strategy process. Was interviewed as a key informant for the CHNA.
Metro Housing Boston	Gregg Cothias, Managing Director	Housing organizations	Partnership with our Co-Location Program. MHB was represented on our CBAC and our grant allocation committee.

Charles River Community Health	Klavdia Brisson, Chief Clinical Officer	Community Health Centers	MAH engages and collaborates with CRCH on a number of different programs. CRCH sits on MAH's CBAC and consulted on our community engagement process. We continue to engage in sharing information, data and strategies.
Local Health Departments	Directors of six local health departments in the MAH Service Area	Local health department	Participated as members of the CBAC; provided input on community engagement and prioritization of health priorities and strategies. Continue to give input on an ongoing basis regarding community needs and priorities.

- 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 in implementing its plan to address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.



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

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

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

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

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

- <u>Opportunity for Public Feedback</u>
  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. September 19, 2024 – Virtual meeting on Zoom platform

- Maternal Health Focus
  - How does your organization assess maternal health status in the Community Health Needs Assessment Process? (150-word limit)
    MAH's Community Health Needs Assessment includes comprehensive collection and review of primary and secondary data sources. Secondary data sources include March of Dimes, MDPH, National Center for Health Statistics. Data specific to maternal health are included in the hospital's data table under Reproductive Health" and include low birth weight (%), Mothers with late or no prenatal care (%), Births to adolescent mothers (%, and mothers receiving publicly funded pre-natal care (%) as well as data on screening for post-partum depression. In addition to secondary data capture and review, throughout the CHNA MAH engaged with the community to collect primary data on priorities identified by community residents. This is through a community survey as well as focus groups.

- How have you measured the impact of your Community Benefits programs and what challenges have you faced in this measurement? (150-word limit)
  MAH partners with Charles River Community Health on maternal health initiatives and has done so for over 15 years. Additionally, MAH is a member of Beth Israel Lahey Health, which, as a system is working to address maternal health equity. Beth Israel Lahey Health established its Maternal Health Quality and Equity Council (MHQEC) in September of 2023. The Council's objective is to improve maternal health outcomes and eliminate inequities in care, with an overarching aim to reduce the occurrence of maternal morbidity and mortality. The Council is comprised of representatives from all of the BILH hospitals providing maternity services, as well as BILH leadership, including BILH Health Equity system leadership. BILH's Chief Clinical Officer serves as the Executive Sponsor. FY 24 was the Council's inaugural year and MHQEC established initial goals related to Equitable Access to Doulas & Midwifery, Perinatal Mental Health, and Severe Maternal Morbidity. Additionally, BILH established a health equity goal beginning in FY 25 – a year over year improvement in maternal transfusion rate (the goal is to reduce disparities in maternal transfusion rates measured at the system level).

- Do you need assistance identifying community-based organizations doing maternal health work in your area?
  MAH currently works with Charles River Community Health. MAH's maternal health work will be guided by the MHQEC and MAH looks forward to spreading this work and collaborating with its myriad of long-standing community partners in pursuit of maternal health equity.

III. Updates on Regional Collaboration

1. If the hospital reported on a collaboration in its Year 1 Hospital Self-Assessment, please briefly describe any updates to that collaboration, including any progress made and/or challenges encountered in achieving the goals of the collaboration.

   MAH continues to work collaboratively with each of the 9 other hospitals in the BILH system on our collective community benefits programming, operations and strategy across each of the system's 10 licensed hospitals. 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 entered a regional collaboration in the past year, please provide the information requested of regional collaborations on p. 5 in the Year 1 Hospital Self-Assessment Form.

   MAH continues to collaborate with Cambridge Health Alliance (CHA). MAH is represented on CHA's Community Advisory Board (CAB). CHA is represented on MAH's CBAC. We continue to share information, data and community health strategies. We are continually looking for ways to enhance our knowledge of the needs of those living in our service areas and how we can have a greater impact on community health.