# Community Benefits Report

## Fiscal Year 2023

Beth Israel Lahey Health
Mount Auburn Hospital

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# SECTION I: SUMMARY AND MISSION STATEMENT

Mount Auburn Hospital (MAH) is a member of Beth Israel Lahey Health (BILH). The BILH network of affiliates is an integrated health care system committed to expanding access to extraordinary patient care across Eastern Massachusetts and advancing the science and practice of medicine through groundbreaking research and education. The BILH system is comprised of academic and teaching hospitals, a premier orthopedics hospital, primary care and specialty care providers, ambulatory surgery centers, urgent care centers, community hospitals, homecare services, outpatient behavioral health centers, and addiction treatment programs. BILH's community of clinicians, caregivers and staff includes approximately 4,000 physicians and 35,000 employees.

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

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

- Increased the capacity of the Coalition of Racial Equity and Mental Health (CORE MH) (formerly CHNA 17) to fulfill its mission to promote healthier people and communities by fostering community engagement, elevating innovative and best practices, advancing racial equity, and supporting reciprocal learning opportunities to address the needs of those most impacted by inequities.
- Provided a grant opportunity to community-based organizations and municipalities. MAH was able to fund five 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 954 community members with health insurance and public assistance programs including help to enroll in and receive health insurance benefits.
- Through the MAH Collaborative Care Model behavioral health services were provided to 1,308 patients across twelve sites. Direct subsidies for this service included $131,454 within MAH's CBSA and $768,546 was accounted for subsidizing these services outside of its CBSA.
- Provided funding to Wayside Youth and Family Services to train youth in Teen Mental Health First Aid. Eighteen youth from Watertown High School were trained.
- Case management and counseling services were provided to over 95 low-to-moderate income individuals to prevent eviction, increase housing stability and economic self-sufficiency and improve overall quality of life through the Metro Housing Boston Co-Location Program.
- Reduced food insecurity by providing food for distribution to those who have been severely impacted by food insecurity.
- Contributed to supporting an increase in SNAP Match enrollments for use at farmer's markets within our service area by collaborating with cities and towns to promote enrollment. There was an increase in SNAP Match enrollments in the collaborating towns between 12% and 25%.
- Provided over 280 women with navigational and emotional support as well as referrals to community resources. This included over 1,500 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 five priority areas. These priority areas collectively address the broad range of health and social issues facing residents living in MAH's CBSA who face the greatest health disparities. These five priority areas are:

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

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

The FY 2022 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions being used to inform and refine MAH's efforts. In completing the FY 2022 CHNA and FY 2023 - 2025 IS, MAH, along with its other health, public health, social service, and community partners, is committed to promoting health, enhancing access and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identify, sexual orientation, disability status, immigration status, or age. As discussed above, based on the FY 2022 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that for MAH'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 its partnership with Somerville Homeless Coalition to support its Upstream Intervention Program.

- **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 partner with Housing Corporation of Arlington to help prevent eviction and improve access to resources for community members facing housing insecurity.

- **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 partner with Transition House to help support its efforts to increase its trauma informed counselors who are members of BIPOC communities.

- **Complex and Chronic Conditions**
  - MAH will continue its health aging program which partners with local Councils on Aging and provides a venue for older adults to learn about preventing and or managing chronic conditions as well as healthy aging.
  - MAH will continue to partner with many area agencies to promote stroke prevention and how to recognize the signs of stroke for early intervention to save lives.

- **Racial Equity**
  - MAH will continue to work with 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 Transition House to help support its efforts to increase its trauma informed counselors who are members of BIPOC communities.

**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 who participated in MAH's CHNA and asked them to submit the form to the AGO website.

# SECTION II: COMMUNITY BENEFITS PROCESS

**Community Benefits Leadership/Team**
MAH's Board of Trustees along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its CBSA and beyond. World-class clinical expertise, education and research along with an underlying commitment to health equity are the primary tenets of its mission. MAH's Community Benefits Department, under the direct oversight of MAH's Board of Trustees, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations. Hospital senior leadership is actively engaged in the development and implementation of 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 15, 2022
March 16, 2023
June 15, 2023
September 21, 2023

**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 in Waltham. This relationship includes providing a strong OB/GYN and Midwifery program there, particularly supporting Latinas, through pre and post-natal care including outreach and home visits. Other support to CRCH includes providing financial counselors, lab tests and IT support.

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).

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| Africano Waltham | Massachusetts Bay Transit Authority |
| American Cancer Society | Metro Cab of Boston |
| Arlington Council on Aging | Metro Housing Boston |
| Arlington Eats | Meadowgreen Rehabilitation and Nursing |
| Arlington Fire Department | More Than Words |
| Arlington Health and Human Services | 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 Center for Adult Learning Experiences (SCALE) |
| Belmont Police Department | Somerville Council on Aging |
| Cambridge Community Foundation | Somerville Health and Human Services |
| Cambridge Community Learning Center | Somerville Homeless Coalition |
| Cambridge Council on Aging | Somerville Police Department |
| Cambridge Department of Public Health | Somerville Stakeholders Coalition |
| Cambridge Fire Department | Springwell Elder Services |
| Cambridge Health Alliance | Transition House |
| Cambridge Neighbors | Town of Arlington |
| Cambridge Police Department | Town of Belmont |
| CASPAR INC. | Town of Watertown |
| Charles River Community Health | Waltham Connections |
| City of Cambridge | Waltham Council on Aging |
| City of Somerville | Waltham Family School |
| City of Waltham | Waltham Fields Community Farm |
| Community Day Center of Waltham | Waltham Health Department |
| CORE Mental Health | Waltham Interagency Group |
| DeNovo Center for Justice and Healing | Waltham Partnership for Youth |

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| Harvard University EMS | Waltham Police Department |
| Healthy Waltham | Watertown Cares |
| Housing Corp. of Arlington | Watertown Council on Aging |
| Kingdom Empowerment Center | Watertown Fire Dept. |
| Lexington Fire Department | Watertown Health Departmetnt |
| Lifeline In Home Services at Mount Auburn | Watertown Police Department |
| Live Well Watertown | Wayside Youth and Family Services |
| Massachusetts Alliance of Portuguese Speakers | Y2Y Network |
| Mass. Institute of Technology EMS | |

# 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

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| **Priority Health Need: Racial Equity**<br>**Program Name: Africano Holistic Health Program**<br>**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<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention | ☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits | |
| **Program Goal 1** | Enter family data into the Upmetrics intake tracking system. | | |
| **Goal 1 Status** | Social worker entered 200 families into the Upmetrics tracking system. | | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** | |
| **Program Goal 2** | Create at least two new partnerships this year. | | |
| **Goal 2 Status** | Three new partnerships created this year. This will help to increase access and referrals to provide culturally relevant care. | | |
| **Time Frame Year: Year 1** | **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** | Successfully served fifteen families with in-depth services and counseling which improved wellness for these families. | | |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** | **Goal Type: Process Goal** | |

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| **Priority Health Need: Mental Health and Substance Use**<br>**Program Name: Bereavement Support Group**<br>**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<br>☒ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Provide at least two Bereavement Support Groups for community members. |
| **Goal 1 Status** | Two eight-week long sessions were completed and twenty-three community members attended. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** \| **Goal Type: Process Goal** |

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| **Priority Health Need: Equitable Access to Care**<br>**Program Name: BILH Workforce Development**<br>**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<br>☐ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☒ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | In FY23, Workforce Development will continue to encourage community referrals and hires. |
| **Goal 1 Status** | In FY23, 225 job seekers were referred to BILH and 70 were hired across BILH hospitals. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal** |
| **Program Goal 2** | In FY23, Workforce Development will attend events and give presentations about employment opportunities to community partners. |
| **Goal 2 Status** | In FY23, sixty-seven events and presentations were conducted with community partners across the BILH service area. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal** |
| **Program Goal 3** | In FY23, Workforce Development will offer paid trainings for community members across BILH. |
| **Goal 3 Status** | In FY23, BILH trained total of eighty-nine community members to Patient Care Technician or Nursing Assistant (30), Pharmacy Tech (16), Perioperative LPN (3), Medical Assistant (21), Behavioral Health roles (4) or into the Associate Degree Nursing Residency program (15). Mount Auburn Hospital participated in offering these trainings. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Process Goal** |

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| **Program Goal 4** | In FY23, Workforce Development will offer internships in BILH hospitals to community members over the age of 18. |
| **Program Status 4** | In FY23, fifty-four community members placed in internships across BILH hospitals to learn valuable skills. MAH participated in offering these internships. |

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| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal** |

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| **Program Goal 5** | In FY23, Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees. |
| **Program Status 5** | In FY23, twenty BILH employees attended citizenship classes, 135 BILH employees attended career development workshops and 189 BILH employees attended financial literacy classes. MAH employees participated in these offerings. MAH employees participated in these offerings. |

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| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal** |

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| **Priority Health Need: Racial Equity**<br>**Program Name: BILH Diversity, Equity and Inclusion Office**<br>**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<br>☐ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☒ Access/Coverage Supports<br>☐ 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 25% increase in BIPOC leadership (directors and above) and clinical (physicians and nurses) hires over FY22. |
| **Time Frame Year: Year 1** | **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 $50 million was contracted to Women and Minority-owned Business Enterprises (WMBE) in FY23. This is a 22% increase over FY22. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal** |
| **Program Goal 3** | Expand system-wide DEI learning, in alignment with enterprise learning management solution. |
| **Goal 3 Status** | Eight system-wide DEI trainings conducted for all BILH staff and hospitals. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Process Goal** |
| **Program Goal 4** | Support creation or expansion of local DEI committees/resource groups. |

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| **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. |

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| **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**

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| **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<br>☒ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Increase the rate of exclusive breast milk feeding among Spanish speaking mothers upon discharge after delivering their baby. |
| **Goal 1 Status** | The rate of exclusive breast milk feeding among Spanish speaking mothers upon discharge improved from thirty-five percent to forty-five percent. |

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

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| **Priority Health Need: Mental Health and Substance Use**<br>**Program Name: Caregiver Support Group**<br>**Health Issue: Mental Health/Mental Illness** | |
| **Brief Description or Objective** | This support group allows those who care for a loved one suffering from Alzheimer's disease or dementia to connect with others who understand their challenges in a safe, supportive, and engaging environment. This safe, supportive, and engaging environment also helps support the mental health of the participants. |
| **Program Type** | ☐ Direct Clinical Services<br>☒ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Provide an ongoing free support group for caregivers. |
| **Goal 1 Status** | An ongoing support group was provided once a month for caregivers to drop in anytime. Ten caregivers attended at least one or more caregiver support group sessions. |

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

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Co-Location Program**<br>**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<br>☒ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Partner with MHB to assist patients in need of housing stability resources. |
| **Goal 1 Status** | MHB provided a dedicated case manager who met with patients and community members and provided assistance and referrals to community programs and governmental assistance programs. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Process Goal** |
| **Program Goal 2** | A dedicated case manager will provide a consultation service or interaction with at least fifty individuals. |
| **Goal 2 Status** | Ninety-five individuals received a service or interaction, which included increased knowledge of eviction prevention, housing search strategies, and or financial assistance programs. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal** |
| **Program Goal 3** | The dedicated case manager will provide support and help with at least fifty housing applications. |
| **Goal 3 Status** | The dedicated case manager worked with individuals to fill out ninety housing applications. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal** |
| **Program Goal 4** | A dedicated case manager will provide a consultation service to help avoid eviction. |
| **Goal 4 Status** | Six individuals received a consultation that resulted in avoiding eviction from their home. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal** |

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Coalition Building**<br>**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<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ 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 fifty-two community coalition, community building or task force meetings in its service area. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** \| **Goal Type: Process Goal** |
| **Program Goal 2** | Build capacity of community-based organizations (cbos). |
| **Goal 2 Status** | MAH provided technical assistance and shared information in order to aid in helping community organizations and residents navigate the health care system. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** \| **Goal Type: Process Goal** |

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| **Priority Health Need: Mental Health and Substance Use Disorder**<br>**Program Name: Collaborative Care Model**<br>**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<br>☐ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | To increase access to behavioral health services. |
| **Goal 1 Status** | Provided behavioral health services to 1,308 patients across twelve sites. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** \| **Goal Type: Outcomes Goal** |

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| **Priority Health Need: Equitable Access to Care**<br>**Program Name: Community and Professional Education for Emergency Care**<br>**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<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | MAH Physicians will serve as EMS Medical Directors to local organizations. |
| **Goal 1 Status** | MAH Physicians served as EMS Medical Directors to MIT EMS, Harvard University EMS and Pro Ambulance EMS. |
| **Time Frame Year: Year 1** \| **Time Frame Duration: Year 3** \| **Goal Type: Process Goal** | |
| **Program Goal 2** | 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 2 Status** | MAH ED physicians provided monthly peer review sessions. |
| **Time Frame Year: Year 1** \| **Time Frame Duration: Year 3** \| **Goal Type: Process Goal** | |

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

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

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| **Program Goal 4** | MAH Emergency Physicians will provide at least two "Life Threatening Emergency - what to do" classes to community organizations who are requesting training. |
| **Goal 4 Status** | Six sessions of "Life Threatening Emergency - What to do" were provided to community organizations and municipal staff. Approximately 165 people were trained. |

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

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| **Program Goal 5** | At least eighty percent of participants who took the survey reported gaining confidence on how to administer chest compressions. |
| **Goal 5 Status** | Eighty-eight percent of participants who took the survey reported gaining confidence on how to administer chest compressions. |

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| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal** |

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| **Program Goal 6** | At least eighty percent of those who participated report they learned new information about how to identify a medical emergency. . |
| **Goal 6 Status** | Eighty-nine percent of participants who took the survey reported they learned new information about how to identify a medical emergency. |

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| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal** |

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| **Program Goal 7** | At least eighty percent who participated and took the survey report gaining confidence on how to use an automated external defibrillator (AED). |

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| **Goal 7 Status** | Eighty-five percent of those who participated reported gaining confidence on how to use an AED. |

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| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal** |

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| **Program Goal 8** | At least eighty percent of participants who took the survey report they are more likely to take steps such as administering compressions and utilizing the AED during a medical emergency if they have the opportunity. |
| **Goal 8 Status** | Eighty-nine percent of those who participated reported they are more likely to take steps such as administering compressions and utilizing the AED during a medical emergency if they have the opportunity. |

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| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal** |

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Community Health Grant Program**<br>**Health Issue: Additional Health Needs Identified by the Community** | |
| **Brief Description or Objective** | To address the priority health needs that were identified by community members through our most recent CHNA, MAH awards grant funding to local community-based organizations, municipalities and/or other non-profit status organizations. This program supports a variety of programs, which positively impact populations in our service area that face health disparities and inequities. |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Provide grant-funding opportunities to community-based organizations, municipalities and other non-profit organizations. |
| **Goal 1 Status** | Provided eleven organizations funding to work on identified projects, which reflect the health priorities, identified in our most recent Community Health Needs Assessment. |

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

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| **Priority Health Need: Equitable Access to Care**<br>**Program Name: Culturally Informed Psychological Care**<br>**Health Issue: Mental Health/Mental Illness** | |
| **Brief Description or Objective** | De Novo Center for Justice and Healing provides culturally informed psychological counseling to uninsured or underinsured adults who are unable to access help by other means, filling a critical gap in access to mental health services for people with low incomes. MAH helps support this program, which offers free or low-cost mental health services including individual therapy, group counseling, assessments and referrals, and case management to help clients heal the emotional effects of violence, abuse, torture and poverty. |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☒ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Support at least 100 clients with free or low-cost individual case management services, such as safety planning, food or clothing assistance, housing navigation, and accompaniment to court hearings, among other services. |
| **Goal 1 Status** | In FY23, De Novo supported 159 clients with case management, counseling services. Thirty-seven percent of these received services in their first language other than English and eighty percent received this service free. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal** |
| **Program Goal 2** | Assist sixty survivors of torture, gender-based violence, war crimes or other human rights violations with specialized services through the Torture Treatment Program. |
| **Goal 2 Status** | In FY23 De Novo assisted ninety survivors through the Torture Treatment Program. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal** |
| **Program Goal 3** | Provide forensic psychological evaluation and in-court testimony as needed to support clients with their humanitarian relief applications. |
| **Goal 3 Status** | Twenty-seven clients received forensic psychological evaluation and in-court testimony as needed to support clients with their humanitarian relief applications. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal** |

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| **Priority Health Need: Equitable Access to Care**<br>**Program Name: Doula Program**<br>**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<br>☒ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Provide a doula for historically underserved populations who request this support during birth. |
| **Goal 1 Status** | A doula support coach is on call to support underserved persons at the time of delivery in person. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 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 twenty-one births. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal** |

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Eviction Homeless Prevention Program**<br>**Housing Corporation of Arlington**<br>**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<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Prevent homelessness and create more stable tenancies for at least forty-five families in the first year of the grant period. |
| **Goal 1 Status** | Thirty-nine families have a more stable situation and avoided eviction by utilizing homelessness prevention grants and referrals to community resources. This occurred within the first six months of the grant period. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** / **Goal Type: Outcomes Goal** |
| **Program Goal 2** | Support an additional ninety families or individuals in the first year of the grant period in resolving urgent financial, housing, employment, or other issues through providing direct social services and referrals to partner agencies as needed. |
| **Goal 2 Status** | Fifty-three households received some kind of social service support (first six months of grant period), including housing search, support negotiating with a landlord regarding a rent increase or possible eviction, signing up for social security or other benefits, domestic violence assistance, accessing free furniture for an apartment, signing up for RAFT or getting a referral to a range of other services. All were low or (more often) very low-income. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** / **Goal Type: Outcomes Goal** |
| **Program Goal 3** | Create a new Tenant Council Leadership Group in order to expand tenant voice. |
| **Goal 3 Status** | A new Tenant Council Leadership Group was created in FY23. Six Housing Corporation of Arlington tenants have joined the new Tenant Council Leadership |

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| | Group. Twenty-six tenants have participated in civic engagement activities including giving input on the Town of Arlington's MBTA Communities draft maps, and other related advocacy activities. |

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

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Food Insecurity**<br>**Health Issue: Food Insecurity** | |
| **Brief Description or Objective** | Using our purchasing power, MAH purchases healthy foods and fresh produce and delivers to local distribution markets in our service area which provide free food to community members in need. |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ 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 families and individuals experiencing food insecurity. |

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

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Fresh Bucks Program**<br>**Health Issue: Food Insecurity** | |
| **Brief Description or Objective** | The Fresh Bucks farmer's market voucher program in Arlington provides vouchers to clients who may not otherwise have the ability to pay for fresh, healthy food at the Farmers Market. This program supports people to increase their purchasing power at the local farmer's markets, and allows Arlington EATS to continue increasing access to fresh local food to community residents. |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Reduce the stigma surrounding food insecurity. |
| **Goal 1 Status** | Forty percent of Fresh Bucks users did not participate in other Arlington EATS programs, demonstrating that Fresh Bucks continues to be a useful program in reaching more food insecure residents in a non-stigmatizing setting. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal** |
| **Program Goal 2** | Increase the number of households using Fresh Bucks from the start of the program by twenty-five percent. |
| **Goal 2 Status** | This year there was a forty percent increase in those using the program; this demonstrates the need to continue this program. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal** |
| **Program Goal 3** | In order to increase the stability of the program conduct an evaluation of the program and make modifications according to the findings. |
| **Goal 3 Status** | Complete: Based on the findings of the evaluation, Fresh Bucks dollars are now offered only to those who use their SNAP card first and then receive Fresh Bucks tokens. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal** |

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| **Program Goal 4** | Increase awareness and participation of HIP/SNAP (government assistance) programs. |
| **Goal 4 Status** | Thirty-five percent of participants learned about HIP or SNAP at the Arlington Farmer's Market or at Arlington EATS. |

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

**Priority Health Need: Equitable Access to Care**
**Program Name: Health Coverage and Public Assistance Enrollment**
**Health Issue: Access to Care**

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| **Brief Description or Objective** | MAH recognizes that navigating applications for health insurance can be overwhelming and cumbersome. To address access to health care, MAH provides Certified Application Counselors (CAC) to assist patients and community members in applying for public assistance programs. MAH provides staffing of CACs to work directly at Charles River Community Health, which is a Federally Qualified Health Center to augment their enrollment staff to help with health coverage and public assistance enrollment. |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☒ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Facilitate connection to health care by providing CACS to work on site at Charles River Community Health in Waltham. |
| **Goal 1 Status** | 1.05 MAH full time equivalents are provided to Charles River Community Health Center to provide these services. |

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

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| **Program Goal 2** | Support community members through the process of enrollment for health insurance and public assistance programs. |
| **Goal 2 Status** | 6.2 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. |

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

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| **Program Goal 3** | Support patients and community members by assisting them with enrollment for health insurance and public assistance programs and referring them to government programs. |
| **Goal 3 Status** | MAH financial counselors assisted 323 individuals with government application forms including help with health insurance applications and or referring them to government programs. |

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| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal** |

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| **Program Goal 4** | Support patients and community members by assisting them with enrollment for health insurance and public assistance programs and referring them to government programs. |
| **Goal 4 Status** | Charles River Community Health financial counselors assisted 631 individuals with government application forms including help with health insurance applications and or referring them to government programs. |

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| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal** |

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Health Literacy Education Program**<br>**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<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Provide at least four health literacy education programs for those who are English language learners. |
| **Goal 1 Status** | In FY23 MAH provided seven health literacy education programs in the community and 143 people attended these programs. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Process Goal** |
| **Program Goal 2** | At least eighty percent of participants who take the survey report increasing their knowledge about navigating our health care system. |
| **Goal 2 Status** | Ninety percent of participants reported increasing their knowledge about navigating our health care system. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal** |
| **Program Goal 3** | At least eighty percent of those participating who took the survey report they increased their knowledge on how to prepare for their doctors appointment. |
| **Goal 3 Status** | Seventy-seven percent reported they increased their knowledge on how to prepare for their doctors appointment. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal** |

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| **Program Goal 4** | Breast Health and Cancer prevention presentation: At least eighty percent of participants who take the survey report they learned new information about what their risks are for breast cancer. |
| **Goal 4 Status** | 100% of participants reported learning some new information about what their risks are for breast cancer. |

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

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| **Program Goal 5** | Breast Health and Cancer prevention presentation: At least eighty percent of participants who took the survey report learning some new information about breast cancer screening. |
| **Goal 5 Status** | 100% of participants reported learning some new information about breast cancer screening. |

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

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| **Program Goal 6** | Lyme Disease Presentation: At least eighty percent of participants who took the survey report increasing their knowledge about protecting themselves and their families against Lyme disease. |
| **Goal 6 Status** | Eighty-three percent of participants reported increasing their knowledge about protecting themselves and their families against Lyme disease. |

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

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| **Program Goal 7** | Skin Cancer Presentation: Eighty percent of participants who took the survey report increasing their knowledge about how to protect themselves and their family from skin cancer. |
| **Goal 7 Status** | Seventy-seven percent of participants reported increasing their knowledge about how to protect themselves and their family from skin cancer. |

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

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| **Priority Health Need: Chronic and Complex Conditions**<br>**Program Name: Healthy Aging Program**<br>**Health Issue: Chronic Disease** | |
| **Brief Description or Objective** | This program provides monthly health and wellness education specifically geared towards our older adult population. Collaboration occurs between MAH, the Councils on Aging and the Aging Services Access Points (ASAP) within the hospitals service area. |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Provide at least four health education presentations geared towards older adults in order to increase knowledge and reduce the feeling of isolation. |
| **Goal 1 Status** | Four presentations were coordinated and presented with 152 older adults in attendance (all four sessions). Presentation topics included Brain Health, Healthy Eating/Healthy Aging, and Heart Health including stroke awareness. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Process Goal** |
| **Program Goal 2** | Brain Health Presentation: At least eighty percent of participants will report learning some new information about keeping their brain healthy. |
| **Goal 2 Status** | Eighty-seven percent of participants reported learning some new information about keeping their brain healthy. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Process Goal** |
| **Program Goal 3** | Brain Health Presentation: At least eighty percent of participants will report that they learned strategies or information to help them make choices that will positively impact their overall health. |
| **Goal 3 Status** | Ninety-three percent of participants reported that they learned strategies or information to help them make choices that will positively impact their overall health. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal** |

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| **Program Goal 4** | Brain Health: At least eighty percent of participants will report that they will be able to take what they learned or skills they learned and try to incorporate it into their weekly routine. |
| **Goal 4 Status** | Eighty-three percent of participants reported they will take what they learned or skills they learned and incorporate it into their weekly routine. |

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

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| **Program Goal 5** | Healthy Eating/Healthy Aging: At least eighty percent of participants will report they learned some new healthy tips or ideas they will use when they go grocery shopping. |
| **Goal 5 Status** | Eighty-seven percent of participants reported learning some new healthy tips and ideas they will use when they go grocery shopping. |

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

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| **Program Goal 6** | Healthy Eating/Healthy Aging: At least eighty percent of participants will report learning new tips or ideas about how to substitute foods in their diet with healthier foods. |
| **Goal 6 Status** | Eighty-seven percent of participants reported learning new tips or ideas about how to substitute healthier foods in their diet. |

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

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| **Program Goal 7** | Heart Health: At least eighty percent of participants will report they increased their knowledge of the risks of heart disease. |
| **Goal 7 Status** | Seventy-three percent of participants reported increasing their knowledge of the signs and symptoms of heart disease. |

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

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| **Program Goal 8** | By September 30, 2023, BILH Community Benefits and Community Relations staff will participate in workshops to build community engagement skills and expertise. |
| **Goal 8 Status** | Seventy-three percent of participants reported increasing their knowledge of the signs and symptoms of heart disease. |

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

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| **Priority Health Need: Equitable Access to Care**<br>**Program Name: Infrastructure to support Community Benefits Collaborations across BILH Hospitals**<br>**Health Issue: Access to Care** | |
| **Brief Description or Objective** | All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital have worked together to plan, implement, and evaluate Community Benefits programs. Staff have worked together to plan the FY22 Community Health Needs Assessment, understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH, in partnership with Mass General Brigham (MGB), has developed a Community Benefits (CB) database. This database is part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model. |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☒ Infrastructure to Support Community Benefits |
| **Program Goal 1** | By September 30, 2023, BILH Community Benefits and Community Relations staff will participate in workshops to build community engagement skills and expertise. |
| **Goal 1 Status** | All ten BILH hospital (Community Benefits and Community Relations) staff participated in four community engagement workshops. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal** |
| **Program Goal 2** | By September 30, 2023, continue to refine a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits data to more accurately capture and quantify CB/CR activities and expenditures. |
| **Goal 2 Status** | All FY23 regulatory reporting data were entered into the Community Benefits Database. The ability for community organizations to apply for grants was added in FY23. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Process Goal** |

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Medical Interpreter Services (IS)**<br>**Health Issue: Additional Health Needs Identified by the Community** | |
| **Brief Description or Objective** | Free interpreter services (IS) are available to non-English speaking, limited-English speaking, deaf, and hard-of-hearing patients. These services are provided in person; by phone using a portable speakerphone to connect patients, their care team, and an interpreter; and through a video-based remote interpreter service using a computer to connect patients with an interpreter. Professional interpretation services in hundreds of languages are available 24 hours a day. |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☒ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Provide free, timely, medical professional interpreter services for patients of all cultural and linguistic backgrounds with limited English proficiency, non-English speaking, and deaf or hard of hearing patients (ASL). |
| **Goal 1 Status** | Provided 18,899 individual encounters either face-to-face, video, or telephonic. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** \| **Goal Type: Outcomes Goal** |

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Patient Clothing Closet**<br>**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 twenty four hours a day. |
| **Program Type** | ☐ Direct Clinical Services<br>☒ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Provide emergency clothing twenty four hours a day for patients in need upon discharge from an inpatient location or the emergency department. |
| **Goal 1 Status** | Provided emergency clothing twenty four hours a day for patients in need upon discharge from an inpatient location or the emergency department. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Process Goal** |
| **Program Goal 2** | Provide an opportunity for hospital staff to donate to the patient clothing closet in order to restock items that will benefit community residents upon discharge. |
| **Goal 2 Status** | Hospital staff organized and ran a clothing drive in order to restock the patient clothing closet. Employees donated over 300 pieces of clothing. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Process Goal** |

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| **Priority Health Need: Equitable Access to Care**<br>**Program Name: Pharmacy Benefit**<br>**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<br>☐ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☒ Access/Coverage Supports<br>☐ 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 fifty-one free prescription medications for our most under-resourced populations who otherwise would not be able to pay for or have access to medication when being discharged from the hospital. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** \| **Goal Type: Outcomes Goal** |

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| **Priority Health Need: Mental Health and Substance Use**<br>**Program Name: Postpartum Support Group**<br>**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<br>☒ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Provide a free postpartum support group, which meets, weekly for community members. |
| **Goal 1 Status** | The postpartum support group met weekly and at least 125 people participated. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal** |
| **Program Goal 2** | At least eighty percent 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 1** | **Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal** |
| **Program Goal 3** | At least eighty percent 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 1** | **Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal** |

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| **Priority Health Need: Equitable Access to Care**<br>**Program Name: Prenatal/Postpartum Bilingual Outreach Program**<br>**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<br>☐ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☒ Access/Coverage Supports<br>☐ 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 1** | **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 280 women with navigational and emotional support as well as referrals to community resources. This included over 1,500 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 1** | **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 eighteen parents with a new infant car seat to assist in transporting their newborn safely home. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal** |

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Produce Prescription Program**<br>**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<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ 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 FY23. This resulted in 4,861 pounds of fresh produce to low income medically identified families. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** \| **Goal Type: Outcomes Goal** |

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| **Priority Health Need: Racial Equity**<br>**Program Name: Racial Equity and Mental Health, Collaborations with CORE MH**<br>**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<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ 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 1** | **Time Frame Duration: Year 3** \| **Goal Type: Process Goal** |
| **Program Goal 2** | Eighty-five percent of coalition members have access to networking opportunities through the coalition. |
| **Goal 2 Status** | Ninety-three of coalition members have access to professional networking opportunities through the coalition. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** \| **Goal Type: Outcomes Goal** |
| **Program Goal 3** | Eighty-five percent of Graduate Fellows in the Fellows Program have access to professional networking opportunities through the coalition. |
| **Goal 3 Status** | 100% of Graduate Fellows have access to professional networking opportunities through the coalition. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** \| **Goal Type: Outcomes Goal** |

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| **Program Goal 4** | By the end of the 2023 programming year, fifty-five percent of training participants improve their skills to incorporate racially explicit programming, policy, or organizational changes. |
| **Goal 4 Status** | Seventy-three percent of training participants improved their skills to incorporate racially explicit programming, policy, or organizational changes |

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

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| **Program Goal 5** | Ninety percent of coalition members feel they have access to peer supports for their work through CORE MH to improve racial equity in mental health. |
| **Goal 5 Status** | Sixty-three percent of coalition members feel they have access to peer supports for their work through CORE MH to improve racial equity in mental health. |

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

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| **Program Goal 6** | By the end of 2023 programming year, convene three events on racial equity and mental health with an average attendance of fifteen. |
| **Goal 6 Status** | Achieved, convened three events with average attendance eighteen. |

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

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| **Priority Health Need: Equitable Access to Care**<br>**Program Name: Safe Beds**<br>**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<br>☐ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☒ Access/Coverage Supports<br>☐ 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 1** | **Time Frame Duration: Year 3** \| **Goal Type: Process Goal** |

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: SNAP Match Program at the Farmers Markets**<br>**Health Issue: Food Insecurity** | |
| **Brief Description or Objective** | The SNAP Match Program, provides eligible (SNAP enrolled) customers a match of up to $15 in free market dollars every week at the farmer's market. The Healthy Incentive Program (HIP), an affiliated benefit for all enrolled in SNAP, HIP is an instant rebate, which can only be used to access produce items at a farmers market or CSA, through HIP certified vendors. This funding supports both Watertown and Belmont's farmer's markets to help grow their SNAP Match Programs and affiliated HIP programs. It also supports the efforts to increase enrollment with outreach and education about the market's food assistance programs. This year MAH worked with the Belmont Food Collaborative and the City of Watertown to increase their capacity to provide residents with increased access to healthy foods. |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Collaborate with local SNAP Match Programs at the Farmer's Markets to help support access to fresh produce for those who are low resourced |
| **Goal 1 Status** | Collaborated and supported both Belmont and Watertown SNAP Match programs with their local farmer's markets in order to increase access to fresh produce for those who are low resourced. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Process Goal** |
| **Program Goal 2** | Increase the number of SNAP Match shoppers at the Belmont Farmer's Market. |
| **Goal 2 Status** | Total SNAP Match shoppers at this year's farmer's market was 263 individuals, an increase of twelve percent from the previous year. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal** |
| **Program Goal 3** | Increase the number of SNAP Match shoppers at the Watertown Farmer's Market. |
| **Goal 3 Status** | SNAP Match customers increased by twenty-five percent this year at the Watertown Farmer's Market from the previous year. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal** |

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| **Program Goal 4** | Increase awareness of food assistance program by providing educational materials and trainings to Watertown community members. |
| **Goal 4 Status** | Reached approximately two hundred residents with educational materials and training opportunities. |

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

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Social Determinants of Health Screening Program**<br>**Health Issue: Social Determinants of Health** | |
| **Brief Description or Objective** | The social determinants of health (SDoH) are the conditions, in which people are born, grow, live, and age and the wider set of forces and systems shaping the conditions of daily life. These conditions have a huge impact on the health of all people especially those who face the greatest inequities and health disparities. MAH worked extensively this year to determine how best to identify patients who are most affected by social determinants of health and develop a system to refer patients to community resources. |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Implement a screening program for providers to identify patients who experience food, housing, transportation and/or financial insecurity. |
| **Goal 1 Status** | Screening process developed. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Process Goal** |
| **Program Goal 2** | Develop a system to identify patients who can benefit from community resources through the screening process. |
| **Goal 2 Status** | A system is now in place to identify patients who can benefit from community resources through the screening process. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal** |
| **Program Goal 3** | Build a SDoH screening process for social work and case management to be able to identify patients for referral to community resources. |
| **Goal 3 Status** | A system is in place for social work and case management to identify patients who can be referred to community resources. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Process Goal** |

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| **Program Goal 3** | Develop and enhance community resource information so it can be readily available for providers. |
| **Goal 3 Status** | Developed and enhanced community resource information, aligned with our identified priority SDoH: transportation, housing, food insecurity and financial instability. |

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

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Social Enterprise Youth Development Program**<br>**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<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Provide job training, youth development programming, intensive case management education and employment coaching and individual advocacy to 100 young people in Waltham in the first year of this 2-year grant period. |
| **Goal 1 Status** | More than 110 youth in Waltham have received these services and training in FY23. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** / **Goal Type: Outcomes Goal** |
| **Program Goal 2** | In FY23 ninety percent of graduates will have or be on track to earn their high school diploma or HiSET certification (high school equivalency). |
| **Goal 2 Status** | Ninety-six percent of graduates have or are on track to earn their high school diploma or HiSET certification. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** / **Goal Type: Outcomes Goal** |
| **Program Goal 3** | At least eighty percent of graduates spent fifteen or more hours per week on education and/or work. |
| **Goal 3 Status** | Eighty-four percent of graduates spent fifteen or more hours per week on education and/or work. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** / **Goal Type: Outcomes Goal** |

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| **Priority Health Need: Equitable Access to Care**<br>**Program Name: Strengthening Y2Y Harvard Square's Case Management Program**<br>**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<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Strengthen Y2Y's Case Management Team via improved training and practices. |
| **Goal 1 Status** | Ten student staff members completed a daylong intensive training on case management best practices and resources. Six of the ten summer season case managers have been retained and are serving as peer coaches. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** / **Goal Type: Process Goal** |
| **Program Goal 2** | Increase Case Management utilization rates and outcomes. |
| **Goal 2 Status** | In progress: Y2Y Network is creating the necessary framework for tracking the percentage of guests who do so and the frequency at which the meetings occur. The program manager, data director, and case management director are working together to establish the best way to track goals and outcomes. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** / **Goal Type: Process Goal** |
| **Program Goal 3** | Redevelop Y2Y Network's service partnerships. |
| **Goal 3 Status** | In process: The shelter space is now visited on a weekly basis by an outreach worker from the Massachusetts Department of Mental Health. The outreach worker is able to help provide vital wraparound services to some of the shelter's most vulnerable guests. In addition, Y2Y Network has also reignited valuable partnerships with a number of key organizations with services to benefit shelter guests. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** / **Goal Type: Process Goal** |

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| **Priority Health Need: Chronic and Complex Conditions**<br>**Program Name: Stroke Navigation and Prevention**<br>**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<br>☒ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Provide stroke education and awareness within the hospital to patients and their family members. |
| **Goal 1 Status** | Provided stroke education and support to over 225 patients and their family members by the stroke nurse coordinator. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal** |
| **Program Goal 2** | Create a Stroke awareness campaign during Stroke Awareness Month. |
| **Goal 2 Status** | Created and developed a video public service announcement, distributed stroke education materials and conducted stroke awareness presentations for community members. |
| **Time Frame Year: Year 1** | **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 and other community organizations hosting food pantries or delivering food to homebound individuals. |
| **Goal 3 Status** | Distributed over 2,000 stroke educational materials in six different languages in addition to English to various community organizations for distribution to community members and for posting in common areas. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** / **Goal Type: Process Goal** |

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| **Program Goal 4** | Create and develop a public service announcement (PSA) video, which includes stroke signs and symptoms, identifying and what to do when you witness a stroke emergency and risk factors of stroke. Distribute and share video widely. |
| **Goal 4 Status** | A video was produced and is available in four languages in addition to English. Languages include Armenian, Haitian Creole, Portuguese and Spanish. The video is posted on the hospital's website and shared with our community partners. The video was shared and aired on the local cable network stations. |

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

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| **Program Goal 5** | Provide in person stroke awareness presentations at local community-based organizations, English Language Learning organizations and Councils on Aging locations. |
| **Goal 5 Status** | Provided eight stroke awareness presentations with 127 people in attendance. |

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| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal** |

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| **Program Goal 6** | Over eighty percent of presentation participants report an increase in their knowledge of the risks of having a stroke. |
| **Goal 6 Status** | Ninety-eight percent of presentation participants reported an increase in their knowledge of the risks of having a stroke. |

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| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal** |

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| **Program Goal 7** | At least eighty percent of presentation participants will report an increase of their knowledge of the signs and symptoms of stroke. |
| **Goal 7 Status** | Eighty-nine percent of presentation participants reported an increase of their knowledge of the signs and symptoms of stroke. |

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| **Time Frame Year: Year 1** | **Time Frame Duration: Year 3** | **Goal Type: Outcomes Goal** |

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| **Priority Health Need: Mental Health and Substance Use Disorder**<br>**Program Name: Substance Use Navigation and Support**<br>**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<br>☒ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ 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. |

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

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| **Priority Health Need: Chronic and Complex Conditions**<br>**Program Name: Support for Community Members with Cancer**<br>**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<br>☒ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Organize a survivorship day for community members with cancer to celebrate and empower those affected by cancer and to improve mental health and overall wellbeing. |
| **Goal 1 Status** | Survivorship Day Event completed in June 2023 (in person) with forty-eight people attending. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Process Goal** |
| **Program Goal 2** | Eighty percent of those who participated in survivorship day will report they learned something of lasting value by participating. |
| **Goal 2 Status** | Ninety-seven of those who took the survey reported they learned something of lasting value by participating in the event. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal** |
| **Program Goal 3** | Eighty percent 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** | Ninety-five percent 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 1** | **Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal** |

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| **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. |

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| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** | **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**

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| **Brief Description or Objective** | MAH in partnership with SCM Transportation provides transportation to medical appointments to community members in need. Metro Cab vouchers and Charlie Cab cards are also available for those who qualify for transportation support. |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☐ Total Population or Community Wide Intervention<br>☒ Access/Coverage Supports<br>☐ 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 1,609 rides provided free of charge to those where transportation is a barrier to medical care. Transportation is provided via SCM Transportation, Metro Cab vouchers and Charlie Cards distributed as determined by the social work staff. |

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

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| **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. |

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

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| **Priority Health Need: Racial Equity**<br>**Program Name: Trauma Informed Counselors Representing the BIPOC Community at Transition House**<br>**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<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | By the end of FY23, three BIPOC identified clinicians will 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: Transition House hired three new clinicians, one of whom is a native Portuguese speaker and another is a native Spanish speaker. The third clinician hired is Black. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** / **Goal Type: Process Goal** |
| **Program Goal 2** | During the summer of FY23 eight new Transition House clients will access counseling within two weeks of request. Five of these eight will continue to actively engage in counseling past three sessions, aligning with our racial equity focus by promoting health access for BIPOC trauma survivors. |
| **Goal 2 Status** | 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 1** | **Time Frame Duration: Year 2** / **Goal Type: Process Goal** |

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| **Program Goal 3** | Seventy-five percent 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. |

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

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| **Priority Health Need: Social Determinants of Health**<br>**Program Name: Upstream Intervention Model Resource Navigator**<br>**Health Issue: Housing Stability/Homelessness** | |
| **Brief Description or Objective** | This program helps support a resource navigator at the Somerville Homeless Coalition (SHC). The resource navigator connects families and individuals to public and private benefits to boost household income. The aim is to use this pilot program as a pivot point to move away from crisis response model to a proactive upstream intervention model. This paradigm shift allows for more critical time and opportunity to introduce clientele to a greater range of services and support. The goal is to help families access resources, which they have found previously unobtainable, to increase household income (e.g., access to job programs) and decrease household expenditures (e.g., securing benefits), thereby fostering a more stabilized lifestyle. |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Support Somerville Homeless Coalition in providing case management services to clients identified as low-income and food insecure. |
| **Goal 1 Status** | Wrap around case management services have been provided to 109 households in FY23. |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal** |
| **Program Goal 2** | All clients using the case management service and, who are entitled to apply for SNAP benefits receive benefits in accordance with their eligibility. |
| **Goal 2 Status** | Fifty-eight households received assistance with signing up for SNAP or benefits recertification. An additional forty households received ongoing case management support during the grant period in FY23. |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal** |
| **Program Goal 3** | Reduce language barriers and increase fair and equitable access to resources by providing services and or referrals in client's primary language. |
| **Goal 3 Status** | 108 households have received case management services in their primary language. |
| **Time Frame Year: Year 2** | **Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal** |

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| **Priority Health Need: Mental Health and Substance Use**<br>**Program Name: Watertown Self Identity Project**<br>**Health Issue: Mental Health/Mental Illness** | |
| **Brief Description or Objective** | This program supports the Watertown Youth Coalition Peer Leaders. These Peer Leaders work with middle school students to support their inclusion work combating the marginalization of LGBTQIA+ and BIPOC communities in particular. The peer leaders create activities and coordinate guest speakers to build understanding of how youth can be genuine and accepted by themselves and in turn by people in their community. The aim is to create an inclusive environment that middle school students can promote and thrive in. Students learn and share effective coping strategies.. This program will leave youth with skills to adapt to stress, ultimately increasing balance and mental health and wellness throughout their lifetimes. |
| **Program Type** | ☐ Direct Clinical Services<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Offer teen Mental Health First Aid (tMHFA), to a group of youth in the community to assist them in learning skills that help them and their peers to access health for mental health challenges. |
| **Goal 1 Status** | Trained and certified eighteen Watertown youth in tMHFA. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal** |
| **Program Goal 2** | Develop a curriculum for Self Identify Project and served 18 youth, which were identified, as at risk for substance use and/or using vapes or vaping. |
| **Goal 2 Status** | Curriculum developed and program was launched with 18 middle and high school students. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Process Goal** |
| **Program Goal 3** | Build the curriculum for sustainability of the project in the Watertown Public Schools. |
| **Goal 3 Status** | This curriculum was completed and revised based on feedback and learnings. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 1** / **Goal Type: Outcomes Goal** |

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| **Priority Health Need: Racial Equity**<br>**Program Name: WHOLE Program (We Heal Ourselves with Love and Empowerment)**<br>**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<br>☐ Community Clinical Linkages<br>☒ Total Population or Community Wide Intervention<br>☐ Access/Coverage Supports<br>☐ Infrastructure to Support Community Benefits |
| **Program Goal 1** | Partner with local clinical practitioners to offer group support sessions for caregivers. |
| **Goal 1 Status** | Partnered with local clinicians to provide "Just Breath" caregiver support group sessions in the spring of 2023. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** / **Goal Type: Process Goal** |
| **Program Goal 2** | Hire a program manager to oversee operational functions, lead in developing evaluation process for all program activities, and represent WHOLE at external community meetings. |
| **Goal 2 Status** | Complete: Two part-time team members were hired for this purpose. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** / **Goal Type: Process Goal** |
| **Program Goal 3** | Engage, educate and empower the BIPOC community with comprehensive health resources. |
| **Goal 3 Status** | WHOLE partnered with Boston College's Racism-Based Violence Injury and Prevention Lab to offer a community event called Addressing Homicide Violence Among Black Emerging Adults. Over twenty people attended. |
| **Time Frame Year: Year 1** | **Time Frame Duration: Year 2** / **Goal Type: Process Goal** |

# SECTION V: EXPENDITURES

| Item/Description | Amount | Subtotal Provided to Outside Organizations (Grant/Other Funding) |
|---|---|---|
| **CB Expenditures by Program Type** | | |
| Direct Clinical Services | $2,382,856 | $0 |
| Community-Clinical Linkages | $530,437 | $11,135 |
| Total Population or Community Wide Interventions | $516,759 | $147,000 |
| Access/Coverage Supports | $798,607 | $30,000 |
| Infrastructure to Support CB Collaborations | $46,864 | $0 |
| Total Expenditures by Program Type | $4,275,523 | |
| **CB Expenditures by Health Need** | | |
| Chronic Disease | $173,322 | |
| Mental Health/Mental Illness | $2,552,705 | |
| Substance Use Disorders | $100,832 | |
| Housing Stability/Homelessness | $95,679 | |
| Additional Health Needs Identified by the Community | $1,352,985 | |
| Total by Health Need | $4,275,523 | |
| **Leveraged Resources** | $10,000 | |
| Total CB Programming | $4,285,523 | |
| **Net Charity Care Expenditures** | | |
| HSN Assessment | $1,671,558 | |
| Free/Discounted Care | $1,325,365 | |
| HSN Denied Claims | $2,580,092 | |
| Total Net Charity Care | $5,577,015 | |
| Total CB Expenditures | $9,862,538 | |

| Additional Information | |
|---|---|
| Net Patient Services Revenue | $343,175,698 |
| CB Expenditure as % of Net Patient Services Revenue | 2.87% |
| Approved CB Budget for FY24 (*Excluding expenditures that cannot be projected at the time of the report) | $4,000,000 |

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| **Bad Debt** | **$7,449,872** |
| **Bad Debt Certification** | **Certified** |
| **Optional Supplement** | |
| **Comments** | |

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

Yvonne Cheung, MD., Chair of Quality and Safety and Rich Guarino, COO, have transitioned out of Mount Auburn Hospital (MAH). Dr. Ed Huang, President of MAH and Beth O'Brien, acting COO, joined the Community Benefits Advisory Committee (CBAC) in 2023. Jacqueline Spencer, MD and MAH Board of Trustee member joined CBAC. In addition to those already mentioned, the following people were added to the MAH CBAC in FY23: Karin Carroll, Director of Somerville Health and Human Services; Derrick Neal, Chief Public Health Officer, Cambridge Health Department; Eberto Pallares, Director of Health and Wellnes, ALPHFA; Dinah Gorelik, MD., MAH Primary Care Provider; Jenica Phelps, MAH Team Lead, Social Work; Claire Hoffman, Senior Public Health Planner at Metroplitan Area Planning Council.

## 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) |
|---|---|---|---|
| Miriam Michel, Executive Director | Miriam Michel, Executive Director | Local health community organizations (CHNAs) | 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 | Miriam Michel, Executive Director | Local health community organizations (CHNAs) | Participates as a member of our CBAC. Participated on prioritization and strategy process. Was interviewed as a key informant for the CHNA. |

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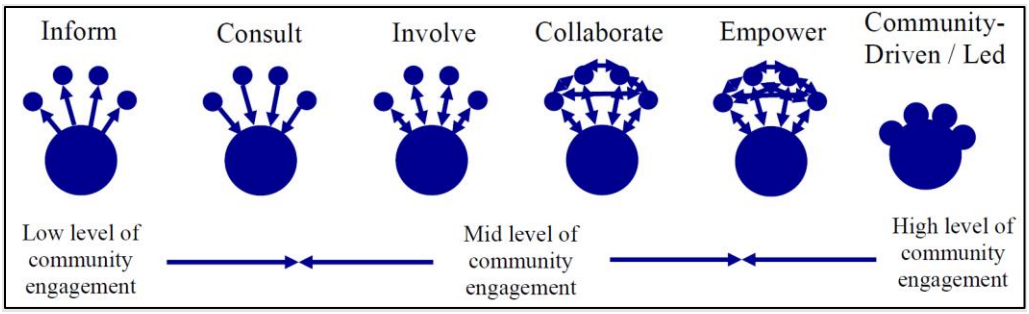
|---|---|---|---|
| Metro Housing Boston | Gregg Cothias, Managing Director | Housing organizations | Partnership with our Co-Location Program. MHB was represented on our CBAC and our grant allocation committee. |
| Charles River Community Health | Elizabeth Browne, Executive Director | Community Health 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.**

[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.

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

| Category | Level of Engagement | Did Engagement Meet Hospital's Goals? | Goal(s) for Engagement in Upcoming Year(s) |
|---|---|---|---|
| Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA | Collaborate | Goal was met | Collaborate |
| Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs | 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:

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

  Yes

  September 21, 2023 – Virtual meeting on Zoom platform

## 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.