September 17, 2021

Newton-Wellesley Hospital
2021-22 Community Health Improvement Plan

Submitted to: Mass General Brigham Newton-Wellesley Hospital

Health Resources in Action
Advancing Public Health and Medical Research

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Executive Summary

This executive summary provides an overview of the Newton Wellesley Hospital (NWH) 2021-2022 Community Health Needs Assessment and Community Health Improvement Plan.

Community Health Needs Assessment and Community Health Improvement Plan

Improving the health of a community is essential to enhancing the quality of life for residents in the region and supporting future social and economic well-being. To fulfill the requirements under the Affordable Care Act and as a continuing best practice in community health, NWH engaged in a community health planning process to improve the health of residents in its primary service area (Natick, Needham, Newton, Waltham, Wellesley, and Weston). This effort included two phases: (1) a community health needs assessment (CHNA) to identify the health-related needs and strengths of the region and (2) a community health improvement plan (CHIP) to identify major health priorities, develop goals, select strategies, and identify partners to address these priority issues across the region.

To accomplish this objective, NWH decided to complete a brief, one-year update to their 2018 CHNA and develop an accompanying one-year CHIP. The new three-year cycle will start in 2022 with the development of a full, detailed CHNA and three-year CHIP.

Impact of COVID-19 & Related Considerations

The COVID-19 pandemic resulted in an unprecedented time of crisis for the NWH community. NWH conducted extensive outreach to respond to residents' and stakeholders' needs throughout the pandemic, and they continue to collaborate with their community members as the pandemic unfolds. Considering COVID's strain on the community, NWH opted for a one-year CHNA and CHIP because they did not want to overburden their community with extensive data collection and look forward to engagement in 2022 that will reveal post-pandemic community needs. Additionally, this one-year CHNA and CHIP will allow NWH to align their CHNA and planning cycle with that of their parent health system, Mass General Brigham.

Health Equity Approach

NWH utilized the social determinants of health framework to guide the CHNA and CHIP process. This framework examines how individual health outcomes are influenced by upstream social and economic factors such as housing, educational opportunities, food access, and economic stability. The CHNA describes social and economic determinants and reviews key health outcomes among residents of the Newton-Wellesley Hospital service area. The CHIP prioritizes addressing these upstream factors to promote health equity, the principle that all people have a fair and just opportunity to be healthy.

Methods

The CHNA was guided by a participatory, collaborative approach, which examined health in its broadest sense. This process included examining existing secondary data on social, economic, and health issues in the region. Instead of pursuing qualitative data collection through resident focus groups and stakeholder interviews, NWH solicited resident feedback though community-wide events such as town hall meetings and forums and obtained programming feedback from community partners and stakeholders. NWH plans to pursue extensive qualitative data collection, incorporate updated secondary data, and conduct a community health survey for the 2022 CHNA cycle.

CHNA Key Findings

- **Housing:** More residents reported having a high housing cost burden (spending >35% on housing costs), especially among renters in the NWH service area. The previous 2018 CHNA noted that lack of affordable housing was a theme across focus groups and key informant interviews.

- **Transportation**: While there are public transportation options, the majority of residents commute driving alone or through carpooling in private vehicles. Previous CHNA findings noted limited transportation options, and wait times, high costs, and language barriers made transportation challenging for low-income residents and seniors.
- **Mental Health:** Community Benefits committee members highlighted mental health concerns in the NWH community especially among youth, elders, and immigrants. Relative to the other cities/towns in the NWH service area, a larger percent of Waltham students reported depression, suicidal ideation, and suicide attempts, as noted in the previous CHNA. Middlesex and Norfolk County had a less favorable ratio of population per one mental health provider compared to the state.
- **Substance Use:** Substance use trends vary across NWH communities, but several stakeholders noted it as a challenge. Newton and Waltham had the highest percentage of patients admitted to substance use treatment programs that indicated heroin as their primary substance of use among the six NWH priority communities. Substance use patterns among youth varied across assessment communities: alcohol use was more prevalent in Weston, electronic cigarette use was highest in Waltham and in the Metro West region, and marijuana use declined in high school youth from Natick, Waltham, and Weston but increased in Newton students.
- **Access to care**: The 2018 CHNA highlighted how residents, especially immigrants, low-income residents, and seniors, have difficulty accessing social and health care services in the focus communities. All towns in the NWH service area experienced a growth in the immigrant population since the 2018 CHNA, apart from Needham. Hispanic/Latino residents in Waltham lacked health insurance more than any other group in the city and surrounding assessment towns.
- **COVID-19**: The novel SARS-COV-2 pandemic, known as COVID-19, led to mild to severe illness, and even death, in communities across the US and Massachusetts starting in early 2020. In addition to physical health concerns, the pandemic affected social and economic wellbeing across Massachusetts leading to increased job losses, economic instability, social isolation, and other concerns.

Process for the Community Health Improvement Plan

During June to August 2021, HRiA led a facilitated process with NWH's Community Benefits Committee members. The committee is comprised of about 24 members representing community stakeholders in the hospital service area and Newton-Wellesley Hospital clinical and non-clinical staff. In July 2021, HRiA presented the priorities identified by the 2021 Community Health Needs Assessment (CHNA), including the magnitude and severity of these issues and their impact on priority populations. Members of the Community Benefits Committee determined that all the community needs identified in the CHNA should be included in the 2021 Community Health Improvement Plan (CHIP) in the following clustered priority categories:

- Priority 1: Mental Health
- Priority 2: Substance Use
- Priority 3: Social Determinants of Health
- Priority 4: Chronic Disease

These priority categories continue from the previous CHNA-CHIP process, as they represent ongoing, critical needs, especially for key populations; and several initiatives are still in progress to address them. While COVID-19 is not being addressed as a standalone priority in the 2021-2022 CHIP, the CHIP strategies address the wider social and economic impacts of the pandemic that are highlighted in the 2021 CHNA.

In late July 2021, committee members utilized a prioritization matrix with commonly agreed upon selection criteria to identify priority areas and strategies and determine which existing programs and initiatives should be continued from the previous 2018-2021 CHIP. Of note, there were six priorities in the previous 2018 CHIP

that were condensed into four broad categories.

In September 2021, HRiA led a CHIP planning session that included mapping current and emerging programs and initiatives against current needs identified in the CHNA, as well as decision-making regarding which existing programs and initiatives would be continued. All areas highlighted by the 2021 CHNA are being addressed by the 2021 Community Health Improvement Plan. This plan is meant to be reviewed quarterly and adjusted to accommodate emerging issues that merit attention.

Vulnerable Populations Addressed by this Community Health Improvement Plan

- Elders (aging population)
- Youth and young adults
- Immigrants
- Housing insecure residents

Social Determinants of Health Issues Addressed by this Community Health Improvement Plan

- High cost of living, including cost of healthcare services
- Housing affordability
- Access to healthy food
- Transportation, as it relates to access to care
- Economic stability and workforce development
- Community violence and safety (including emergency preparedness, domestic and sexual violence)

Partnership Development & Ongoing Collaborations

NWH continues to build and maintain relationships with partner organizations in the community to ensure their community health improvement work is carried out collaboratively. Partners include school systems, senior services organizations, social services agencies, youth development groups, local cities and towns, faith-based community organizations, and others. NWH identified key partners who collaborate on strategies in this CHIP; they are featured in the CHIP matrixes on the following pages.

Collaborative for Healthy Families & Communities (Community Collaborative)

The Newton-Wellesley Collaborative for Healthy Families and Communities (CHF&C), known as the Community Collaborative, was formed in 2017 to identify opportunities and enhance services to meet the health and wellness needs of patients, families, and communities served by NWH. The Collaborative contains eight councils around focus areas of need from the previous 2018 CHNA. Each council has approximately 20 members, with representation of community members, community stakeholders, and NWH staff. The councils serve as a vital bridge by ensuring community members' and stakeholders' voices are heard while addressing documented needs identified in the CHNA.

The Councils meet quarterly to address health needs. The eight councils are listed by name below:

- Cardiovascular Health Council
- Domestic and Sexual Violence Council
- Elder Care Services Council
- Maternity Service Council
- Palliative Care Council
- Resilience Project Council (Youth Mental Health Services)
- Substance Use Services Council
- Workforce Development Council

NWH Community Health Improvement Plan

Priority 1: Mental Health

Priority Area 1: Mental Health **GOAL 1:** Increase access and use of mental health services, alleviate the fragmentation of services, and address issues of stigma associated with mental health care.			
Strategic Initiatives (Strategies):	**Due Date (Timeline): 09/2021-09/2022**	**Partners (Lead, Support)**	**Success Measures**
1. Expand access to hospital-based youth mental health services.		Support Child and Adolescent Psychiatry Clinic Service.	Increase in # of mental health visits for youth over 2020 baseline Data collected to inform programming and advocacy (2020 baseline- 4000 visits in CAPS clinic, 600 in emergency department)
2. Collaborate with local schools to create school-specific mental health programing.		Partner with 7 high schools and 11 middle schools in NWH primary service area through the Resilience Project.	Increase in # of school-specific mental health consultations, educational outreach, small group programming, and professional development talks over 2020 baseline (2020 baseline- 1000 participants)
3. Support local initiatives on youth mental health including education sessions for students and parents in community venues.		Partner with schools, local departments of health, parent teacher organizations, local parent groups, faith-based organizations, local colleges, and the Resilience Project.	# of education sessions delivered to community groups (2020 baseline- 20 presentations)

Priority Area 1: Mental Health

GOAL 1: Increase access and use of mental health services, alleviate the fragmentation of services, and address issues of stigma associated with mental health care.

Strategic Initiatives (Strategies):	Due Date (Timeline): 09/2021-09/2022	Partners (Lead, Support)	Success Measures
4. Implement cultural considerations when addressing mental health among immigrant populations, in Waltham, in particular.		NWH	# of languages offered in programming and educational collateral (2020 baseline – focused on 3 languages: Spanish, Haitian Creole and Chinese Mandarin)
5. Collaborate with partners and conduct programs on social isolation and frailty in elderly (eg., senior events including Tai Chi, Matter of Balance program, and Mindfulness workshops).		Partner with senior centers, assisted and independent living facilities, Elder Care Services Council.	# of programs and sessions offered to elder community (2020 baseline- 90 seniors in Matter of Balance, 1000 in Tai Chi, 50 seniors for senior supper, 3 Mindfulness Workshops)
6. Provide education, advocacy, and screening mechanisms alongside to address maternal mental health.		Support the Post-Partum Perinatal Mood Disorders Initiative. Partner with the Maternity Services Council.	# of patients referred into Postpartum Perinatal Mood Disorders Initiative (2020 baseline- 337 patient referrals) # attendees at Post-Partum new mothers' group 2020 baseline – 11 participants per session)

Priority 2: Substance Use

Priority Area 2: Substance Use **GOAL 2:** Increase prevention and expand access to treatment of substance use disorders, and address issues of stigma in collaboration with providers, patients and the community.			
Strategic Initiatives (Strategies):	**Due Date (Timeline): 09/2021-09/2022**	**Partners (Lead, Support)**	**Success Measures**
1. Educate clinicians, public health officials, and general community on substance use disorders.		Lead education conducted through the SUS clinic for PCP practices, medical community. Support with Substance Use Services Council.	# of education sessions on substance use (2020 baseline – 15 education sessions)
2. Develop Community Referral Resource database for substance use patients.		NWH with community partners	# of resources identified and compiled (2020 baseline – Resources compiled by Substance Use Service Clinic staff; Community Guide with substance use resources created by Integrated Care Management Program with distribution to key stakeholders)

Priority Area 2: Substance Use

GOAL 2: Increase prevention and expand access to treatment of substance use disorders, and address issues of stigma in collaboration with providers, patients and the community.

Strategic Initiatives (Strategies):	Due Date (Timeline): 09/2021-09/2022	Partners (Lead, Support)	Success Measures
3. Provide education, advocacy, and prevention mechanisms alongside community partners to address substance use.		Support local police and fire departments, schools, shelters, and emergency department. Support community organizations including SOAR Natick, Newton PATH, Metro Boston Project, Substance Use Services Council, Charles River Opioid Regional Task Force, Middlesex District Attorney's Office.	# of education sessions on substance use and prevention (2020 baseline -20 educational related events # doses of Narcan distributed to the community organizations. (2020 baseline – 250 doses of Narcan distributed)
4. Address substance use in college age students.		Lead Health in Higher Education Forums with support from local colleges and universities.	# of Health in Higher Education Forums (2020 baseline- 2 virtual forums)
5. Address stigma around substance use by partnering with community partners on outreach efforts.		Support SOAR Natick, Newton PATH, school systems.	# of outreach efforts (2020 baseline – 5 outreach events with community partners)

Priority Area 2: Substance Use

GOAL 2: Increase prevention and expand access to treatment of substance use disorders, and address issues of stigma in collaboration with providers, patients and the community.

Strategic Initiatives (Strategies):	Due Date (Timeline): 09/2021-09/2022	Partners (Lead, Support)	Success Measures
6. Expand access to and resource of substance use service		Support Substance Use Service Clinic.	Increase in # of substance use service visits over 2020 baseline (2020 baseline- 800 patient visits)

Priority 3: Social Determinants of Health

Priority Area 3: Social Determinants of Health **GOAL 3: Develop programmatic solutions to address SDOH factors that impact the overall health of NWH communities.**			
Strategic Initiatives (Strategies):	**Due Date (Timeline): 09/2021-09/2022**	**Partners (Lead, Support)**	**Success Measures**
Sub priority 1: Access to Care			
1. Raise awareness and education among healthcare providers regarding delivering care to vulnerable populations with cultural humility.		Support the efforts of the NWH DEI Office in training medical and clinical providers and overall hospital staff on cultural humility, advocacy instructions, and hospital-wide communication.	# of education sessions that include cultural humility (DEI Office launched 2020, assess baseline during 2021)
2. Explore opportunities to provide health/educational programming and clinical services/support to housing facilities and homeless shelters.		Support local housing structures and medical providers.	# of programs held (2020 baseline – 7 collaborative interactions/events)
3. Provide transportation options and other resources to support patients in receiving care.		Support NWH Carefinder service, Circulation Lyft-Non emergent transport, NWH community health workers (CHWs).	# of rides provided (2020 baseline- 1422 rides) # of patients assisted through Carefinder service (2020 baseline - 7500 calls to Carefinder service)

Priority Area 3: Social Determinants of Health **GOAL 3: Develop programmatic solutions to address SDOH factors that impact the overall health of NWH communities.**			
Strategic Initiatives (Strategies):	**Due Date (Timeline): 09/2021-09/2022**	**Partners (Lead, Support)**	**Success Measures**
4. Identify and develop solutions to address barriers to accessing care with community partner groups.		Lead the convening of local community agencies and Departments of Public Health	# of solutions adopted (2020 baseline – 5 DPH meetings held. Solutions focused on Covid response – 6 solutions adopted)
Sub priority 2: Community Violence and Safety			
5. Oversee and participate in the National SANE Telenursing Center at NWH to expand access to sexual assault services in rural and Indigenous communities.		Support NWH DSV Program and the SANE telenursing center.	# of telenursing visits (2020 baseline - 8 pilot sites for SANE Center) # of visits to DSV program (2020 baseline- 734 visits to DSV program), 8 pilot sites for SANE Center)

Priority Area 3: Social Determinants of Health **GOAL 3: Develop programmatic solutions to address SDOH factors that impact the overall health of NWH communities.**			
Strategic Initiatives (Strategies):	**Due Date (Timeline): 09/2021-09/2022**	**Partners (Lead, Support)**	**Success Measures**
6. Expand trauma-informed care approach by educating and providing consultative services to providers and interdisciplinary professionals		Support Custody Awareness Collaborative, local police departments, attorney's offices, shelters, faith leaders, homeless service providers, and therapists. Support from NWH Domestic and Sexual Violence Program.	# of organizations and providers educated (2020 baseline – 16 organizational partners; 350 requests for guidance and consultation)
7. Position the hospital as a key contributor and convener for community emergency preparedness.		Lead emergency planning. Support Boston Marathon, City of Newton, Town of Wellesley, and other service area communities, as well as local ems, fire, and police departments.	# of emergency preparedness trainings # of planning sessions (2020 baseline – need to reassess post-covid)
Sub priority 4: Housing Affordability			

Priority Area 3: Social Determinants of Health

GOAL 3: Develop programmatic solutions to address SDOH factors that impact the overall health of NWH communities.

Strategic Initiatives (Strategies):	Due Date (Timeline): 09/2021-09/2022	Partners (Lead, Support)	Success Measures
8. Address housing insecurity through a multi-faceted approach including case management, emergency financial assistance, mental health, and economic self-sufficiency through Determination of Need (DoN) initiative.		NWH with future partner	Identifying recipient of DoN grant – Fall 2021
Sub priority 4: Economic Stability- Workforce Development			
9. Create healthcare career exposure opportunities for the community including work-skill based opportunities through volunteer and internship programs.		Lead youth internships with support from Waltham Partnership for Youth and Newton Health and Human Services, NWH Volunteer Services, and Workforce Development Council	# of student interns (2020 baseline – 20 WPY interns) # of career exploration sessions (2020 baseline – 10 sessions; 33 NWH staff participants)

Priority 4: Chronic Disease Prevention and Management

Priority Area 4: Chronic Disease Prevention and Management **GOAL 4: Provide programs, education and preventive care to address prevalent on-going health concerns in NWH communities.**			
Strategic Initiatives (Strategies):	**Due Date (Timeline): 09/2021-09/2022**	**Partners (Lead, Support)**	**Success Measures**
1. Provide community prevention and outreach for chronic diseases, cardiovascular disease and cancer diagnosis e.g., screenings, clinics, educational forums, speaking engagements, etc.		Support Cardiovascular Council, senior centers, housing complexes, social service agencies, faith-based communities, MGH Cancer Center @ NWH,	# of prevention and outreach programs held (2020 baseline – 75 programs)
2. Support/partner on local health & wellness initiatives.		NWH led with multidisciplinary community partners.	# of partners (2020 baseline – 20 partners) # of efforts focused on food access (2020 baseline – 3 focused efforts)
3. Provide immunizations and primary care to uninsured school age children that are uninsured or use MassHealth.		Support Pediatric Primary Care Clinic (PPCC) and NWH Waltham Family Medicine.	# of children receiving care (2020 baseline = 375 child visits)

Priority Area 4: Chronic Disease Prevention and Management

GOAL 4: Provide programs, education and preventive care to address prevalent on-going health concerns in NWH communities.

Strategic Initiatives (Strategies):	Due Date (Timeline): 09/2021-09/2022	Partners (Lead, Support)	Success Measures
4. Enhance community education as to palliative care services and treatment and options to improve management of serious and terminal diseases.		Support NWH Palliative Care Service through the Palliative Care Council	# of education sessions (2020 baseline – 1 session held)
5. Promote and influence enhanced food access and healthy eating		Partner with Healthy Waltham, Waltham Connections for Healthy Aging, Waltham Boys & Girls Club, Newton Food Pantry, other Newton food-focused organizations	# of meals distributed (Assess baseline for 2021)

Acronyms

ACRONYM	TERM
CAPS	Child and Adolescent Psychiatry Service
CHIP	Community Health Improvement Plan
CHNA	Community Health Needs Assessment
CHW	Community Health Worker
DON	Determination of Need
DSV	Domestic & Sexual Violence
CHF&C	Newton-Wellesley Collaborative for Healthy Families and Communities
HRIA	Health Resources in Action
NWH	Newton-Wellesley Hospital
PPCC	Pediatric Primary Care Clinic
PATH	Prevention, Awareness, Treatment, Hope
SANE	Sexual Assault Nurse Examiners
SMART	Stress Management and Resiliency Training
SUS	Substance Use Services
SOAR	Supporting Outreach and Addition Recovery