Organization Information

Organization Name:	Newton-Wellesley Hospital
Address:	2014 Washington Street
City, State, Zip:	Newton, Massachusetts 02462
Website:	www.nwh.org
Contact Name:	Lauren Lele
Contact Title:	Director
Contact Department (Optional):	Community Benefits
Phone:	(617) 243-6330
Fax (Optional):	(617) 243-5363
E-Mail:	llele@partners.org
Contact Address: (Optional, if different from above)	2014 Washington Street
City, State, Zip: (Optional, if different from above)	Newton, Massachusetts 02462

Organization Type:	Hospital
For-Profit Status:	Not-For-Profit
Health System:	Partners HealthCare
Community Health Network Area (CHNA):	West Suburban Health Network (Newton/Waltham)(CHNA 18),
Regions Served:	Natick, Needham, Newton, Waltham, Wellesley, Weston,

Mission and Key Planning/Assessment Documents

Community Benefits Mission Statement:

For Newton-Wellesley Hospital to provide effective and coordinated local support and action to address and help prevent socio-medical problems that face the hospital's communities. Efforts to help community residents stay healthy include: raising awareness of health issues, advocating for change to improve health, presenting prevention programs, and partnering with the community to develop additional treatment resources to address unmet needs of the community. The hospital focuses on making a difference in the health and wellness of those who live and work in our communities with specific emphasis on the social determinants of health through,
increased access to care in an equitable and efficient fashion to all.
identification and addressing specific health care needs which are unique to the hospital's community.
improving the health of the community and reducing health care costs through programs of preventative medicine and health promotion.

Target Populations:

Name of Target Population	Basis for Selection
Child & Adolescent Health	CDC Risk Behavior Surveys; local community Youth Risk Behavior Surveys
Seniors	Emergency Department data sources
Low Income Community Residents	Community Health Needs Assessment; Local Housing Department data
People affected by domestic, family, or sexual violence	National, state, and local statistics
Residents impacted by Substance Use Disorders	National, state, and local statistics; Community Needs Assessment data; Youth Risk Behavior Survey

Non-English Speakers	NWH Interpreter Survey data; US Census data
Immigrant Populations	Community Health Needs Assessment; Departments of Public Health data

Publication of Target Populations:
Marketing Collateral, Annual Report, Website

Community Health Needs Assessment:

Date Last Assessment Completed:

NWH's CHNA was completed and approved by the Hospital Board in November of 2018.

Data Sources:

Community Focus Groups, Consumer Groups, Hospital, Interviews, Other, Surveys, Hospital, Surveys, Consumer and providers focus groups and structured interviews. Data sources included: the U.S. Census Bureau, American Community Surveys, County Health Rankings, the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS), the Massachusetts Department of Public Health, MetroWest Health Foundation, the Massachusetts Department of Elementary and Secondary Education, and the Federal Bureau of Investigation.

CHNA Document: NWH 2018 CHNA FINAL REPORT.PDF

Implementation Strategy:

Implementation Strategy Document: NWH 2018 CHIP.PDF

Key Accomplishments of Reporting Year:

Among community elders, fall-related injuries are the most common type of injury. In FY19, 128 elders participated in the Matter of Balance program, bringing the total number of participants since the program inception in 1997 to 1,873.
Tai Chi has also been identified to improve balance and well-being among elders. In collaboration with Newton Senior Services, 120 seniors took part in Tai Chi sessions in the community with an overwhelmingly positive response for balance, socialization, and a feeling of wellness.
In FY19, the Domestic Violence/Sexual Assault Program at NWH:
Provided free, voluntary, and confidential services to over 500 survivors of domestic, family, or sexual violence.
Provided a $50,000 grant to REACH beyond Domestic Violence to better serve the over half client population who are of Latina descent.
Created culturally and linguistically specific services and resources for survivors such as the translation into Spanish of a Custody Awareness Collaborative toolkit and implementing a bilingual/bicultural Capacitor series for both survivors and survivor advocates.
Partnered with staff of The Network/La Red to present a day-long conference on LGBTQ partner abuse and trauma in LGBTQ communities.
Program staff continued to serve on the project management team of the National SANE Tele-nursing Center located at NWH to six pilot sites across the nation with plans to expand to 9 more healthcare facility sites in the coming year.
In FY19, the Pediatric Primary Care Mass Health Clinic at NWH provided care to 491 children. At NWH Waltham Family Medicine 20 children were provided immunizations while they were in the application phase for Mass Health to ensure on-time access to school entry. A Community Health Worker was hired into the family medicine practice to address issues experienced by families to include food access, financial constraints, housing challenges and language barriers.
In FY19, facilitated 1507 rides through the Circulation/Lyft platform for ease of access to and from hospital care. Supported transport options through taxi vouchers from Veteran's Taxi for clients of low-income housing or senior agencies to have on-going access to needed healthcare services. Sponsored the continuation of the Waltham Partnership for Youth Rides Together study to take action to address transportation needs of youth and families in Waltham.
Provided assistance to 104 patients in the areas of food, lodging, safety and others. A multidisciplinary team ensures linkage to on-going clinical and social services.
Convened NWH's six community Departments of Public Health on a quarterly basis, expanding opportunities for shared communication, knowledge of resources, collaborations, and improved access to health care services. In addition, NWH convened quarterly meetings with local area higher education leadership to address prevalent health concerns on college campuses.
Provided 7,365 completed Interpreter Service requests, including face-to-face, telephonic, video, ASL.
In FY19, provided CPR/First Aid certification classes for 54 Domestic Violence workers relieving the agencies of the need to provide the training.
In FY19, NWH administered 1103 flu vaccines at 13 flu clinics held at various locations in the NWH service areas. NWH conducted 10 specialty clinics/screenings in the community to include blood pressure and skin screenings.

In FY19, NWH had representatives at 100 health community events promoting health, wellness and safety. 60 NWH clinical experts spoke at various community agencies/group/school events.
In FY19, 150 seniors attended the annual senior supper held at NWH. The event fostered socialization, nutrition and wellness.
Conducted 12 Mindfulness workshops at local senior centers and senior housing complexes. A total of 200 seniors attended.
In FY19, held a mental health summit with 100 attendees (principals school nurses, social work, guidance staff, school librarians and therapeutic staff) from the six school districts in our primary service area.
The Resilience Project incorporated school teams (psychiatrist and social worker) into the 7 high schools. Increased clinic access with a 5% increase in visits for FY19 (3490 patients). 15% of the clinic visits were referrals from local schools.
Conducted instructive and supportive groups in the following areas: The Parents Program (60 attended), a Resilient Parents Drop-In Group (30 attended), DBT skills, High School Teens group, and a Transition to College group.
The Resilience Project clinical team held 17 professional development events (500 professionals attended). Held 25 parent and community programs (550 attended). Created the framework for a Building Resilience Skills Building Series.
NWH hired a social worker into the newly created Perinatal Mood and Anxiety Disorder Initiative. Started use of a maternal mental health screening tool at 6 months post-partum, in addition to 24 weeks pre-natal and 6 weeks post-partum. Responded to 105 referrals in first six months of the program.
In FY19, NWH distributed 300 doses of Narcan to community agencies/partners. NWH dispensed 61 naloxone kits to patients in the NWH Emergency Department with diagnosis of opioid overdose.
Substance Use Service clinicians completed 337 patient visits.
Collaborated with SOAR Natick on efforts to reduce stigma and promote engagement and discussion on the issue of addiction. Displayed the Opioid Art Project and the Purple Flag Project at NWH.
The hospital continues partnership with the Middlesex District Attorney's Office to hold a monthly forum of the Charles River Regional Opioid Task Force.
In FY19, NWH continued the Waltham Wellness Collaborative in partnership with Healthy Waltham to promote health and wellness across the age spectrum.
Supported the Summer Eats program for students during the summer months which saw a 15% increase in free meals delivered to Waltham youth.
In FY19, active participation with the work of Waltham Connections for Healthy Aging to create a model for incorporating age-friendly aspects into the policies and practices of Waltham organizations to improve lives of local seniors. Conducted 7 "Walk with A Doc" programs for Waltham Connections that combine health education, physical activity, and socialization. Each session attended by 60 seniors (approx. 400 seniors).
Hired fourteen Waltham High School students through the Waltham Partnership for Youth Summer Internship program (the largest number of students hired by any one partner organization). Four students were offered employment opportunities at the conclusion of the internship program. Hosted two student interns from the Newton Mayor Youth Internship Program through Newton Health and Human Services.
Provided 84 individuals in youth and adult vocational programs with separate, on-going, placement opportunities to learn, practice and be exposed to work place skills.
For a second year, NWH sponsored the Waltham Partnership for Youth Language Access for Civic Engagements (LACE) Program for 25 Spanish/English bilingual teens to be trained as interpreter liaisons and interpret at community events that focus on substance use, strategies and available resources. 20 community events were held hiring a total of 45 youth interpreters.
Held a Career Night at NWH focused on careers requiring a two-year degree, certificate programs, or alternative training. 70 attended. 15 departments participated.
Conducted Stop the Bleed Train the Trainer sessions for community First Responders (10 attendees) and to school nurses.
Hosted an Emerging Infectious Disease Conference for hospitals and public health partners.
Convened and participated in numerous local, state and regional planning meetings, committees, and initiatives for emergency management planning, including 4 active shooter drills in Newton.
Further developed the Collaborative for Healthy Families & Communities (CHF&C). The following Councils are now established: Resilience (youth mental health), palliative care, domestic and sexual violence, maternal health, substance use, elder care, work force development, cardiovascular. Each Council is comprised of approximately 20-25 members of both the community and the hospital. Councils are led by community co-chairs. Each Council strives to address the unmet needs of the community for their focus area through the development of programs/services/initiatives as well as community-wide education and awareness.

Plans for Next Reporting Year:

In addition to the ongoing programs sponsored or in partnership with other organizations, the hospital will continue to focus on key findings highlighted in the 2018 Community Health Needs Assessment: addressing needs for specific populations (youth, seniors, low income, immigrant), access to care and transportation, Waltham as a unique community in the service area, and a focus on mental health and substance use. These identified populations and specific issues are viewed as critical and have a growing need for more resources and collective action. NWH efforts in all priority areas emphasize improvement in health status and working collaboratively within and across its communities.

Specific priority categories were established and will continue to be of focus to NWH. These include:
Mental Health (youth, senior, maternal, immigrant)
Access to Care
Social Determinants of Health - Food access and healthy eating, transportation, housing, violence and trauma, and employment/education - workforce development
Chronic Disease Management and Prevention
Community Emergency Preparedness
Substance Use

The monitoring of a variety of strategies within each of these priority initiatives are in collaboration with the community benefits committee, the hospital's Strategic Leadership Team, Board of Trustees, and Collaborative for Healthy Families & Communities Leadership.

Self-Assessment Form: Hospital Self-Assessment Update Form - Years 2 and 3

Community Benefits Programs

Access to Care	
Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	To assist with access issues, NWH develops for and supports various community agencies with transportation to facilitate client access to needed healthcare. NWH facilitates access to providers and resources for patient needs. NWH regularly convenes community health departments, community agencies and higher education institutions to engage in discussion and strategy development for improved access to healthcare.
Program Hashtags	Community Education, Prevention,
Program Contact Information	Lauren Lele, Director, Community Benefits , Newton-Wellesley Hospital, 2014 Washington St., Newton, MA 02462 617-243-6330

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide transport options to facilitate transition to and from hospital care.	Facilitated 1,507 rides through the Circulation/Lyft platform for ease of access to and from hospital care. This was an increase of over 200% compared to FY18.	Outcome Goal	Year 2 of 3
Provide access to transportation for underserved populations who are otherwise unable to obtain health care service due to transportation obstacles.	In FY19, supported transport options through taxi vouchers from Veteran's Taxi for residents of low-income housing to have on-going access to needed healthcare services.	Outcome Goal	Year 2 of 3
Support transportation initiatives in hospital service area.	Sponsored the Waltham Partnership for Youth Rides Together study to address transportation needs of youth and families. The study considers how transportation systems can be designed to serve all people more efficiently, affordably and safely. The study identified three priorities to lead to better outcomes for transportation in Waltham. Engagement and collaboration with stakeholders to facilitate change is taking place.	Process Goal	Year 2 of 3
Provide resources for assistance with basic needs related to patients' medical condition when no alternative option is accessible.	Provided assistance to 104 patients in the categories of food, lodging, safety, and others. Program administered through a multidisciplinary team. In addition, patients are linked to on-going clinical and social services.	Outcome Goal	Year 2 of 3
Make appointments for those in need of accessing clinical services for either primary or specialty care.	In FY19, the hospital's Care Finder program facilitated scheduling appointments for patients in need of a physician or hospital service. Total year end call volume for this patient population was 8000 calls.	Process Goal	Year 2 of 3
Create a community hospital model for palliative care in inpatient and outpatient settings.	Currently in collaboration with an organization partner to build a plan for a model that can be operationalized in the hospital and within provider practice locations.	Process Goal	Year 2 of 3
	NWH convenes quarterly meetings with local health departments and other community agencies (senior services, etc.). Approximately 25 community and NWH leaders attend each meeting. Goals are to communicate		

Collaborate with local health departments and other community agencies.	challenges, share best practices, review services, and strategize solutions on access and types of care, in hospital and in community. Topics included Stop the Bleed program, vaping diversion and cessation programs, tools for data gathering, substance use, and behavioral health. NWH Emergency Department data is provided on a quarterly basis in the areas of top five diagnosis, overdose, and behavioral health.	Process Goal	Year 2 of 3
Collaborate with area higher education leaders to addresses challenges faced by higher education institutions.	NWH convenes quarterly meeting with local area higher education leadership that includes Deans of Student Life, Directors of Student Health, Medical Directors, Public Safety Leadership, Chaplain Services. Approximately 25 leaders attend each forum. Forum topics included mental health, depression, opioid use, international travel, sexual violence, and wellness communities.	Process Goal	Year 2 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	Built Environment,
Health Issues	Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Uninsured/Underinsured,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** Adults, Elderly, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Disability Status, Domestic Violence History, Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
Circulation, Inc.	www.circulation.com
Wellesley Health Department	www.wellesleyma.gov
Veteran's Taxi	www.veteranstaxi.com
Natick Health Departments	www.natickma.gov
Needham Health Department	www.needhamma.gov
Newton Health Department	www.newtonma.gov
Waltham Health Department	www.city.waltham.ma.us
Waltham Partnership for Youth	www.walthampartnershipforyouth.org
Wellesley College	Not Specified
Babson College	Not Specified
Bentley University	Not Specified
MassBay College	Not Specified
UMASS (Newton Campus)	Not Specified
LaSalle College	Not Specified
Boston College	Not Specified
Brandeis University	Not Specified
Regis College	Not Specified
William James College	Not Specified
Weston Health Department	www.weston.org
NWH Carefinder	www.nwh.org

Child and Adolescent Mental Health Services at Newton-Wellesley Hospital

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	The National Institute of Mental Health reports that 1 in 5 children or adolescents experience a mental health problem before the age of 18, yet only 1 in 5 of these children or adolescents receives the treatment they need. Studies show that school-based anxiety prevention programs result in a 60 percent reduction in symptoms. Moreover, 80 percent of children respond to individual evidence-based treatment. Unfortunately, most children do not have access to prevention programs, and only 20 percent of children with psychiatric illness have access to treatment. The hospital is focused on addressing the mental health needs of the families in our community through collaboration with area high schools with emphasis on managing mental health problems and prevention initiatives.
Program Hashtags	Community Education, Health Professional/Staff Training, Prevention,
Program Contact Information	Liz Booma, MD, Chief, Child & Adolescent Psychiatry, 2014 Washington St., Newton; 617-243-6490

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
The Resilience Project is an innovative school and community based initiative designed to promote the mental health and well-being of adolescents. It provides support to students, parents, educators, counselors and communities with school personnel, customized educational programming and improved access to treatment services.	The goals of the Resilience Project are to expand clinical access to mental health services, foster school partnerships, and develop and conduct parent programs. All three goals have seen growth during FY 19 through increased patient volume, enhanced school collaborations, and expansion of offerings and participants attending parent programs.	Process Goal	Year 2 of 3
Expand access to mental health services.	In FY 19 there were 3490 clinic visits (a 5% increase over FY 18). There was an 8% decrease in child psych consults in the NWH Emergency Department. This indicates that more access to the child and adolescent psychiatric clinic is decreasing the need to seek mental health services in an emergency setting. 15% of clinic referrals are from local schools indicating that the hospital/.school partnership is creating enhanced access to care. Current clinic capacity is further expanding with the hiring of additional staff that include two child psychiatrists and two clinical social workers.	Outcome Goal	Year 2 of 3
Address parenting education and the development of skill-building tools for mental health and resilience.	Conducted the Parents Program ("Raising Resilient Teens") within The Resilience Project. Run by Child psychiatrist and psychologist. Approximately 60 parents attended the sessions. The Program promotes the well-being of children and families in the community by offering to parents, education, support and practical strategies for managing and preventing the problems that can arise in their children. Created a Resilient Parents Drop-In group for on-going support and education. There have been 30 participants in the groups. Created an alumni group to continue the connection for parents with the clinic and with one another.	Outcome Goal	Year 2 of 3
	The Resilience Project incorporated school teams into the 7 high schools. A child psychiatrist and social worker		

Create school-specific mental health programming to include a clinical consultation service and professional development.	provided clinical consultation to the schools and offered customized support on multiple occasions to address issues of mental health. Included consultations with Special Education teams guidance, nursing, and administration. The Resilience Project clinical team held 17 professional development events with a total of 500 professionals attending.	Process Goal	Year 2 of 3
Expanded clinical expertise for the school program.	Further integrated a psychologist as part of The Resilience Project Team. Enabled expansion of group-based supports for the community.	Process Goal	Year 2 of 3
Provide education and awareness to community on the topic of mental health.	Held 25 events for parents through PTO's, local parent groups, faith-based organizations, etc. A total of 550 attended the events. Held a community-wide film screening of "Like" with a panel discussion at the hospital. 100 attendees. Creating a Building Resilience Skill Building Series for the community. The monthly series will include a wide array of topics to include vaping, school refusal, the benefits of family meal time, etc.	Process Goal	Year 2 of 3
Provide opportunity for collaboration with high schools on the issue of mental health.	Held the fourth annual Mental Health Summit with attendees from the six school districts in NWH's PSA. The Summit titled, Resilience in Education - Effective Tools for Overcoming Obstacles, featured speakers who focused on promoting agency in youth ad de-stigmatizing mental health on a college campus. The 100 attendees included Principals, school nursing, social work, therapeutic staff, guidance staff, school librarians, and coaching staff. The Summit is also designed to offer participants a chance to connect with and learn from their counterparts from other schools. Both nursing and social work CEU's are offered at the free event.	Process Goal	Year 2 of 3
Support local initiatives focusing on mental health.	NWH clinical staff was represented on numerous local committees, and task forces across communities that focus on mental health in adolescents.	Process Goal	Year 2 of 3
Create a framework for supportive group guidance in mental health.	Conducted instructive groups in the following areas: DBT skills, High School Teens group, Transition to College group, and Multi-Family DBT Skills Group.	Process Goal	Year 2 of 3
The Resilience Project Council (youth mental health), within the Newton-Wellesley Collaborative for Healthy Families and Communities (CHF&C), is an innovative school-and community-based initiative designed to promote the mental health and well-being of adolescents.	The Resilience Council, comprised of 25 community and hospital members, meets four times per year and focuses on key initiatives that include: providing support to students parents, educators, counselors and communities through collaboration with school personnel, customized educational programming and improved access to treatment resources.	Process Goal	Year 2 of 3

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Social Environment,
Health Issues	Health Behaviors/Mental Health-Mental Health,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** Teenagers, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
High Schools: Natick, Needham, Newton, Waltham, Wellesley,	Not Specified

Weston	
The Manton Foundation	Not Specified

Collaborative for Healthy Families & Communities (CHF&C)

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	The Collaborative for Healthy Families and Communities (CHF&C) is an initiative of Newton-Wellesley Hospital to address unmet needs of our community and redefine the role of community hospitals. Health care is no longer narrowly focused on individuals who only have contact with the hospital in moments of acute illness or crisis. Health care now includes wellness, prevention, anticipating the lifetime needs of a family, and recognizing the social determinants of health. Prevention, early recognition, community-based interventions, and primary care are as much part of health care as a hospital bed or emergency room. The Collaborative combines community leadership and hospital resources to weave services into the fabric of our communities through educational efforts and the development of services for individuals and families throughout the life cycle.
Program Hashtags	Community Education, Mentorship/Career Training/Internship, Prevention,
Program Contact Information	Lauren Lele, Director, Community Benefits and Volunteer Services; 617-243-6330; Michael Jellinek, MD, Medical Director, CHF&C; 617-726-0519;

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Creation of a model for enhanced community engagement, extension of outreach, and expanded services in areas identified in the NWH community health needs assessment.	Developed an operational framework in the hospital for the creation of the Collaborative for Healthy Families & Communities. The Collaborative includes a Medical Director, a Director, and a program outreach coordinator.	Process Goal	Year 2 of 3
Grow and develop established Councils to further address identified unmet health needs and that have community impact.	Supported the work of the Resilience Project Council, a school-based initiative focused on mental health in adolescents, the Palliative Care Council with a focus on access to palliative care in outpatient settings, the Maternity Services Council with a focus to specifically address depression and mental health concerns in maternal patients.	Process Goal	Year 2 of 3
Create additional councils that address identified unmet health needs and have community impact	Created the following additional Councils: Domestic and Sexual Violence Council, Elder Care Council, Substance Use Council, Work Force Development Council, and Cardiovascular Council.	Process Goal	Year 1 of 3
Involve community in CHF&C	Each council has 20-25 members and is comprised of approx. 50% community members - those with expertise on the subject and those engaged on the topic. Co-Chairs for each of the councils are community members. Each Council meets four times per year.	Process Goal	Year 2 of 3
Provide community programming and education through the CHF&C.	Each council identifies a program, service or initiative that addresses an unmet need related to the area of focus. Each Council also conducts an annual lecture for the community. Six lectures about postpartum depression, youth mental health, substance use, domestic and sexual violence, caregiving, health careers were held. Attendance ranged from 20-160 community members at each lecture.	Process Goal	Year 2 of 3

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Mental Illness and Mental Health, Substance Use Disorders,

DoN Health Priorities	Built Environment, Social Environment,
Health Issues	Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Violence and Trauma, Substance Addiction-Alcohol Use,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Domestic Violence History, Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
NWH Development Office	www.nwh.org
NWH Office of Public Affairs	www.nwh.org

Community Emergency Preparedness

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	The hospital participates with other local hospitals, emergency management systems (EMS), local police, and other related agencies in the development, implementation, and notification of a community-wide disaster plan designed to provide a coordinated effort to assure essential medical services in the event of a community disaster. The system is based on the recognition that there are common elements that form the foundation for any emergency program at the federal, state, and local level. These common elements in emergency preparedness planning include evacuation, shelter, communications, direction and control, continuity of government resources, and law and order.
Program Hashtags	Community Education, Health Professional/Staff Training,
Program Contact Information	Edward Ubaike, Emergency Management/Safety Officer; 617-243-6923;

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Convene community partners for emergency management planning. Serve in leadership capacity for local emergency management and disaster planning.	Convened and participated in numerous local, state and regional planning meetings, committees, and initiatives for emergency management planning. Collaborated with EMS, Fire, Police, City Services, Health and Human Services, and others on emergency preparedness.	Process Goal	Year 2 of 3
Conduct community-wide emergency management exercises and drills.	Planned and conducted Active Shooter Drills in City of Newton. Conducted drills with Newton Fire and Cataldo Ambulance. Conducted tabletop exercise in Waltham.	Outcome Goal	Year 2 of 3
Provide designated resources and expertise for emergency management to community partners, i.e., Stop the Bleed.	Conducted Stop the Bleed Train the Trainer sessions for community First Responders (10 attendees) and to school nurses. Presented program to Public Health Leaders.	Process Goal	Year 2 of 3
Serve as key convener for Boston Marathon preparation and planning. Conduct functional planning exercises.	Worked with multi-agencies to prepare for the Boston Marathon. Conducted a Massachusetts Emergency Management Agency functional exercise for the Boston Marathon.	Process Goal	Year 2 of 3
Provide community education in the area of emergency management and disaster planning.	Conducted numerous presentations and education on emergency management to community organizations.	Process Goal	Year 2 of 3

Provide emergency and disaster training, and relevant health-related emergency planning to various community groups.	Hosted an Emerging Infectious Disease Conference for hospitals and public health partners.	Process Goal	Year 2 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	Built Environment, Social Environment, Violence,
Health Issues	Other-Emergency Preparedness,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Natick Public Health Departments	Not Specified
Needham Public Health Department	Not Specified
Newton Public Health Department	Not Specified
Waltham Public Health Department	Not Specified
Wellesley Public Health Department	Not Specified
Weston Public Health Department	Not Specified
Natick Police Department	Not Specified
Needham Police Department	Not Specified
Newton Police Department	Not Specified
Waltham Police Department	Not Specified
Wellesley Police Department	Not Specified
Weston Police Department	Not Specified
Natick Fire Department	Not Specified
Needham Fire Department	Not Specified
Newton Fire Department	Not Specified
Waltham Fire Department	Not Specified
Wellesley Fire Department	Not Specified
Weston Fire Department	Not Specified
Emergency Medical Services Providers, Cataldo and Fallon Ambulance	Not Specified

Employee Assistance Services to City of Newton Employees

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	Employee Assistance Program services through CMG Associates provides services and resources to City of Newton employees.

Program Hashtags	Support Group,
Program Contact Information	Tina McKinney, Vice President, Human Resources NWH; 617-243-6482

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide Employee Assistance Services to City of Newton employees.	Enable ease of access to EAP services for City of Newton employees.	Process Goal	Year 2 of 3
Create a customized EAP program that meets the needs of the City of Newton.	Provided resources and services that include domestic violence, substance use, work/life wellness, financial assistance resources, etc.	Process Goal	Year 2 of 3

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Social Environment,
Health Issues	Health Behaviors/Mental Health-Stress Management, Social Determinants of Health-Access to Health Care,
Target Populations	• **Regions Served:** Newton, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** Adults, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
CMG Associates	www.cmgassociates.com
City of Newton	www.newtonma.gov

Fall Prevention Among Community Seniors

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	Among community dwelling elders, fall-related injuries are the most common type of injury. A Matter of Balance is an intervention that mitigates the negative effects that the fear of falling has among elders. The program focuses on coping skills, fall risk reduction and decreasing activity restrictions. The purpose of the program is to reverse or prevent loss of function and disablement commonly associated with fear of falling among older persons. Tai Chi twice a week reduces deaths from falls in a recent study in 75+ age range and there is growing clinical evidence that physical activity programs are highly effective for prevention of falls for older persons living in the community. To support this finding, Tai Chi has been introduced as a program intervention in response to this growing trend and to facilitate fall-reduction.
Program Hashtags	Community Education, Prevention,
Program Contact Information	Kim Gerard, Manager, Newton-Wellesley Hospital Wellness Center, 2014 Washington St., Newton, 617-243-6792,

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Reverse or prevent loss of			

function and disablement commonly associated with fear of falling among older persons.	In FY19, the Matter of Balance program served 128 participants for a total of 1,873 since inception in 1997.	Outcome Goal	Year 2 of 3
Provide a group experience to reduce maladaptive ideas and beliefs about falls. Set realistic goals for increasing activity. Change their environment to reduce fall risk. Promote exercise to increase strength & balance.	In FY19, eight programs were held at local senior centers in Newton, Needham, Watertown, Waltham and Weston. Participants showed signs of fall efficacy (degree of confidence in performing common daily activities).	Process Goal	Year 2 of 3
Provide exercise activity that promotes balance and prevents falls	Held 4, 12-week Tai Chi Sessions in collaboration with the Newton Senior Center. 120 community members participated in the program.	Outcome Goal	Year 1 of 3
Provide an outlet for group interaction and socialization among seniors through Tai Chi	Tai Chi participants identified benefits of the program to include: physical well-being, balance, relaxation, joy, and being active. Opportunities to participate in the program with loved ones who have dementia was a particular advantage of the program. Feedback is as follows: "My doctor says that since I have been coming my balance has really improved. This was problem for me, and I feel I am doing something positive to address." "I appreciate the opportunity to be with others for a peaceful Friday morning. I hate exercise but really enjoy this movement very much." "My husband has Parkinson's disease, and this is something we can do together. We both are getting a lot of class."	Process Goal	Year 1 of 3

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Built Environment, Social Environment,
Health Issues	Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Physical Activity, Injury-Home Injuries, Injury-Other, Other-Senior Health Challenges/Care Coordination,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Watertown, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** Adults, Elderly, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Waltham Community Senior Center	Not Specified
Needham Community Senior Center	Not Specified
Watertown Community Senior Center	Not Specified
Newton Community Senior Center	Not Specified
Weston Community Senior Center	Not Specified
New England Research Institute (NERI)	http://www.neriscience.com/
Maine Health's Partnership for Healthy Aging	www.mainehealth.org

Health Education, Promotion and Disease Prevention Education

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	In response to health education needs identified in the community health needs assessment, NWH conducts a series of screenings, clinics, and health awareness programs in the community. Additional health promotion education is conducted on various topics such a senior living, health and sports, heart, cancer, nutrition, diet and others.
Program Hashtags	Community Education, Health Screening, Prevention,
Program Contact Information	Kim Gerard, Manager, Community Outreach, Newton-Wellesley Hospital, 2014 Washington St., Newton, MA 02462 617-243-6792,

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Conduct community flu clinics.	In FY19, NWH administered 1103 flu vaccines at 13 flu clinics held at various locations in the NWH service areas.	Outcome Goal	Year 2 of 3
Promote education through health education.	In FY19, 60 NWH clinical experts spoke at various community agencies/school events. Through the Collaborative for Healthy Families & Communities, the Hospital offered a Speaker's Bureau available to the community and created a monthly on-line Hot Topics segment for health education.	Process Goal	Year 2 of 3
Provide a source of health education and socialization for local seniors in the community.	Continued holding an annual senior supper that has been taking place for over 20 years. In FY19, 150 seniors attended. The event fostered socialization, nutrition and wellness.	Process Goal	Year 2 of 3
Provide CPR/First Aid certification classes for childcare workers, workers in Domestic Violence Programs, and parents living in homeless family hotels seeking.	In FY19, 54 Domestic Violence workers were CPR/First Aid trained and certified at no cost to attendees.	Process Goal	Year 2 of 3
Provide health awareness and disease prevention programs	In FY19, NWH conducted 10 specialty clinics/screenings in the community (blood pressure and skin screenings). 40 patients were seen during the annual skin cancer screening.	Outcome Goal	Year 2 of 3
Representation and involvement on local community boards and activities.	Numerous NWH clinicians and staff served on local community boards and offered their specialized perspectives on strategic initiatives.	Process Goal	Year 2 of 3
Support local initiatives that promote health and wellness.	In FY19, NWH had representatives at 100 health community events promoting health, wellness and safety. NWH held annual events such as Empowered Health/Empowered You - Women's Cancer Event (100 attendees) and Cancer Survivorship (90 attendees) as well as established several first -time events on such topics such as a Swim Safety Event in partnership with the Jewish Community Center, "Living Well, Dying Wisely" in partnership with Good Shepard Community Care and a Loneliness Forum in partnership with the Middlesex District Attorney's Office.	Process Goal	Year 2 of 3

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities	Social Environment,
Health Issues	Cancer-Breast, Cancer-Colorectal, Cancer-Lung, Cancer-Other, Cancer-Skin, Chronic Disease-Alzheimer's Disease, Chronic Disease-Asthma/Allergies, Chronic Disease-Diabetes, Chronic Disease-Overweight and Obesity, Chronic Disease-Stroke, Health

	Behaviors/Mental Health-Depression, Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Physical Activity, Health Behaviors/Mental Health-Stress Management, Injury-First Aid/ACLS/CPR, Injury-Other, Injury-Sports Injuries, Maternal/Child Health-Parenting Skills, Other-Senior Health Challenges/Care Coordination, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Nutrition, Social Determinants of Health-Violence and Trauma, Substance Addiction-Alcohol Use, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** Adult, • **Race/Ethnicity:** All, • **Language:** All, English, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Natick Health Department	Not Specified
Needham Health Department	Not Specified
Waltham Health Department	Not Specified
Wellesley Health Department	Not Specified
Weston Health Department	Not Specified
Natick Senior Services	Not Specified
Needham Senior Services	Not Specified
Newton Senior Services	Not Specified
Waltham Senior Services	Not Specified
Wellesley Senior Services	Not Specified
Weston Senior Services	Not Specified
Community Day Center, Waltham	https://www.communitydaycenter.org/
MGH Cancer Center at NWH	https://www.nwh.org/mass-general-cancer-center/cancer-center
Natick School Department	Not Specified
Needham School Department	Not Specified
Newton School Department	Not Specified
Waltham School Department	Not Specified
Wellesley School Department	Not Specified
Weston School Department	Not Specified

Interpreter Services

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	No
Program Description	Interpreter Services provides a free service for accurate and complete interpretation to patients and their families to maintain high quality care, safe and appropriate access to health care services. This service is available 24 hours a day/7 day a week. Interpreter Service are made available -- both in person at the hospital and by telephone -- depending on the patient's needs. Services are provided to a variety of patients including non-English speakers and deaf or hard of hearing individuals.
Program Hashtags	Not Specified
Program Contact Information	Lauren Lele, Director, Community Benefits â€“ NWH, 617-243-6330

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide Interpreter Services to the Newton-Wellesley Hospital patient population.	Provided 7,365 completed Interpreter Service requests, including face-to-face, telephonic, video, ASL.	Outcome Goal	Year 2 of 3
Ensure that Interpreter Services are available in all areas of the hospital.	The top five hospital departments utilizing interpreter services were Emergency, Urgent Care, Medicine, Surgery, and Pediatrics.	Process Goal	Year 2 of 3
Provide training to medical/clinical providers, and staff including, but not limited to, effective use of all interpreters, use of equipment, cultural competency, patient health belief systems, health disparities.	Included how to access Interpreter Services in new employee orientation. Educated and raised awareness on cultural competence through an on-line education platform. Provided clinical staff with training on providing patient advocacy that included instructions on cultural factors. Provided hospital-wide communication on utilizing interpreter services.	Process Goal	Year 2 of 3
Provide patient information documents in translated languages.	Provided translated documents for: discharge instructions, patient rights, menus, and patient education.	Outcome Goal	Year 2 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	Social Environment,
Health Issues	Social Determinants of Health-Access to Health Care, Social Determinants of Health-Language/Literacy,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
Cross Cultural Communications, Inc	https://embracingculture.com/
Pacific Interpreters	https://www.languageline.com/pacific_interpreters
Deaf Talk Video	www.dtinterpreting.com
Bulfinch Temporary Service	www.partners.org

Maternal Mental Health

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	One out of seven women experience depression or anxiety during pregnancy or postpartum. Untreated perinatal mood and anxiety disorders leads to increased costs of medical care, inappropriate medical care, child abuse and neglect, discontinuation of breastfeeding, family dysfunction and adversely affects early brain development. Children of parents with depression and anxiety may develop learning, attention or behavioral difficulties as they grow older.
Program Hashtags	Prevention, Support Group,
Program Contact Information	Tom Beatty, MD, Chair, Obstetrics and Gynecology, David Wolfe, MD, Chair Psychiatry Buffy Sheff-Ross, MSW, LICSW, Clinical Social Work

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Address the issue of post-partum depression in maternal patients. Affects 10-15% of the NWH maternal patient population.	Established a Perinatal Mood and Anxiety Disorder Initiative. Hired a licensed social worker to launch the program.	Process Goal	Year 1 of 3
Extend the post-partum screening tool further after pregnancy.	Collaborated with 3 OB practices to pilot using screening for maternal patients at 24 pre-natal, 6 weeks postpartum, AND 6 months postpartum. NWH is the first Partners hospital to screen at 6 months postpartum.	Process Goal	Year 1 of 3
Respond to referrals directly from MD's, MA's, RN's.	Received referrals for reasons of anxiety and depression, substance use, family dynamics, homelessness, unplanned pregnancy, traumatic delivery, and others. There were 105 referrals in FY 2019. (Only 6 months of data as program started in April 2019) Worked with community partners for collaboration of resources.	Outcome Goal	Year 1 of 3
Provide on-going methods of support for maternal patients.	Started the development of a post-partum support group for new mothers. Increase socialization, respond to concerns after pregnancy, establish on-going interaction during immediate time after birth.	Process Goal	Year 1 of 3
The Maternity Services Council, within the Collaborative for Healthy Families & Communities (CHF&C), is focused on improving Maternity Services during pregnancy and after delivery with a special mission to increase awareness and improve treatment of pregnancy-related depression.	The Maternity Services Council is comprised of 25 hospital and community members. The Council evaluates strategies on how best to meet the needs of women and families, engaging related community and hospital services to enhance care.	Process Goal	Year 2 of 3
Provide opportunities for community education on post-partum depression and maternal wellness.	Held a community-wide lecture on post-partum depression with 40 attendees. Established web-based platforms for on-going education and information sharing.	Process Goal	Year 1 of 3

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Social Environment,
Health Issues	Health Behaviors/Mental Health-Depression, Maternal/Child Health-Parenting Skills, Social Determinants of Health-Access to Health Care,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** Female, • **Age Group:** Adults, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Domestic Violence History,

Partners:

Partner Name and Description	Partner Website
Wellesley Women's Care	https://www.careforwomen.com/
Newton-Wellesley Obstetrics and Gynecology	https://www.newtonwellesleyobgyn.com/
About Women by Women in Wellesley	https://aboutwomenbywomen.net/
Jewish Family & Children's Services	https://www.jfcsboston.org/
MCPAP	https://www.mcpapformoms.org/

Primary Care to Children and Adolescents - Access to Care and Services

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	No
Program Description	The Pediatric Primary Care Clinic (PPCC) and NWH Waltham Family Medicine provide medical care to children and adolescents who do not have access to a private physician. Additionally, a wide range of specialty clinics associated with Massachusetts General Hospital for Children are available to Clinic patients. Create linkages to services and resources associated with the social determinants of health for children and adolescents.
Program Hashtags	Health Screening, Prevention,
Program Contact Information	Joel Bass, MD Chair, Department of Pediatrics Newton-Wellesley Hospital 617-243-6565 ; Carrie Goodhue, Practice Manager, Waltham Family Medicine, 781-

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide primary care to children and adolescents who are uninsured or present other challenges interfering with accessing primary care.	In FY19, provided care to pediatric uninsured patients while they were in the application phase for Mass Health so as not to delay school entry. In collaboration with Waltham Public Schools provided bi-lingual information on how to access care.	Process Goal	Year 2 of 3
Provide primary care to children and adolescents.	In FY19, there were 491 visits to the pediatric clinic (Mass Health Clinic) at NWH. Facilitated having link to a primary care physician for on-going care.	Outcome Goal	Year 2 of 3
Accept agency referrals for children/adolescents without primary care.	In FY19, continued to serve a consistent number of youths for referrals.	Process Goal	Year 2 of 3
Facilitate services to ease access of care.	At the Waltham practice location, hired a community health worker to navigate patient/family needs related to SDOH needs. CHW links families to community resources and offers on-going support for accessing services.	Process Goal	Year 1 of 3
Consult to schools and agencies and coordinate services for disadvantaged youth.	In FY19, collaborated with numerous Waltham agencies to address areas of concern by patients and families presenting at the clinic; to include food access, behavioral health, and language barriers.	Process Goal	Year 2 of 3
Participation by clinicians on various local and state-wide agencies as experts on pediatric health.	In FY19, there were numerous school consultations and participation on agency boards, e.g. Newton Boys & Girls Club, local Boards of Public Health and Mass Medical Society - School Health Committee.	Process Goal	Year 2 of 3

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Social Environment,
Health Issues	Health Behaviors/Mental Health-Immunization, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Uninsured/Underinsured,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** Children, Teenagers, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website

Waltham Public Schools, Patricia McCaffrey, MSN, BSN, RN; Director of Health Services, Waltham Public Schools, 781-314-5462, patriciamccaffrey@walthampublicschools.org	www.walthampublicschools.org
Waltham Family Medicine, Ashley Dillon, Community Health Worker, aedillon@partners.org	https://www.nwh.org/primary-care/family-medicine/waltham
Mass Health Pediatric Clinic, Karen Sadler, MD, ksadler@mgh.harvard.edu	https://www.nwh.org/pediatrics/massgeneral-for-children-at-newton-wellesley

Senior Wellness

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	Addressing the goals of our community seniors is a priority in developing Senior Wellness initiatives. Services and programs are created to value increased independence, safety, and happiness throughout life. They examine many elements of physical and emotional well-being.
Program Hashtags	Community Education, Health Screening, Prevention,
Program Contact Information	Lauren Lele, Director, Community Benefits, Newton-Wellesley Hospital, 617-243-6330

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide a source of health education and socialization for local seniors in the community.	Continued holding a senior supper that has been taking place for 22 years. In FY19, 150 community seniors attended. The event fostered socialization, nutrition, and health education on GERD (acid reflux).	Outcome Goal	Year 2 of 3
Provide Mindfulness workshops for community seniors on the importance of the mind-body connection of overall health to help prevent adverse outcomes of stress.	Mindfulness program popularity continues to increase among our seniors. 12 Mindfulness Workshops were conducted at area senior centers and elder housing complexes. Approximately 200 seniors took part in the workshops.	Outcome Goal	Year 2 of 3
Provide increased knowledge to seniors on local activities and information.	Support the publication of the Waltham Senior Center Newsletter. Provided in Spanish.	Process Goal	Year 2 of 3
Enhance senior wellness, specifically related to balance through the Matter of Balance program and Tai Chi programming.	A total of 250 seniors took part in Matter of Balance and Tai Chi programs. Programs held in partnership with local senior centers.	Outcome Goal	Year 2 of 3
Provided specific health education and health screenings to seniors in the community.	At senior centers and housing complexes, held flu clinics, blood pressure screenings, and health education to include advanced care planning, nutrition, stroke prevention, and safe driving.	Process Goal	Year 2 of 3
Provide opportunities for physical activity, health education, and wellness.	Held 7 "Walk with A Doc" sessions in collaborations with Waltham Connections. Approximately 400 seniors took part in the sessions. An NWH provider gave a brief health presentation and Q&A, and then walked with seniors, providing physical activity and social interaction.	Outcome Goal	Year 2 of 3
The Elder Services Council, within the Newton-Wellesley Collaborative for Healthy Families and Communities (CHF&C), is focused on the socialization of elders as well as primary and secondary falls prevention.	The Elder Services Council is comprised of 25 hospital and community members. The Council meets four times per year. The needs of our elders are unique and require tailored strategies. The Council explores solutions and evaluates options through the lens of elders themselves, health care providers, home caregivers, municipal professionals and others.	Process Goal	Year 1 of 3

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Mental Illness and Mental Health,
DoN Health Priorities	Built Environment, Social Environment,
Health Issues	Chronic Disease-Stroke, Injury-Other, Other-Senior Health Challenges/Care Coordination, Social Determinants of Health-Access to Health Care,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** Elderly, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Community Senior Centers	Not Specified
Good Shepherd Community Care	https://gscommunitycare.org/
Healthy Waltham	Healthy-waltham.org
Waltham Connections	Not Specified
Community Housing Facilities: 2lifecommunities; Newton Housing Authority	https://www.2lifecommunities.org/live-here/our-campuses/golda-meir-house; www.newtonhousing.org
Integrated Care Management Program (iCMP)	www.nwh.org

Substance Use Outreach, Treatment and Education

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	The substance use program at NWH is designed to provide multidisciplinary addiction consultation and coordinate a treatment transition for long term recovery for patients; educate clinicians on caring for substance use disorders; and collaborate with the community on substance use disorder prevention and treatment.
Program Hashtags	Community Education, Health Professional/Staff Training, Prevention,
Program Contact Information	Catharina Armstrong, MD, Associate Director, Substance Use Service; 617-243-6142 ; Wendy Daigle, Laboratory Outreach Program Manager,

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Access and use of Narcan is an effective option of treating drug overdose. The use of this resource in the community is a need for various agencies. NWH is able to provide Narcan and training to our community partners to support their efforts of dealing with the opioid crisis.	In FY19, NWH provided 300 doses of Narcan to local community partners - police and fire, public health, schools and shelters. Provided training to community partners, as necessary.	Outcome Goal	Year 2 of 3
Provide preventive substance use resources to ED patients and families.	In FY19, NWH dispensed 61 naloxone kits to patients in the Emergency Department with diagnosis of opioid overdose.	Outcome Goal	Year 2 of 3

Provided a location for safe medication disposal within the hospital.	Maintained a MedSafe receptacle for the safe disposal of medications. Promote use among staff, the community and physician practices of this option.	Process Goal	Year 2 of 3
Provide education on various forms of substance use.	Conducted community wide lectures on vaping, marijuana and substance use with internal and external experts. Provided education forums to various organizations in the community. Numerous clinicians provided education to school programs with audiences of youth, parents and educators.	Process Goal	Year 2 of 3
Provide education to clinicians and pharmacists and public health officials on role in pain management and addiction.	Expert substance use clinicians provided training in pain management and addiction.	Process Goal	Year 2 of 3
Provide resources to community partners for needed substances.	Provided 104 doses of Epi-pens to local fire departments and colleges.	Outcome Goal	Year 2 of 3
Use the hospital as a site to increase public awareness on the opioid epidemic and decrease stigma around substance use.	Partnered with SOAR Natick during International Overdose Awareness Day and National Recovery Month to bring two displays to the community internal and external to the hospital. The Opioid Project displayed artwork and recordings of personal stories to bring to life the human costs of the opioid epidemic. The Purple Flag Project displayed a visible and startling reminder of lives lost to the opioid epidemic in Massachusetts. Both displays encouraged engagement by hospital staff and community and were efforts to reduce the level of stigma around addiction.	Process Goal	Year 1 of 3
Provide care to substance use patients in the SUS clinic.	SUS clinicians completed 337 patient visits (68% increase over FY18) for those referred by NWH primary care, inpatient Hospitalist service, and emergency department clinicians. Patients presented with alcohol disorder (61%), opioid disorder (35%), and others (4%).	Outcome Goal	Year 2 of 3
Collaborate with various local multi-community, and state-wide agencies to address the opioid crisis.	In FY19, NWH staff and clinicians played a leadership role on various community initiatives and collaborations with local health departments, police, fire and schools. Involvement included Newton PATH and MetroBoston Project Outreach, in addition to others. The hospital collaborated with the Middlesex District Attorney's office to create the Charles River Regional Opioid Task Force and held monthly forums with multidisciplinary community partners to promote education of community programming, sharing of data, exchange of best practices and opportunity for collaboration.	Process Goal	Year 2 of 3
The Substance Use Council, within the Newton-Wellesley Collaborative for Healthy Families and Communities (CHF&C), is focused on the recognition and treatment of substance use, outreach and education of the community and providers.	The Substance Use Council, comprised of 25 community and hospital members, represent both clinical and societal perspectives. The Council meets four times per year and focuses on key initiatives that further ways to provide critical services at the time of greatest impact. These initiatives currently include expansion of recovery coaches and psychiatry clinical expertise and embedding treatment and preventive care throughout our community with enhanced primary care provider support and training.	Process Goal	Year 1 of 3

EOHHS Focus Issues	Substance Use Disorders,
DoN Health Priorities	Social Environment,
Health Issues	Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Newton Health Department	www.newtonma.gov
Waltham Health Department	https://www.city.waltham.ma.us/health-department
Wellesley Health Department	www.wellesleyma.gov
Natick Health Department	www.natickma.gov
Needham Health Department	www.needhamma.gov
Weston Health Department	www.weston.org
Newton Police and Fire Department	www.newtonpolice.com
Waltham Police and Fire Department	https://www.city.waltham.ma.us/police-department
Wellesley Police and Fire Department	www.wellesleyma.gov
Natick Police and Fire Department	www.natickma.gov
Needham Police and Fire Department	www.needhamma.gov
Weston Police and Fire Department	www.weston.org
Middlesex County District Attorney	http://www.middlesexda.com/
Babson College	www.babson.edu
Waltham School Department	www.walthampublicschools.org
Boston College	www.bc.edu
Bentley University	www.bentley.edu
Newton YMCA	https://www.wsymca.org/

The Domestic Violence/Sexual Assault Program at Newton-Wellesley Hospital (DV/SA Program)

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	The DV/SA Program provides free, voluntary, and confidential services to patients and employees who are experiencing domestic violence, family violence and sexual assault. In FY19, over 500 survivors were served through support groups, counseling and safety planning, and several hundred consults to providers.
Program Hashtags	Community Education, Health Professional/Staff Training, Prevention,
Program Contact Information	Erin C. Miller, Equity, Inclusion, and Abuse Prevention Officer Newton-Wellesley Hospital 617-243-6521

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provides free, voluntary, and confidential services to patients, employees and community members who are experiencing domestic violence, partners abuse, sexual assault/abuse, and/or stalking.	In FY19, the program served over 500 survivors. Staff saw a significant increase in demand for direct services, and in the complexity and acuity of that demand, likely as a result of the #MeToo movement and the backlash to the #MeToo movement. In addition, staff served a number of clients with highly lethal or longstanding abuse dynamics, often complicated by serious mental illness of substance use disorders.	Outcome Goal	Year 2 of 3

Expand Domestic Violence services in the community and to Spanish-speaking, immigrant survivors of partner abuse.	Provided a $50,000 grant to REACH Beyond Domestic Violence to better serve Latinx survivors of abuse and their children. Of REACH's total number of clients, over half are of Latina descent.	Process Goal	Year 2 of 3
Provide domestic and sexual violence training as mandated for healthcare providers the Massachusetts state legislature.	Implemented a DPH-approved training for several thousand healthcare providers across the state, and locally at NWH. Seven unique training topic modules were presented for nursing staff, social work, physicians, and others. In addition, a conference was held on trauma and oppression in the childbearing year, the Black maternal health crisis, transgender parents, and the impact of the political climate on immigrant parents and their children.	Outcome Goal	Year 2 of 3
Continue to increase safety, health and well-being of patients, employees and community members by providing comprehensive services to those experiencing domestic and sexual violence and stalking.	In FY19, the program provided 1500 of hours of safety planning, counseling & advocacy to survivors. In addition, thousands of hours of additional time were devoted to community education, training, policy development, & collaboration with community organizations. Among those groups participating in the trainings were public health nurses, school-based personnel, social workers, physicians and case managers, and many other health care providers and non-healthcare providers.	Process Goal	Year 2 of 3
Establish a staff wellness initiative to promote workplace safety.	Communicated to staff tools and options in response to an increase in aggressive behaviors experienced in the workplace.	Process Goal	Year 2 of 3
Grow accessibility for Latin, Spanish-speaking, and, in particular, undocumented survivors (who are disproportionately at risk).	In FY19, the program continued collaboration with REACH Beyond Domestic Violence and Greater Boston Legal Services to support the Latinas Know Your Rights Program. This multi-program collaboration resulted in culturally and linguistically-specific support groups and expressive art therapy groups, as well as a community education series for parenting survivors concerned about their children's experiences of bullying. In addition, a notable number of community education events were marketed in Spanish, with fully bilingual materials and interpretation available.	Process Goal	Year 2 of 3
Increase access to services for patients and employees by increasing education and consultation services to health care providers and affiliated professionals both inside and outside the hospital.	In FY 19, the DV/SA Program provided education and consultation to hundreds of healthcare providers and multidisciplinary professionals on topics ranging from partner abuse to childhood sexual abuse, to the intersections of trauma and substance use disorders.	Process Goal	Year 2 of 3
Take a leadership role in a multi-year, state-wide effort to improve the response of the probate and family courts to survivors of domestic violence, sexual assault, and child abuse. This effort, is known as the Custody Awareness Collaborative (CAC),	Translated a CAC toolkit into Spanish. Advised on and facilitated the publication of "Like I am Invisible": IPV Survivor- Mothers' Perceptions of Seeking Child Custody through the Family Court System.	Process Goal	Year 1 of 3
Continued participation in multi-year, multidisciplinary abuse in later life partnership that has historically included REACH Beyond DV, Springwell Elder Protective Services, & the Middlesex County DAs office.	In FY 19, the partnership trained numerous community-based victim service providers through conferences, trainings, and roundtables.	Process Goal	Year 2 of 3
Build capacity around LGBTQ partner abuse and trauma.	Partnered with staff of The Network/La Red to present a day-long conference on LGBTQ partner abuse and trauma in LGBTQ communities. Additional trainings were also held that included, a panel presentation on "Breaking the Silence: Confronting Domestic Violence in LGBTQIA Communities" at Brandeis University. Participate on the LGBTQIA Domestic and Sexual Violence Coalition.	Process Goal	Year 2 of 3

Support capacity of multidisciplinary DSV specialists in the community.	Lent substantive time and expertise to community and healthcare-based domestic violence programs across the Commonwealth, in order to build capacity to better support the following: 1) survivors in probate and family court to protect traumatized/abused children, 2) trauma-informed responses to all survivors, and 3) relationships with healthcare providers and institutions.	Process Goal	Year 2 of 3
Serve as expert members, representatives on committees, task forces and boards related to DSV.	Program staff serve on a variety of boards and committees focusing on child abuse, neglect, diversity and inclusion.	Process Goal	Year 2 of 3
Provide First Aid and CPR training to DSV organizations across the state.	Provided three First Aid and CPR certification trainings to DSV organization providers at no charge. A total of 54 staff were certified.	Outcome Goal	Year 2 of 3
Support shelter infrastructure. and DV/SA agencies in the community.	In FY19, the program provided substantial donations and other in-kind expertise to support the shelter infrastructure and DV/SA agencies in the community.	Process Goal	Year 2 of 3
Establish a Domestic and Sexual Violence Council to ensure robust healthcare and community-based responses to violence and abuse.	The Council, comprised of 25 members, meets four times per year. The Council has been instrumental in expanding written and web-based program outreach materials as well as the cultivation of relationships with organizations serving historically marginalized survivors (ex. Southeast Asian and Deaf).	Process Goal	Year 1 of 3
Hold an annual lecture for the community on DSV.	Held a lecture titled "Courageous Conversations: A Discussion about Domestic and Sexual Abuse." Consisted of a 6-member panel and a survivor story. 25 community members attended.	Process Goal	Year 1 of 3
Build options for DSV support and empowerment groups.	Implemented a bilingual/bicultural Capacitor series for both survivors and survivor advocates, designed to impart skills release toxic stress, alleviate anxiety and grow skills for self-soothing. Program staff partnered with multiple community partners, including The Victim Rights Law Center and the Center for Hope and Healing, to support "Healing Together," a one-day retreat for queer, transgender, non-binary Black, Latinx, Indigenous, and Asian Pacific Islander survivors of childhood sexual assault and/or abuse. Program staff implemented three separate support and empowerment groups for Spanish-speaking survivors of partner abuse in partnership with REACH Beyond Domestic Violence. Program staff continued to co-facilitate a support group entitled "Body, Truth, and Power" with The Second Step staff. This group was designed to educate survivors about the impact of trauma on mind, body, and spirit, and help cultivate and strengthen healthy coping skills in the face of such traumas. Program staff continue to provide support and technical assistance to the leadership of the SNAP (Survivors Network of those Abused by Priests) group that operates on the NWH campus. Click or tap here to enter text.	Process Goal	Year 2 of 3

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Built Environment, Social Environment, Violence,
Health Issues	Health Behaviors/Mental Health-Mental Health, Injury-Other, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Violence and Trauma, Substance Addiction-Alcohol Use,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Domestic Violence History, LGBT

	Status, Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
Boston Area Rape Crisis Center	http://www.barcc.org/
GLBT Domestic Violence Coalition	http://www.thenetworklared.org/glbtdvcwebappl.pdf
Jane Doe, Inc.	http://www.janedoe.org/
Middlesex Co DA's Office	http://www.middlesexda.com/
REACH Beyond Domestic Violence	http://www.reachma.org/
The Second Step	http://www.thesecondstep.org/
The Network/La Red	www.tnlr.org

Waltham Wellness Collaborative with Healthy Waltham

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	NWH facilitates access to healthy, nutritious food and opportunities for physical activity for all residents of Waltham. Emphasis on access to food and activity regardless of income, age, or background. Partner with Waltham based organizations - Healthy Waltham, Waltham Connections and others. In the NWH service area of Waltham, the obesity rate is higher than all other communities NWH serves. In addition, Waltham youth have higher obesity percentage rates than youth statewide.
Program Hashtags	Community Education,
Program Contact Information	Lauren Lele, Director, Community Benefits, Newton-Wellesley Hospital, 2014 Washington St., Newton, MA 02462 617-243-6330

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Create platforms for the promotion of healthy living.	Supported the Walking Waltham initiative to engage the entire community and get more people walking-from ages 2-96. Promote physical activity and help combat obesity and stress. Initiative promotes walking in Waltham's natural spaces and on city streets.	Process Goal	Year 2 of 3
Link clinical providers with the community health activities.	Held 7 physician led "Walk with Doc" sessions through the Waltham Connections walking program. Attended by approx. 60 seniors at each session. Incorporated both education, physical activity, and socialization.	Outcome Goal	Year 2 of 4
Provide educational programming on healthy lifestyle.	Conducted in-school programming around healthy eating and promoting healthy choices for youth in Waltham.	Process Goal	Year 2 of 3
Partner with other organizations in Waltham to promote age-friendly activities in Waltham.	Actively participate in Waltham Connections for Healthy Aging. A model created for incorporating age-friendly aspects into the policies and practices of Waltham organizations to improve lives of local seniors. Goals are to include seniors who typically face economic, ethnic or other barriers; as well as to provide mechanisms for social interaction and engagement.	Process Goal	Year 2 of 3
Provide food access during non-school hours (summer)	Support the Summer Eats program for Waltham youth during the summer months. Includes breakfasts, snacks, lunch and dinner. In 2019 there was a 15% increase in meals served from 2018 and a 56% increase over 2017. Created and distributed promotional material about the program in both Spanish and English.	Outcome Goal	Year 2 of 3

Involvement in Waltham community wellness educational initiatives.	Supported Healthy Waltham to participate in the School Health Advisory Committee to implement policy change as necessary.	Process Goal	Year 2 of 3

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Mental Illness and Mental Health,
DoN Health Priorities	Built Environment, Social Environment,
Health Issues	Chronic Disease-Overweight and Obesity, Health Behaviors/Mental Health-Mental Health, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Nutrition,
Target Populations	• **Regions Served:** Waltham, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Healthy Waltham, Myriam Michel, Executive Director	www.healthy-waltham.org
Waltham Connections, Maria DiMaggio, Project Coordinator	www.healthy-waltham.org
Waltham Boys and Girls Club, Nick Cacciolfi, Director of Operations	www.walthambgc.org
Project Bread, Miriam Avila	www. Projectbread.org

WorkForce Development

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	By promoting work force development, youth and adults are exposed to a range of job opportunities, gain new skills applicable to specific job positions, are empowered to explore career options and gain financial resources. The hospital partners with the school system and youth and adult organizations to develop programs that improve employment opportunity at all levels of the spectrum.
Program Hashtags	Mentorship/Career Training/Internship,
Program Contact Information	Lauren Lele, Director, Community Benefits and Volunteer Services 617-243-6330

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide skills based learning and transferrable work place skills for young teens. Provide paid employment to youth. Engage teens in the community using their skills to further health education.	Sponsored the Waltham Partnership for Youth Language Access for Civic Engagements (LACE) Program. 25 Spanish/English bilingual teens were trained as interpreter liaisons by Cross Cultural Communications, Inc. Program provides paid employment, transferrable skills and possibility for career development. Adds a component of community engagement by having teens interpret at community events that focus on substance use, strategies and available resources. 20 community events were held hiring a total of 45 youth interpreters. Program allows outreach events to occur in culturally and linguistically diverse venues.	Process Goal	Year 2 of 3

Provide opportunities for youth to gain exposure to the health care environment and learn from professionals about career options.	Hosted two student interns from the Newton Mayor Youth Internship Program through Newton Health and Human Services. Students spent 7 weeks at the hospital exploring different departments and working alongside a variety of staff professionals. Learned about the skills necessary to perform a variety of health care functions.	Outcome Goal	Year 2 of 3
Provide paid employment opportunities to underserved youth in the community. Enhance exposure and opportunities for a career in the healthcare industry with varying levels of post-education.	Hired 14 Waltham High School students through the Waltham Partnership for Youth Summer Internship program. This was the largest number of students sponsored by one organization. Students worked for 7 weeks in the areas of Imaging, outpatient clinics, nursing, environmental services, human resources, primary care, Rehabilitation, and others. Students interacted with hospital personnel, patient populations, and learned new skills. Weekly skill building programming was held at the hospital. Four students were offered employment at the conclusion of the program.	Outcome Goal	Year 2 of 3
Support on-going youth work force development initiatives I the community.	Established a three-year plan to provide sponsorship for the Youth Intern Coordinator at Waltham Partnership for Youth. Position is responsible for the placement, training, and development of over 80 summer interns in the City of Waltham	Process Goal	Year 1 of 2
Provide work-skill based opportunities for students and adults through the NWH vocational volunteer program.	Provided 84 adult and youth individuals, in vocational programs, with separate, on-going placement opportunities to learn, practice and be exposed to work place skills. Individuals contributed over 5000 hours of service in the year. NWH Volunteer Services works with 20 schools and organizations to facilitate program. Over 25 hospital staff provide instruction, training and a mentor presence for individuals.	Outcome Goal	Year 2 of 3
Provide exposure to the health care setting and career options to adult learners in the community.	Partnered with One Family, Inc and held a Lunch and Learn at Newton-Wellesley Hospital for the One Family Scholars Program. Consisted of a six member-employee panel representing various healthcare disciplines. Also included a speaker from Human Resources. Workshop included Q&A and networking time. Provided a variety of opportunities for adult learners to learn and be exposed to a healthcare environment	Process Goal	Year 1 of 2
Provide outlets for exposure to health-related educational and employment opportunities to those with less economic stability and means to pursue education opportunities.	Held a Career Night at NWH focused on careers requiring a two-year degree, certificate programs, or alternative training. Geared to high school students. Had 70 attendees. 15 different NWH departments and staff represented healthcare specialties. The event included a resume and interview skills workshop and a "career journey" story from an NWH employee.	Process Goal	Year 2 of 3
Provide community outreach to student populations to expose individuals to healthcare careers	Staff took part in numerous fairs, club meetings and spoke at events to educate attendees on healthcare career options.	Process Goal	Year 2 of 3
The Work Force Development Council, within the Newton-Wellesley Collaborative for Healthy Families and Communities (CHF&C), focuses on expanding potential career options, through training, education and career development. Providing opportunities for both youth and adults enhances family financial security and, importantly, provides a ready pool of talent for local businesses. A strong local economy can positively and more broadly impact health and wellness.	The Work Force Development Council, comprised of 25 community and hospital members, meets four times per year and focuses on key initiatives that include: Waltham summer youth intern program; Student and community exposure to healthcare careers across all levels, highlighted by an annual career fair; Opportunities for non-working adults and adults in the workforce in need of additional support. Community collaborations and business partners have increased awareness of efforts to provide opportunities to develop a regional workforce.	Process Goal	Year 1 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	Education, Employment, Social Environment,
Health Issues	Social Determinants of Health-Education/Learning, Social Determinants of Health-Income and Poverty,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** Adults, Teenagers, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
Waltham Partnership for Youth	www.walthampartnershipforyouth.org
Newton Dept. Health and Human Services	www.newtonma.gov
NWH Volunteer Services	www.nwh.org

Wrap Around Waltham

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	NWH's most recent Community Health Needs Assessment demonstrated that high school graduation rates among Waltham students are lower than that of other communities in the hospital's catchment area and of Massachusetts overall. The dropout rate in Waltham (3.5%), is twice that of Massachusetts. Furthermore, among English Language Learners (ELL), graduation rates are 15% lower and dropout rates are 10.5% higher compared to the overall student population. NWH is operationalizing a grant initiative to address this disparity made possible by the approval of two Determination of Need (DoN) - Community Health Initiative (CHI) processes of Partners HealthCare System, Inc., Massachusetts General Waltham and Partners HealthCare System, Inc. - Massachusetts General Physician's Organization Waltham.
Program Hashtags	Mentorship/Career Training/Internship,
Program Contact Information	Kaytie Dowcett, Executive Director, Waltham Partnership for Youth, Liz Homan, Assistant Superintendent, Waltham Public Schools,

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Reduce ethnic and cultural disparities in graduation and dropout rates in Waltham. The target population is focused on Waltham students who are recent immigrants or refugees, and primarily are English Language Learners.	Wrap Around Waltham, the Collaborative grantee comprised of five identified community partners was awarded funding. Partners are: Waltham Partnership for Youth, Waltham Boys and Girls Club, Children's Charter, The Right to Immigration Institute, Doc Wayne.	Process Goal	Year 1 of 4
Ensure collaboration with Waltham Public Schools to incorporate Wrap Around Waltham in to the current programming.	Convened a team within Waltham Public Schools to establish support for the program. Created collaboration with Wrap Around Waltham to launch the program.	Process Goal	Year 1 of 4
	Commitment to work is based on objectives for		

Form a collaborative approach to address non-academic barriers to high school graduation.	decreasing barriers to high school persistence associated with lacking basic needs, such as stable housing, reliable transportation, and food security; with economic and/or cultural pressures to work; reducing students' linguistic and cultural isolation; increasing students' sense of belonging and engagement in school; increasing students' skills to adapt to new environments and form relationships both in and outside of school; increasing access to and utilization of mental health services for students struggling with trauma, extreme stress, anxiety, or depression; and increasing access to culturally competent health education and/or health services.	Process Goal	Year 1 of 4
Support students' successful transition into the community and provide the supports necessary for students to graduate college and career ready; re-engage those who are currently off-track.	Hired a bi-lingual Wraparound Coordinator to launch program.	Process Goal	Year 1 of 4

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Education, Employment,
Health Issues	Health Behaviors/Mental Health-Mental Health, Social Determinants of Health-Education/Learning, Social Determinants of Health-Income and Poverty,
Target Populations	• **Regions Served:** Waltham, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** Teenagers, • **Race/Ethnicity:** Hispanic/Latino, • **Language:** Spanish, • **Additional Target Population Status:** Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
Wrap Around Waltham Collaborative	Not Specified
Waltham Partnership for Youth	http://www.walthampartnershipforyouth.org/
Waltham Boys and Girls Club	https://walthambgc.org/
Children's Charter	https://www.key.org/programs/childrens-charter
The Right to Immigration Institute	https://www.therighttoimmigration.org/
Doc Wayne	http://docwayne.org/
Waltham Public Schools	www.walthampublicschools.org

Newton Wellesley Hospital Certified Application Counselors

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	No
Program Description	Newton Wellesley Hospital Certified Application Counselors (CACs) provide information about the full range of insurance programs offered by EOHHS and the Health Connector. Our CACs help individuals complete an application or renewal; work with the individual to provide required documentation; submit applications and renewals for the Insurance Programs; interact with EOHHS and the Health Connector on the status of such applications and renewals; and help facilitate enrollment of applicants or beneficiaries in Insurance Programs. In FY19, NWH CACs contributed to the estimated 68 patient financial counselors that served patients who needed assistance with their coverage.
Program Hashtags	Prevention,
Program Contact Information	Kim Simonian, Director for Public Payer Patient Access, Community Health, Partners

	Healthcare,

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide information about the full range of insurance programs offered by EOHHS and the Health Connector.	In FY19, NWH CACs contributed to the estimated 68 patient financial counselors that served patients who needed assistance with their coverage.	Process Goal	Year 1 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	N/A,
Health Issues	Social Determinants of Health-Access to Health Care, Social Determinants of Health-Uninsured/Underinsured,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Massachusetts Health Connector	https://www.betterhealthconnector.com
Mass Health	http://www.mass.gov.eohhs/gov/departments/masshealth
Health Care for All	https.www.hcfama.org
Massachusetts Health and Hospital Association	https://mhalink.org
Massachusetts League of Community Health Centers	http://www.massleague.org

---

Newton Wellesley Hospital Summer Jobs Program

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	In 2019, about 463 BPS students had jobs at BWH, MGH, and Faulkner through Mayor Walsh's Summer Jobs Program. In addition, Newton Wellesley Hospital provided 14 summer jobs. The total count for all summer jobs across Mass General Brigham hospitals in 2019 was as follows: Brigham and Women's Hospital: 208 Brigham and Women's Faulkner Hospital: 10 Massachusetts General Hospital: 245 Newton Wellesley Hospital: 14 North Shore Medical Center: 18
Program Hashtags	Mentorship/Career Training/Internship,
Program Contact Information	Lauren Lele, Director, Community Benefits and Volunteer Services; 617-243-6330;

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame

Provide students with meaningful summer job experiences and mentoring.	In FY19, Newton Wellesley Hospital provided 14 summer jobs.	Outcome Goal	Year 3 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	Education,
Health Issues	Social Determinants of Health-Education/Learning, Social Determinants of Health-Income and Poverty,
Target Populations	• **Regions Served:** Newton, • **Environments Served:** Urban, • **Gender:** All, • **Age Group:** Teenagers, • **Race/Ethnicity:** All, • **Language:** English, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

Rize Massachusetts

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	RIZE Massachusetts Foundation (RIZE) was founded in response to the opioid overdose crisis. RIZE is dedicated to expanding access to treatment and other services for opioid use disorder (OUD), measuring the effectiveness of our work, and replicating programs achieving the greatest impact. To date, RIZE has distributed over $4.9 million in grants to more than fifty Massachusetts organizations. RIZE's focus areas are: Care - comprehensive, compassionate, and sustainable approaches to prevention, harm reduction, treatment, and recovery; knowledge - data, commissioned research, and evaluation to expand the evidence base and inform policy; and; human impact - efforts to reduce the economic impact on workers, businesses, and communities. We conduct our work mainly in three ways: grantmaking; policy and research; and convenings.
Program Hashtags	Research, Support Group,
Program Contact Information	RIZE Massachusetts Foundation, Inc. 101 Huntington Ave., Suite 1300, MS 0111 MA 02199

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Commission research studies to generate new knowledge about: evidence-based strategies to address the epidemic the economic and social imperative to address the crisis; systems, regulatory, and stigma-related barriers; and the needs and opportunities related to the epidemic. use the data gathered from our grant program evaluations to generate new knowledge about the impact of RIZE-funded programs and successful approaches to harm reduction,	Findings from research we commissioned on the effectiveness of recovery coaches in OUD treatment were presented to the Massachusetts Recovery Coach Commission and referenced in the official commission findings. In addition, the research we commissioned from the Massachusetts Health Policy Forum and the Massachusetts Taxpayers Foundation on the impact of the opioid crisis on our workforce and economy were presented in stakeholders at forums that were attended by approximately 500 attendees combined, including Governor Baker and Attorney General Maura Healy. Both reports were downloaded more than 1,000 times from the RIZE website.	Outcome Goal	Year 3 of 3

treatment, and recovery support.			
Commission research studies to generate new knowledge about: evidence-based strategies to address the epidemic the economic and social imperative to address the crisis; systems, regulatory, and stigma-related barriers; and the needs and opportunities related to the epidemic. use the data gathered from our grant program evaluations to generate new knowledge about the impact of RIZE-funded programs and successful approaches to harm reduction, treatment, and recovery support.	RIZE also commissioned research on stigma in the health care professions, which shows that one in four emergency medicine or family/internal medicine providers feel that treating patients with OUD will attract undesirable patients to their practice. The findings were cited in the Massachusetts legislature's Medication Assisted Treatment Commission report and widely covered by the media.	Outcome Goal	Year 3 of 3
Provide effective and compassionate services and supports to people with OUD; address barriers to care for people with OUD; and support the staff who are providing services to people with OUD by equipping them to do their work effectively, compassionately, and sustainably.	To date, RIZE has distributed over $4.9 million in grants to more than fifty Massachusetts organizations. An example is our Saving Lives, Improving Health: Redesigning Opioid Use Disorder Care - $2.1 million grant program focused on collaborative approaches to expanding access to community-based treatment. After one year, in three out of the four programs funded, 1,466 patients combined started medicated assisted treatment (MAT) and over half of these patients were still engaged in treatment a year later, despite experiencing significant socioeconomic difficulties.	Outcome Goal	Year 1 of 3

EOHHS Focus Issues	Substance Use Disorders,
DoN Health Priorities	N/A,
Health Issues	Substance Addiction-Opioid Use, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** All Massachusetts, • **Environments Served:** All, • **Gender:** All, • **Age Group:** Adults, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
AIDS Support Group Cape Cod	Not Specified
Boston Healthcare for the Homeless Program	Not Specified
Boston Public Health Commission	Not Specified
Brandeis University	Not Specified
Brockton Neighborhood Health Center	Not Specified
Cambridge Health Alliance	Not Specified
Center for Human Development	Not Specified
Charlestown HealthCare Center MGH	Not Specified
City of Chelsea	Not Specified
City of Everett	Not Specified
City of Medford	Not Specified

Community Healthlink	Not Specified
Fenway Health	Not Specified
FrameWorks Institute	Not Specified
Geiger Gibson Community Health Center	Not Specified
Greater Lawrence Family Health Center	Not Specified
Greater Roslindale Medical and Dental Center	Not Specified
Harbor Health Services	Not Specified
Health Resources in Action	Not Specified
HRH413	Not Specified
Institute for Community Health	Not Specified
Kraft Center at MGH	Not Specified
Life Connection Center	Not Specified
Lynn Community Health Center	Not Specified
Malden Overcoming Addiction	Not Specified
Massachusetts Health Policy Forum at Brandeis University	Not Specified
Massachusetts Taxpayers Foundation	Not Specified
Mattapan Community Health Center	Not Specified
Municipal Naloxone Bulk Purchasing Program (Commonwealth of MA)	Not Specified
New Health Charlestown	Not Specified
Police Assisted Addiction Recovery Initiative (PAARI)	Not Specified
Recovery Research Institute	Not Specified
Rhode Island Hospital	Not Specified
Shatterproof	Not Specified
The Philanthropic Initiative	Not Specified
Tufts University School of Dental Medicine	Not Specified
Tufts University School of Medicine	Not Specified
University of Massachusetts Medical School's Center for Health Law and Economics	Not Specified

The Mass. League's CHC Provider Loan Repayment Program

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	Partners collaborates with the Massachusetts League of Community Health Centers (Mass. League) and other organizations to ensure patients have access to primary care close to home. Toward that end, since 2007, Partners has provided annual funding to

	support the administration of state-wide educational loan repayment programs for primary care providers and other clinicians and grant programs to retain existing clinicians. The Mass. League has worked with a variety of funders to support these initiatives over the past 13 years, including Bank of America, Mass. Dept. of Public Health, Mass. Dept. of Mental Health, and MassHealth. Several hundred clinicians, including primary care physicians, nurse practitioners, dentists, and social workers have benefited from these programs.
Program Hashtags	Community Health Center Partnership, Health Professional/Staff Training,
Program Contact Information	Kristen Barnicle, Executive Director, Partners Community Health, 857-282-1421,

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Expand the state's supply of primary care providers at community health centers.	The Mass. League's CHC Provider Loan Repayment Program: Since 2007, more than 300 providers have committed to work in a community health center for up to three years in exchange for loan repayment.	Outcome Goal	Year 3 of 3
Encourage retention of primary care providers at community health centers.	Since 2009, more than 80 special project grants have been awarded to providers at Massachusetts community health centers.	Process Goal	Year 3 of 3

EOHHS Focus Issues	Not Specified
DoN Health Priorities	N/A,
Health Issues	Chronic Disease-Diabetes, Health Behaviors/Mental Health-Mental Health, Social Determinants of Health-Access to Health Care,
Target Populations	• **Regions Served:** All Massachusetts, • **Environments Served:** All, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Mass League of CHCs	https://massleague.org/Programs/PrimaryCareProviderInitiatives/LoanRepaymentPrograms-Other.php

Expenditures

Total CB Program Expenditure	**$2,650,902.33**

CB Expenditures by Program Type	Total Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
Direct Clinical Services	$0.00	$0.00
Community-Clinical Linkages	$0.00	$0.00
Total Population or Community-Wide Interventions	$1,820,364.60	$450,150.52
Access/Coverage Supports	$830,537.73	$249,193.09
Infrastructure to Support CB Collaborations Across Institutions	$0.00	$0.00
CB Expenditures by Health Need	**Total Amount**	

Chronic Disease with a Focus on Cancer, Heart Disease, and Diabetes	$115,517.33
Mental Health/Mental Illness	$461,140.11
Housing/Homelessness	$16,003.23
Substance Use	$607,307.95
Additional Health Needs Identified by the Community	$1,450,933.71
Other Leveraged Resources	$1,717,648.50

Net Charity Care Expenditures	Total Amount
HSN Assessment	$6,342,743.40
HSN Denied Claims	$85,056.41
Free/Discount Care	$669,940.86
Total Net Charity Care	$7,097,740.67

Total CB Expenditures: $11,466,291.50

Additional Information	Total Amount
Net Patient Service Revenue:	$501,353,935.00
CB Expenditure as Percentage of Net Patient Services Revenue:	2.29%
Approved CB Program Budget for FY2020: (*Excluding expenditures that cannot be projected at the time of the report.)	$11,466,291.50
Comments (Optional):	Not Specified

Optional Information

Hospital Publication Describing CB Initiatives:	Not Specified
Bad Debt:	Not Specified
Bad Debt Certification:	Not Certified
Optional Supplement:	Wrap Around Waltham (WAW) Collaborative awarded grant through MGH DoN in the amount of $1.5 M over four years. ($300,00/year to WAW and $78,000/year to Waltham Public Schools). Model is a collaborative approach to addressing non-academic barriers to high school graduation. Description of WAW in Program Detail of the NWH submission. Newton Wellesley Hospital anticipates that the resource allocation will be the similar in future years. FY 19 direct spending = approx. $2M In addition to commitments made by the Newton Wellesley Hospital, Partners HealthCare makes system investments aimed at: * Addressing critical public health issues impacting all of our communities. In response to the opioid overdose crisis, RIZE Massachusetts Foundation is dedicated to expanding

access to treatment and other services for opioid use disorder (OUD).
* Ensuring access to care for our low-income community residents by supporting state program enrollment. Partners Community Health staff provide education and support across the system to ensure that patients on MassHealth, Health Safety Net, and the subsidized Connector plans can access care smoothly across the system.
* Ensuring access to primary care close to home. Partners provides administrative support to the Mass League of Community Health Centers Provider Loan Repayment Program that recruits primary care physicians to work at community health centers.
* Exposing low income youth to health care and science as a career path. In addition to the hospital programs, system support is provided to Camp Harborview, The Scholarship Program, and Partners Summer Jobs for youth.