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 address the unmet needs, improve the health of disadvantaged populations, increase prevention efforts, and impact healthcare disparities in the communities it serves. Efforts and support to prevent socio-medical challenges and 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.

- To increase access to care in an equitable and efficient fashion to all.
- To identify and address specific health care needs which are unique to the hospitalâ€™s community.
- To improve the health of the community and reduce 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:

Health Resources in Action (HRIA) was consulted and retained to conduct the community health needs assessment in 2018. The assessment was completed and approved by the NWH Board in November 2018.
HRIA has been engaged to conduct the 2021 needs assessment.

Data Sources:

Community Focus Groups, Consumer Groups, Hospital, Other, 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: CHIP - UPDATED, APRIL 2021.PDF

Key Accomplishments of Reporting Year:

- Among community dwelling elders, fall-related injuries are the most common type of injury. In FY20, 90 elders participated in the Matter of Balance program, bringing the total number of participants since the program inception in 1997 to 1,835.
- Tai Chi has also been identified to improve balance and well-being among elders. In collaboration with Newton Senior Services, 1000 seniors took part in NWH Tai Chi sessions hosted in the community with an overwhelmingly positive response for balance, socialization, and a feeling of wellness.
- In FY20, the Domestic Violence/Sexual Assault Program at NWH provided free, voluntary, and confidential services to over 734 survivors of domestic, family, or sexual violence.
- Provided a $15,000 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 in written information and electronically.
- Facilitated the SANE Tele-nursing Center at NWH. Provided technical assistance and education to program expansion in Massachusetts and across the country.
- DSV program facilitated a Creative Flow expressive arts workshop series that included dance, yoga, nutrition and empowerment skills.
- Provided $17,000 in emergency assistance to survivors during Covid-19. Assistance was in the form of food, rent, and utilities.
- In FY20, the Pediatric Primary Care Mass Health Clinic at NWH provided care to 375 children.
- In FY20, facilitated 1422 rides through the Circulation/Lyft platform for ease of access to and from hospital care. Supported transport options through taxi vouchers from Veteranâ€™s Taxi for clients of homeless shelters, low income housing or senior agencies to have on-going access to needed healthcare services.
- Aided 130 patients in the areas of food, lodging, safety and others. A multidisciplinary team ensured linkages to on-going clinical and social services.
- Convened on-going meetings and forums with stakeholder community groups. Expanded opportunities for shared communication, knowledge of resources, collaborations, and improved access to health care services. This included quarterly meetings with NWHâ€™s local Departments of Public Health; quarterly forums with local area higher education leadership to address prevalent health concerns on college campuses; and during Covid-19, a collaboration with local ALFâ€™s/ILFâ€™s began with a very positive response and will now continue on a quarterly basis.
- Expanded the presence of NWH Community Health Workers to all the communities served by NWH. This was in response to a recognized need to provide support to patients in the areas related to SDOH.
- In FY20, NWH administered 1103 flu vaccines at a variety of community locations.
- In FY 20, NWH had representatives at 20 health community events promoting health, wellness and safety. 50 NWH clinical experts spoke at various community agencies/group/school events.
- Provided numerous education and opportunities for engagement on the topic of Covid-19. This included audiences of businesses, school personnel, and others.
- In FY20, held a mental health summit with 120 attendees (principals, school nurses, social work, guidance staff and therapeutic staff) from high schools, middle schools, private schools, and youth-based organizations in NWHâ€™s primary

service area.
- In FY 2020, 50 seniors attended an engagement event held at NWH. The event fostered socialization, nutrition and wellness.
- During Covid-19, a Senior Webinar Series was created to engage with seniors and inform them on topics such as cardiovascular health, telehealth and others.
- A total of 45 seniors took part in mindfulness workshops through a collaboration with local senior centers. Introduced the SMART program to give seniors tools to relieve stressors experienced in day-to-day living. This became particularly pertinent during Covid-19.
- The Resilience Project expanded patient access through the inclusion of a social worker and pediatric psychologist onto the school teams Clinic visits for 2020 were 4000 (14% increase over FY19), and 600 in the Emergency Department. 15% of the clinic visits were referrals from local schools.
- Expanded the Resilience Project to include Middle schools (8,000 students).
- Had 120 parents take part in the Parenting Series. Created the â€œBuilding Resilienceâ€ educational series, provided community engagement, and professional development. Over 1000 individuals took part in all the programs.
- In FY20, NWH distributed 250 doses of Narcan to community agencies/partners. NWH dispensed 66 naloxone kits to patients in the NWH Emergency Department with diagnosis of opioid overdose.
- Substance Use Service clinicians completed 800 patient visits, 284 of which were new patients visits.
- Began weekly SUS recovery group run by the teamâ€™s recovery coach with a total of 200 participants.
- Collaborated with SOAR Natick on efforts to reduce stigma and promote discussion on the issue of addiction. Displayed the Opioid Art Project and the Purple Flag Project at NWH.
- The hospital continued its partnership with the Middlesex District Attorneyâ€™s Office in the Charles River Regional Opioid Task Force, holding monthly program sessions.
- A Primary Care Physician Champion role was created to consult and provide training and tools to increase the safe care of SUS patients in a primary care setting.
- In FY 20, 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. Continued the â€œWalk With A Docâ€ program for Waltham Connections to combine both education and physical activity. Session attended by 60 seniors.
- Supported Healthy Waltham in their expansion of the Mobile Food Market in response to community need during Covid-19. Increase went from 200 to 800 individuals.
- Sponsored the Waltham Partnership for Youth Language Access for Civic Engagements (LACE) Program. Haitian/Creole was added to the curriculum. 8 new bilingual teens were trained as interpreter liaisons by Cross Cultural Communications, Inc. to become interpreters for community events that focus on substance use, strategies and available resources. During the year 51 students were hired for 27 events.
- Hired 20 Waltham High School students through the Waltham Partnership for Youth Summer Internship program (the largest number of students from any participating organization). Program became virtual during Covid-19. In partnership with Mass Bay Community College, student employment included a college credit biology course with lab.
- In 2020, Waltham Partnership for Youth recognized NWH with the Good Neighbor Award for, as an institution, going above and beyond to make a positive difference in the lives of Waltham youth.
- Provided 47 individuals in youth and adult vocational programs with separate, on-going, placement opportunities to learn, practice and be exposed to workplace skills.
- Held a career event over two nights (virtually due to Covid-19). 75 attendees. Focused on careers requiring a two-year degree, certificate programs, or alternative training.
- To address maternal mental health, grew the Post-Partum Mood and Anxiety Disorder Program with 537 patients referred since the program began in May 2019.
- Expanded the Post-Partum Mothers Support group to two days per week with 11-15 new moms attending each session.
- In response to Covid-19, served as a key community contributor and convener in on-going extensive planning for community Covid-19 preparedness.
- Provided 10,616 completed Interpreter Service requests, including face-to-face, telephonic, video, ASL. A 44% increase over FY19.
- Grew the Collaborative for Healthy Families & Communities to 8 Councils (Cardiovascular Health, Elder Care, Maternity Services, Palliative Care, Resilience - youth mental health, Work Force Development, Domestic and Sexual Abuse, Substance Use). Each Council strives to address unmet needs of the community for their focus area through the development of programs/service/initiatives as well as community-wide education and awareness. Councils are comprised of, and led by, community members.
- Facilitated the Wrap Around Waltham Collaborative with Waltham Public Schools through an MGH Determination of Need grant program to address ethnic and cultural disparities in dropout rates for students in Waltham.
- Responded to and shifted programs, resources, and outreach in reaction to Covid-19. Details of that work can be found in the specific program description summaries.
- Provided 4000 Covid-19 Care Kits to the Waltham community (a hot spot community) that included self-care products and PPE, and informational material in 14 languages.

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 assessment (2018): addressing needs for specific populations (youth, seniors, low income) to include those related to SDOH, access to care, chronic disease management, 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.
Newton-Wellesley Hospital will also begin to strategize on plans in reaction to the findings in the 2021 Needs Assessment which

will be completed at the end of the year. The Councils within the NWH Collaborative for Healthy Families & Communities will evaluate and re-direct, as needed, their efforts and engagement, to be in alignment with the 2021 needs assessment.

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.
In 2021, the hospital will facilitate the process and dissemination of funds through a NWH DON.

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 challenges, NWH develops for and supports various community agencies with transportation support 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, higher education institutions and living communities 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 and Volunteer Services; 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 1422 rides through the Circulation/Lyft platform for ease of access to and from hospital care. Expanded use by the Emergency Department, Cancer Center, and Integrated Care Management Program.	Outcome Goal	Year 3 of 3
Provide access to transportation for underserved populations who are otherwise unable to obtain health care service due to transportation obstacles.	In FY20, supported transport options through taxi vouchers from Veteranâ€™s Taxi for residents of low-income housing to have on-going access to needed healthcare services.	Outcome Goal	Year 3 of 3
Support transportation initiatives in hospital service area.	Continued engagement with the Waltham Partnership for Youth Rides Together study to address transportation needs of youth and families. The study considered how transportation systems can be designed to serve all people more efficiently, affordably and safely. Work continues in these three priority areas to lead to better outcomes for transportation in Waltham.	Process Goal	Year 3 of 3
Provide resources for assistance with basic needs related to patients' medical condition when no alternative option is accessible.	Provided assistance to 130 patients in the categories of food, lodging, safety, and others. This was a 30% increase over FY 19 for number of patients assisted. Program administered through a multidisciplinary team. In addition, patients are linked to on-going clinical and social services.	Outcome Goal	Year 3 of 3
Make appointments for those in need of accessing clinical services for either primary or specialty care.	In FY20, the hospitalâ€™s Care Finder program facilitated scheduling appointments for patients in need of a physician or hospital service. Total year end call volume was 7500 calls.	Process Goal	Year 3 of 3
	NWH convenes quarterly meetings with local health departments and other community agencies (senior services, etc.). Goals are to communicate challenges, share best practices, review services, and strategize		

Collaborate with local health departments and other community agencies.	solutions on access and types of care, in hospital and in community. Topics include substance use, behavioral health, and safety. NWH Emergency Department data is provided on a quarterly basis in the areas of top five diagnosis, overdose, and behavioral health. The frequency of these meetings increased starting in March due to the need to communicate Covid-19 related concerns and information. Having the structure already in place helped to facilitate ease of communication and solution building.	Process Goal	Year 3 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 30 leaders attend each forum. Forum topics included mental health, depression, and opioid use. Forums were held with clinical experts to specifically address concerns around Covid-19. Hospital information was shared, strategies for maintaining safety for the student populations was discussed, as well as options for testing and residential approaches were shared. Regular communication has continued throughout the pandemic.	Process Goal	Year 3 of 3
Provide Community Health Worker support to patients and linkages to the community	Expanded the role of the CHW in the Waltham community. Hired a CHW to serve the communities of Newton and Needham. Exploring CHW roles in the Natick, Weston and Walpole communities.	Process Goal	Year 2 of 3
Colloborate with care providers in home care settings.	During Covid-19, began convening the ALFâ€™s and ILFâ€™s in the NWH communities with over 25 gathering for the first meeting. Has provided an opportunity to share content expert information, relay best practices and align services. Given the positive feedback, this forum will continue quarterly.	Process Goal	Year 1 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. The hospital is focused on addressing the mental health needs of the families in our community through collaboration with area high schools and middle 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 and community programs. All three goals have seen growth during FY20 through increased patient volume, enhanced school collaborations, and expansion of offerings and participants attending community and parent programs.	Process Goal	Year 3 of 3
Expand access to mental health services.	Increased access for referrals to Child and Adolescent Psychiatry clinic. 15% of total clinic and ED volume were referrals from local school partners.	Outcome Goal	Year 3 of 3
Address parenting education and the development of skill-building tools for mental health and resilience.	Conducted the parentâ€™s programs (â€œRaising Resilient Teensâ€; â€œRaising Resilient Kidsâ€; and Resilient Parent Drop-In Group). All programs were facilitated by a child psychiatrist and child psychologist. There were 130 participants in the programs. The programs promote 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 care arise in their children.	Outcome Goal	Year 3 of 3

Create school-specific mental health programming to include a clinical consultation service and professional development.	Customized support for individual schools to address issues of mental health. The Resilience Project team engaged with 1000 participants through educational outreach, clinical consultation, small group programming, and professional development talks.	Outcome Goal	Year 3 of 3
Provide opportunity for collaboration with high schools on the issue of mental health.	Held the fourth and fifth annual Mental Health Summit with attendees from the local high schools, middle schools, private schools and other youth related organizations. The themes were Resilience in Education: Effective Tools for Overcoming Obstacles, and The Compassionate Classroom: Balancing Emotional Health and Academic Success (held virtually). There were over 120 attendees at each summit and included Principals, school nursing, social work, therapeutic staff, guidance staff and coaching staff. The Summit is also designed to offer participants a chance to connect with and learn from their counterparts from other schools.	Process Goal	Year 3 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 3 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 time per year and focuses on key initiatives that include: providing support to students, parents, educators, counselors and communities through collaborating with school personnel, customized educational programming, and improved access to treatment resources.	Process Goal	Year 3 of 3
Provide mental health care services to patents in the Child and Adolescent Clinic and in the Emergency Department.	In FY20, 4000 patients were seen in the Child and Adolescent Clinic. This is a 14% increase over FY19. Visits became virtual visits starting in April 2020 due to Covid-19, without issue. 600 pediatric patients were seen for mental health care in the Emergency Department.	Outcome Goal	Year 3 of 3
Expand the Child and Adolescent and Resilience Project clinical team to meet the needs of the patient population.	Hired a clinical social worker who began providing referrals and resources to families in distress, along with providing clinical support through virtual visits. Additionally, a pediatric psychologist was hired to oversee The Resilience Project as well as provide clinical evaluations and psychological testing in the clinic.	Process Goal	Year 1 of 3
Continue the Resilience Project collaboration with the local high schools.	Collaborate with the 7 local high schools for services to 10,000 students, provided clinical consultation to school adjustment counselors, and provided professional development to school staff.	Outcome Goal	Year 3 of 3
Widen the scope of The Resilience Project into middle schools to address knowledge that 50% of all lifetime cases of mental illness begin by age 14 .	Expanded The Resilience Project to include 11 middle schools in six towns served by Newton-Wellesley Hospital. This growth impacts at total of 8,000 students and strives to expand mental health access.	Outcome Goal	Year 1 of 3
Create a regular platform for parent and community education and awareness on the topic of mental health.	Launched the â€œBuilding Resilienceâ€ Series with monthly educational sessions for parents and community members. Topics included school avoidance/refusal; marijuana/vaping; DBT; and others.	Process Goal	Year 1 of 3
Inform the community on topics related to mental health.	Provided 20 psychosocial presentations for community, parents, and professionals. Published three community newsletters with mental health resources. Worked with local media to promote supportive information for parents during Covid-19.	Process Goal	Year 3 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, Weston	Not Specified
The Manton Foundation	Not Specified
NWH Development Office	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 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 one contact with the hospital in moments of acute illness and 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 as hospital resources to weave service 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.	Further developed the operational framework of the Collaborative for Healthy Families & Communities. The multi-pronged approach includes the development of a community-oriented clinical programs, community educational programming, and community engagement through council involvement. The Collaborative includes a Medical Director, a Director, and a program outreach manager.	Process Goal	Year 3 of 3
Create additional councils that address identified health needs.	Established a community-focused Cardiovascular Health Council to address chronic cardio conditions evidenced in NWH communities.	Process Goal	Year 3 of 3
Involve community in CHF&C	Each council has approximately 20-25 members and is comprised of approx. 50% community members â€“ those with expertise on the subject and those passionately engaged on the focus area. Co-Chairs for each of the councils are community members. Each Council meets four time per year.	Process Goal	Year 3 of 3
	Each Council conducts community programming to provide		

Provide community programming and education through the CHF&C.	education on the topic area. The platform for these programs switched to be virtual during Covid-19. The result was a growth in attendance given ease of access. In total there were over 500 individuals who attended the Council programs.	Process Goal	Year 3 of 3
Foster the continued development of 8 Councils that address identified unmet health needs in the NWH communities.	Supported the work of 8 Councils: the Resilience 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; the Domestic and Sexual Abuse Council focused on multilingual and emergency supports for victims of abuse; the Elder Care Services Council focused on addressing fall prevention and social isolation and, made more evident by the pandemic; the Work Force Development Council to provide employment to low-income youth in the surrounding community; and the Substance Use Council focused on increasing capacity for primary care clinicians to address addiction evidenced in community patient populations.	Process Goal	Year 3 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 3 of 3
Conduct community-wide emergency management exercises and drills.	Conducted 2 Active Shooter Drills in City of Newton. Conducted drills with Newton Fire and Cataldo Ambulance. Conducted a tabletop exercise with Waltham.	Outcome Goal	Year 2 of 3
Provide designated resources and expertise for emergency management to community partners, i.e., Stop the Bleed.	Provided hemorrhage control kits for Newton Public Schools, as needed. Provide City of Newton with replacement Halo seals for kits, as needed.	Process Goal	Year 2 of 3
Serve as key convener for Boston Marathon preparation and planning. Conduct functional planning exercises.	Began the work of preparation for the Boston Marathon. Planning was suspended and subsequently cancelled due to Covid-19.	Process Goal	Year 3 of 3
Provide community education in the area of emergency management and disaster planning.	Conducted numerous presentations on emergency management to community organizations.	Process Goal	Year 2 of 3
Collaborate, coordinate, and communicate with community partners related to emergency planning efforts.	In response to Covid-19, served as a key community contributor in on-going extensive planning sessions for Covid-19 response. Convened partners regularly to ensure consistent communication with local departments of health, first responders, and others. As a hospital served as a content expert to multiple agencies and in many forums.	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.	Enabled ease of access to EAP services for City of Newton employees.	Process Goal	Year 3 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 3 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. The intervention, A Matter of Balance, mitigates the negative effects 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 person living in the community. To support this finding, Tai Chi has been introduced as an intervention program 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 FY20, the program served 90 participants for a total of 1,835 since inception in 1997.	Outcome Goal	Year 3 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 FY20, participants (four programs offered through senior centers, Newton, Needham, Weston and Watertown) showed signs of fall efficacy (degree of confidence in performing common daily activities).	Process Goal	Year 3 of 3
Provide exercise activity that promotes balance and prevents falls	Held twice weekly Tai Chi sessions free to the community in collaboration with the Newton Senior Center. 1,000 community members participated in the program. During Covid-19 the sessions were offered virtually and became open to all seniors in any of the six NWH communities. The program continues to successfully engage participants.	Outcome Goal	Year 2 of 3
Provide an outlet for group interaction and socialization among seniors through Tai Chi	Continued positive feedback from program participants. Has enable patients and caregivers to interact in new ways despite disease related conditions. Participants also interact among one another. When in person, there is a consistent waitlist for the program.	Process Goal	Year 2 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:** 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, 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 other topics.
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 FY20, NWH administered 1103 flu vaccines at flu clinics held at various locations in the NWH service areas. Since they were held pre-pandemic the clinics were held at community centers, YMCAâ€™s, homeless shelters, and at health fairs. Promotion of the flu clinics located in Waltham were communicated in Spanish.	Outcome Goal	Year 3 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. These included health departments, youth organizations, business chambers, and other non-profit agencies.	Process Goal	Year 3 of 3
Support local initiatives that promote health and wellness.	In FY20, NWH had representatives at 20 health community events promoting health, wellness and safety. Topics for these events including chronic health conditions, mental health, senior care, and others. Most in-person community events were canceled the second half of the year due to Covid-19.	Process Goal	Year 3 of 3

Conduct community educational programs through community outreach and specifically, through the 8 Councils of the Collaborative for Healthy Families and Communities.	600 individuals attended community health educational programs hosted by NWH and the Newton-Wellesley Collaborative for Healthy Families & Communities (CHF&C). The programs were held virtually during Covid-19. The responses from program surveys highlighted a high level of health learning as well as appreciation for the chance for social engagement.	Outcome Goal	Year 3 of 3
Promote education through health education.	In FY20, 50 NWH clinical experts spoke at various community agency/school events. Through the Collaborative for Healthy Families & Communities, Hospital a Speakerâ€™s Bureau is offered to the community covering a broad subject areas focused on health. Due to the impact of Covid-19 there was a time period that these programs were suspended. As the pandemic continued, all programs became virtual. The transition was successful as accessibility and convenience was enhanced for attendees.	Process Goal	Year 3 of 3
Provide health awareness and disease prevention programs.	In FY20, NWH conducted specialty clinics/screenings in the community, including blood pressure and sports clinics. Several annual screening events were not held due to Covid-19. Addressing these topic areas were covered through virtual educational programming. Covid-19 specific educational forums were held for the business community, school personnel, and others to inform them about the pandemic, explain proper protocols, and to explore next steps.	Process Goal	Year 3 of 3
Conduct community programs with a specific focus on cancer care.	NWH Cancer Center conducted Empowered Health, Empowered You, a three-evening event focused on self-care. 102 individuals attended the event. Included was discussion related to Covid-19, breast cancer and a live cooking demonstration for a cancer diet. A three-night annual Cancer Survivorship event was also held with a theme of â€œStrategies for Coping: During the Pandemic and Beyondâ€. The three programs included education on: well-being, Covid-19, and thriving in survivorship. 120 individuals attended. All programs were held virtually due to Covid-19 and met with great success for accessibility and convenience by attendees.	Outcome Goal	Year 3 of 3
Provide a source of health education and socialization for local seniors in the community.	Held a senior social event that has been taking place for over 20 years. In FY20, 50 seniors attended. The event fostered socialization, nutrition and health education on being heart healthy.	Outcome Goal	Year 3 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:** 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
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
Newton School Department	Not Specified
Weston Health 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 in operation 24 hours a day/7 days a week. Interpreters are made available -- both in person at the hospital and by telephone and video -- 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 10,616 completed Interpreter Service requests, including face-to-face, telephonic, video, ASL. A 44% increase over FY19.	Process Goal	Year 3 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 3 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.	Provided translated documents for: discharge instructions, patient rights, menus, and patient education and patient guidebook.	Process Goal	Year 3 of 3
Provide patient information documents in translated languages.	Provided translated documents for: discharge instructions, patient rights, menus, and patient education and patient guidebook.	Process Goal	Year 3 of 3

Provide information and enhanced directional support to patients.	Ensured that the website and signage was available in the top five NWH languages: English, Spanish, Russian, Chinese â€" Cantonese, Chinese-Mandarin	Process Goal	Year 3 of 3
Provided translated documents to the community on Covid-19.	Translated Covid-19 Safe Care guidance in 12 languages, including Covid-19 Hotline information. Translated FAQ documents. Distributed materials to over 4000 Waltham residents a community which was highlighted as a hot-spot community in the pandemic.	Outcome Goal	Year 1 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	Health Screening, 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
Identify patients who are experiencing depression and/or anxiety during pregnancy and postpartum that affects 10-15% of the NWH maternal patient population. Provide outreach and intervention by a clinical social worker (LICSW).	Continued the growth of the Perinatal Mood and Anxiety Disorder Initiative. 537 patients have been referred to the PMAD social worker since the program began in May 2019. On average, receiving 22-48 new patients monthly, communicating with 20-30 patients a week. Successfully shifted to virtual visits during Covid-19.	Outcome Goal	Year 2 of 3

Extend the post-partum screening tool further after pregnancy.	Collaboration with 3 OB practices to use the screening tool 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. To respond to increase in patient referrals, social work hours has increased to 24 hours.	Process Goal	Year 2 of 3
Respond to referrals directly from MD's, MA's, RN's.	Referrals to social work are patients with a score of 10 or more on the Edinburgh Postnatal Depression Scale. Received referrals for reasons of anxiety and depression, substance use, family dynamics, homelessness, unplanned pregnancy, traumatic delivery, and others. Expanded relationship with community partners for collaboration of resources and support services.	Outcome Goal	Year 2 of 3
Provide on-going methods of support for maternal patients.	Expanded the post-partum support group for new mothers to two days per week. Goal of the program is to provide emotional/mental well-being to new mothers. Switched to virtual platform during Covid-19. Approximately 11-15 attendees per session. Increase socialization, respond to concerns after pregnancy, establish on-going interaction during immediate time after birth. An educational component is included and has focused on topics such as nutrition, sleep, exercise, lactation and others. A survey conducted in Winter 2020 had results of participants rating the support program as having an extremely positive impact on their well-being.	Outcome Goal	Year 2 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 and met quarterly. The Council evaluates strategies on how best to meet the needs of women and families, and engaging related community and hospital services to enhance care.	Process Goal	Year 3 of 3
Provide opportunities for community education on post-partum depression and maternal wellness.	Held a community-wide lecture with four workshops focused on a healthy pregnancy. 30 attendees. The Collaborative Council continued to expand presence on the web for on-going education and information sharing.	Process Goal	Year 3 of 3
Expand data collection to enhance evaluation of the program.	Collected data on race, ethnicity, language, referral source, timing of referral.	Process Goal	Year 2 of 3

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Social Environment, Violence,
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	https://aboutwomenbywomen.net/

Wellesley	
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

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 FY20, provided care to pediatric uninsured patients while they were in the application phase for Mass Health so as not to delay school entry.	Process Goal	Year 3 of 3
Provide primary care to children and adolescents.	In FY20, there were 375 visits to the pediatric clinic (Mass Health Clinic) at NWH. Facilitated having link to primary care physician for on-going care.	Outcome Goal	Year 3 of 3
Accept agency referrals for children/adolescents without primary care.	In FY20, continued to serve a consistent number of youth for referrals.	Process Goal	Year 2 of 3
Facilitate services to ease access of care.	At the Waltham practice location, Community Health Worker provided support and resources for challenges related to health care access, food, housing, immigration status, education and employment. Leveraged partnerships in the community to address social determinants of health.	Process Goal	Year 2 of 3
Consult to schools and agencies and coordinate services for disadvantaged youth.	Developed partnerships in the Waltham community to collaborate and best serve patients and families.	Process Goal	Year 2 of 3
Participation by clinicians on various local and state-wide agencies as experts on pediatric health.	In FY20, there were numerous school consultations and participation on youth-focused agency boards, e.g. Newton Boys & Girls Club, local colleges and universities, local YMCAâ€™s; local Boards of Public Health and Mass Medical Society â€“ School Health Committee.	Process Goal	Year 3 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 â€" Nursing Department	www.walthampublicschools.org
Waltham Family Medicine, Ashley Dillon, Community Health Worker, aedillon@partners.org	https://www.nwh.org/primary-care/family-medicine/waltham
MGH Hospital for Children at NWH	Not Specified

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 elders is a priority in developing Senior Wellness initiatives. Services and programs are created to value increased independence, safety, and happiness throughout life. They examine a variety of 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 socialization event that has been taking place for 23 years. In FY 20, 50 community seniors attended. The event fostered socialization, nutrition, and health education on being heart healthy.	Outcome Goal	Year 3 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 among our seniors. Three Mindfulness Workshops were conducted at area senior centers and elder housing complexes. Approximately 45 seniors took part in the workshops.	Outcome Goal	Year 3 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 3 of 3
Enhance senior wellness, specifically related to balance through the Matter of Balance program and Tai Chi programming.	Programs held in partnership with local senior centers. A total of 90 seniors took part in the Matter of Balance Program. The program was suspended in March due to Covid-19. Tai Chi sessions were held twice a week in collaboration with the Newton Senior Center from October to March with 1000 seniors participating. The sessions shifted to virtual in March and were made available to all seniors in any of the six NWH communities.	Process Goal	Year 3 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, diabetes, and safe driving.	Process Goal	Year 3 of 3
	Held â€œWalk With A Docâ€ session in collaboration with		

Provide opportunities for physical activity, health education, and wellness.	Waltham Connections. Approximately 60 seniors took part in the session. A NWH provider gave a brief health presentation and Q&A, and then walked with seniors providing physical activity and social interaction. The program was suspended in March due to Covid-19.	Process Goal	Year 3 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. Areas of concentration are social isolation among seniors, opportunities for enhanced engagement, and addressing risks related to falls.	Process Goal	Year 1 of 3
Provide on-going socialization outlets for seniors in the community.	Created the Senior Webinar Series during Covid-19 to address increased isolation among our seniors. Conducted webinars on Telehealth and Cardiac Care during Covid-19. Over 220 seniors attended. Provided an opportunity for exchange of questions and comments.	Outcome Goal	Year 1 of 3
Provide wellness programs for seniors to exercise.	During Covid-19, re-created the NWH wellness program to be free of charge to the community over a virtual platform. All programs are specifically geared to the senior community.	Process Goal	Year 1 of 3
Provide the SMART program developed by the Benson-Henry Institute for Mind Body Medicine at Massachusetts General Hospital to local senior center participants.	SMART program provides coping tools to relieve stressors encountered in day-to-day living. Also services to enhance health and quality of life and reduce negative thinking. Partnered with several senior centers. Shifted to a virtual program given Covid-19. 10 Newton seniors attended. Two programs with two other community senior centers are scheduled for FY21.	Outcome 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
NWH Wellness Center	Kim Gerard, Manager, Wellness Center, kgerard1@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

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.	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 FY20, NWH provided 250 doses of Narcan to local community partners â€“ police and fire, public health, schools and shelters. Provided training to community partners, as necessary.	Outcome Goal	Year 3 of 3
Provide preventive substance use resources to ED patients and families.	In FY20, NWH dispensed 66 naloxone kits to patients in the Emergency Department with diagnosis of opioid overdose.	Outcome Goal	Year 3 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 3 of 3
Provide education on various forms of substance use.	Conducted community wide lectures on alcohol use, adolescent prescription drug misuse, and substance use with internal and external experts. A variety of mediums were used such as film documentaries, Q&A, personal story sharing, research. Resources and treatment options were provided at all events. Events were conducted virtually post-March 2020. 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 3 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 medical management of addiction. A medical grand rounds open to the medical community was conducted specific to addiction and Covid-19.	Process Goal	Year 3 of 3
Provide resources to community partners for needed substances.	Provided 100 doses of Epipens to local fire departments and colleges.	Process Goal	Year 3 of 3
Use the hospital as a site to increase public awareness on the opioid epidemic and decrease stigma around substance use.	For the second year, 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. Staff, hospital administrative and clinical leadership, patients, families, and community members attended the event.	Process Goal	Year 2 of 3

Provide care to substance use patients in the SUS clinic.	SUS clinicians completed 800 patient visits (137% increase over FY 19). There was a 350% increase in new patient visits (FY20 = 284 vs. FY19 = 63). Patients were referred by NWH primary care, inpatient Hospitalist service, and emergency department clinicians. Patients presented with alcohol disorder (70%), opioid disorder (30%).	Outcome Goal	Year 3 of 3
Collaborate with various local multi-community, and state-wide agencies to address the opioid crisis.	In FY20, 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 Boston Bulldogs, in addition to others. The hospital continues to partner with the Middlesex District Attorneyâ€™s office for the Charles River Regional Opioid Task Force. The programs shifted to virtual with much success as it allowed for increased collaboration among community organizations for the purpose of education of community programming, sharing of data, and exchange of best practices. Members of the NWH SUS clinical team and community benefits regularly participated and presented at the meetings.	Process Goal	Year 3 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 2 of 3
Expand the Substance Use Service team to meet needs of the patient population.	Expanded the SUS Service team to include a recovery coach and a licensed clinical social worker.	Process Goal	Year 1 of 3
Increase resources for primary care physicians to address substance use issues in patients.	A Primary Care Physician Champion was hired to consult and provide training on prescribing guidelines, tools, and safety in a primary care setting. Works as a liaison for referrals and transition of care between PCP practices and SUS clinic.	Process Goal	Year 1 of 3
Provide support options for those experiencing substance use addiction.	Recovery Coach conducted weekly support sessions (via zoom during Covid-19). There have been 200 participants involved in the sessions.	Outcome 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/
SOAR Natick	www.soarnatick.org
West Suburban 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 FY 2020, the program served 734 distinct survivors of violence and abuse, providing thousands of hours of crisis intervention, safety planning, advocacy, case management, accompaniment, and warm referral.
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 FY20, the program served over 734 distinct survivors of violence and abuse. This is a 45% increase over FY19. Staff saw a significant increase in demand for direct services, and in complexity and acuity of that demand.	Outcome Goal	Year 3 of 3
Expand Domestic Violence services in the community and to Spanish-speaking, immigrant survivors of partner abuse.	Provided a $15,000 grant to REACH Beyond Domestic Violence to better serve Latinx survivors of abuse and their children. Of REACHâ€™s total number of clients, over half are of Latina descent.	Process Goal	Year 3 of 3

Continue to increase safety, health and well-being of patients and employees by providing comprehensive services to those experiencing domestic and sexual violence.	In FY20, the program provided 1000 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.	Process Goal	Year 3 of 3
Grow accessibility for Latin, Spanish-speaking, and, in particular, undocumented survivors (who are disproportionately at risk).	In FY20, the program continued collaboration with REACH Beyond Domestic Violence and Greater Boston Legal Services to directly serve over 150 Latinx survivors in Waltham. Ensuring that 60 families received emergency rental assistance, relocation assistance, utility assistance, and assistance with other basic needs such as food. In addition, the partnership assisted 60 survivors to apply for UVisas and Asylum based on violence they experienced in their home countries or while in the US. Once again, a bilingual- intern was placed with the Latinas Know Your Rights Program resulting in culturally and linguistically specific support groups. In addition, a notable number of community education events were marketed in Spanish, with fully bilingual materials and interpretation available including those related to Covid-19 .	Process Goal	Year 2 of 3
Continued participation in implementation of the DOJ-funded National SANE Tele-nursing Center. The hospital provides space for the Center & technical expertise and education to providers across the country.	The Center currently serves eight pilot sites across the nation on a 24/7 basis, providing real-time consultation to clinicians serving survivors of acute sexual assault at military installations, on Native American reservations, and in rural parts of the country. During FY 2020, the NTC continued its expansion within Massachusetts, and expects to add three new pilot sites imminently, including Athol Hospital, Beverly Hospital, and Sturdy Memorial Hospital. In FY 20120, the NTC provided technical assistance and education to hundreds of providers across the country to include Alaska, Arkansas, South Dakota and Texas. Influenced expanded adherence to national SANE protocols, and contributed to institutionalizing the advocacy response at several pilot sites (most notably in MA). This, in addition, to its core work of serving as clinical presence for survivors and their providers during real-time post-assault exams across the country.	Process Goal	Year 3 of 3
Work to build options for support and empowerment groups through alternative modalities.	Program staff facilitated a Creative Flow expressive arts workshops series for survivors of violence and abuse, many of whom are still living with their abusive partner as a result of COVID. - Program staff co-facilitated a trauma-informed Creative Dance group with the Center for Violence Prevention and Recovery at Beth Israel Deaconess Medical Center. - Program staff offered two online nutrition groups in partnership with The Second Stepâ€"one for trauma survivors, and another for trauma workers. - Program staff continue to facilitate both Domestic Violence Support and Empowerment groups and Seeking Safety groups at Genesis House. Genesis House is the local residential center for mothers with substance use disorders. Approximately 90% of the participants there have experiences of severe violence and abuse. - Program staff offered a 6-month trauma-informed yoga group for survivors of violence, abuse, and trauma. - In addition to the above, program staff continued 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.	Process Goal	Year 3 of 3
Increase access to services for patients and employees by increasing education and consultation services to health care providers and affiliated	In FY 20, the DV/SA Program provided education and consultation to over 1000 healthcare providers and interdisciplinary professionals that also included faith leaders, homeless service providers, private practice therapists, and district attorneys. Topics ranged from identifying abuse in the age of telehealth, dynamics of	Process Goal	Year 3 of 3

professionals both inside and outside the hospital.	childhood abuse, abuser psychology, safety planning, post-separation abuse, trauma informed care, oppression and historical trauma.		
Specialized consultation with community organizations.	Provided regular consults for Fervently Orthodox school-based providers around safety planning, the impact of witnessing domestic violence on children, childhood sexual abuse, and developmental trauma.	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 20, the partnership trained numerous community-based victim services through trainings and consultations.	Process Goal	Year 3 of 3
Support capacity of multidisciplinary DV 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 3 of 3
Support shelter infrastructure . and DV/SA agencies in the community.	In FY20, 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 3 of 3
Respond to Covid-19 related survivor needs.	Provided $17,000 in emergency funding to victims for basic needs such as housing, rent, utilities, and food. Provided Covid-19 self-care informational materials in multiple languages, Covid-19 Care Kits, and PPE to shelters and DSV organizations. Served as the pilot site for The Boston Area Rape Crisis Center (BARCC), which tested a tele-advocacy response to survivors of acute sexual assault during the surge.	Process Goal	Year 1 of 3
The Domestic and Sexual Abuse Council, within the Collaborative for Healthy Families & Communities (CHF&C), is focused on enhancing access for survivors who face linguistic and cultural barriers.	The Domestic and Sexual Abuse Council, comprised of 25 members, meets four times per year. The Council has been instrumental in disseminating emergency resources to victims of abuse. The Council has also had DSV resource materials translated into 13 languages.	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,

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/

Waltham Wellness Collaboration

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. Partners with Waltham based organizations â€" Healthy Waltham, Waltham Connections, Waltham Senior Center, 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, 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
Create platforms for the promotion of healthy living.	Supported the Walking Waltham initiative to engage the entire community and get more people walkingâ€"from ages 2-96. Promote physical activity, and help combat obesity and stress. Initiative promotes walking in Walthamâ€™s natural spaces and on city streets.	Process Goal	Year 3 of 3
Link clinical providers with the community health activities.	Held physician led â€œWalk With A Docâ€ session through the Waltham Connections walking program. Attended by 60 seniors. Incorporated both education and physical activity. Program suspended due to Covid-19.	Outcome Goal	Year 3 of 3
Conducted various community programs around healthy-eating and nutrition.	Provide educational programming on healthy lifestyle.	Process Goal	Year 3 of 3
Partner with other organizations in Waltham to promote age-friendly activities in Waltham.	Actively participated 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 3 of 3
Provide food access during out of school hours	Supported the Summer Eats program for students during the summer months. Program adjusted to meet Covid-19 needs.	Process Goal	Year 3 of 3
Partner with the efforts of Healthy Waltham.	Supported Healthy Waltham in their efforts for food distribution during Covid-19. The numbers of clients increased from 200 to 800 during this time. NWH support has included financial to expand services, providing Covid materials, distributing 2000 Covid carekits and administering 61 flu vaccines at the mobile food market site.	Process Goal	Year 3 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	Built Environment, Social Environment,
Health Issues	Chronic Disease-Diabetes, Health Behaviors/Mental Health-Mental Health,
Target Populations	• **Regions Served:** Waltham, • **Environments Served:** Suburban,

	• **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** English, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Healthy Waltham	www.healthy-waltham.org
Waltham Boys and Girls Club	www.walthambgc.org
Waltham Connections	www.healthy-waltham.org
Waltham Boys and Girls Club	www.walthambgc.org
Waltham Connections	www.healthy-waltham.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. 8 new bilingual teens were trained as interpreter liaisons by Cross Cultural Communications, Inc. Both Spanish and Haitian-Creole translation were part of this yearâ€™s program. 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, mental health, use of technology, school processes, and other topics. A total of 51 teens were hired at 27 events throughout the year. Allows outreach events to occur at locations with culturally and linguistically diverse venues.	Outcome Goal	Year 3 of 3
Provide opportunities for youth to gain exposure to the health care environment and learn from professionals about career options.	Conducted weekly career exploration sessions for community teenagers through the NWH Volunteer Program. Focus on both clinical and non-clinical roles. Held virtually due to Covid-19. 38 student volunteers attended the sessions.	Outcome Goal	Year 3 of 3
	Hired 20 Waltham High School students through the Waltham Partnership for Youth Summer Internship program with the goal of providing paid opportunities that cultivate professional skills and allow for the exploration of		

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.	future career interests. This was the largest number of students sponsored by one organization. The format of the program was innovatively re-designed due to Covid-19 . Through a partnership with MassBay Community College, students were enrolled in an on-line biology course with lab. All 20 completed the course and received college credit and were paid at $15 per hour for 32 hours per week. In addition, over the 6 weeks, the students attended weekly hospital career focused sessions with panelists from all different areas of the hospital. A total of 25 NWH staff participated in the career exploration sessions.	Outcome Goal	Year 3 of 3
Support on-going youth work force development initiatives I the community.	Continued sponsorship for the Youth Intern Coordinator at the Waltham Partnership for Youth. Position is responsible for the placement, training, and development of over 60 summer interns in the City of Waltham.	Process Goal	Year 3 of 3
Provide work-skill based opportunities for students and adults through the NWH vocational volunteer program.	Provided 47 individuals adult and youth in vocational programs with separate, on-going, placement opportunities to learn, practice and be exposed to workplace skills. Individuals contributed over 1600 hours of service in the year. These figures represent half the year as volunteer service was suspended in March 2020 due to Covid-19. NWH Volunteer Services works with 20 schools and organizations to facilitate the program. Over 30 hospital staff provide instruction, training and a mentor presence for individuals.	Outcome Goal	Year 3 of 3
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 virtual NWH Career Event over two evenings with 75 attendees. Made available to high school students, adult learners, NWH employees, and school guidance counselors. A keynote speaker, skill building workshops and panels were a part of each program. In particular, departments and staff were chosen to represent healthcare areas that require less than four-year degrees, certificate programs or no formal schooling.	Process Goal	Year 3 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 3 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, and student and community exposure to healthcare careers across all levels. The goal is for the hospital to serve as a career hub, that through collaborations and partnerships can provide opportunities for youth to enhance family financial security.	Process Goal	Year 2 of 3
Promote and foster value for multicultural and multilingual backgrounds among youth.	Provided a means of income, mentorship, and development of leadership and empowerment skills among the youth involved in the youth interpreter program. G.has been one of our most active interpreters in the community. She had this to say about the program, â€œCommitting to the Interpreterâ€™s training was seriously the best thing I decided to do while I was in high school. It has opened numerous doors for me, I have been an interpreter for multiple organizations in different settings, with different types of professions and members of the community. I have made many connections with people who became mentors for me as well as inspiring	Process Goal	Year 3 of 3

	role models of leadership. Not only has it provided a source of income for me, but the experience I earned was invaluable, it looks great on my resume and employers are always eager to hear about it; they are especially impressed by the fact that this is something I started in high school and I continue to bear fruits from it to this date.â€		
Form partnerships to promote youth development and leadership skills.	Partnered with SparkShare as a community facilitator with a goal of empowering youth to influence their own lives, drive change and create a positive outlook on their future. Participated in two SparkShare Summits and participated in multiple planning sessions to created content development to optimize youth engagement.	Process Goal	Year 2 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
SparkShare	www.sparkshare.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	NWHâ€™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 hospitalâ€™s catchment area and of Massachusetts overall. The dropout rate in Waltham (3%) is nearly twice that of Massachusetts. Furthermore, graduation rates and dropout rates among Hispanic/Latino students and English Language Learners (ELL) are far worse. NWH is operationalizing a grant initiative made possible by the approval of two Determination of Need (DoN) â€“ Community Health Initiative (CHI) processes of Partners HealthCare System, Inc. â€“ Massachusetts General Waltham and Partners HealthCare System, Inc. â€“ Massachusetts General Physicianâ€™s Organization Waltham
Program Hashtags	Mentorship/Career Training/Internship, Support Group,
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 (Waltham Partnership for Youth, Waltham Boys and Girls Club, Childrenâ€™s Charter, The Right to Immigration Institute, Doc Wayne) work collaboratively with Waltham Public Schools for student referrals.	Process Goal	Year 2 of 4
The Collaborative and WPS use a collective approach to support students and families.	Components of the approach are: *Wraparound Coordinator and Case Manager conduct individual intakes; *Development of Individual *Student Success Plans (ISSP); support to students and caregivers in following through on their ISSPs, with a focus on accessing and coordinating community supports. *Weekly group therapy through Doc Wayne and Childrenâ€™s Charter. *Individual therapy/clinical support provided by Childrenâ€™s Charter *Caregiver support *Immigration and basic needs support through their partnership with TRII *Flex Fund support; and *Academic support.	Process Goal	Year 2 of 4
The target population for this program includes: â€¢ Freshman and sophomores (at time of referral) who are newcomers to U.S. (defined as not attending elementary school in U.S.) â€¢ English-language learners (ELLs) that are primarily Spanish speaking from Latin America Referred students are those likely to benefit from mental health supports and/or opportunities to socialize and form positive relationships with peers and adults. These students also face one or more of the following non-academic barriers to graduation: housing insecurity, food insecurity, need to earn income, transportation, access to healthcare services, or other basic needs	42 students were referred to Wrap Around Waltham. 22 students became active participants (13 males and 9 females). Average attendance at weekly sessions was 11 students. At the end of FY20: 3 students began receiving individual supports from Childrenâ€™s Charter 9 students were referred to other community services through Wraparound 7 households have been connected to other community services (i.e. Watch City Market) 14 households have received basic needs supports 5 Wraparound students engaged in a Participatory Action Research summer paid internship 5 students received Wi-Fi support 8 households received support in applying for City of Waltham rental assistance 2 families received COVID care support	Outcome Goal	Year 2 of 4
Adapt program in response to Covid-19.	WAW shifted to a virtual format due to the pandemic for group therapy and check-ins. The switch presented some issues related to reliable internet and technology access as well as the availability of private spaces in households for private conversations. Some aspects of WAW have not progressed as rapidly due to a slowdown in hiring as well as scheduling issues due to the hybrid school model. Alternative strategies are being explored as recruitment and engagement into the program have become more challenging.	Process Goal	Year 2 of 4
Make impact in the lives of immigrant students and their families.	Several case examples of impact (one case, generically described here): Student referred; participated in Doc Wayne and Childrenâ€™s Charter sessions; coordinated courses for mom to pursue English proficiency; food and rental assistance provided due to impact of Covid-19 on the family; student encouraged and accepted into summer internship program. â€œWaltham High School, Doc Wayne, Childrenâ€™s Charter, and WPY worked in partnership to play a key role in supporting this student and her family, beginning with referrals, meeting basic	Process Goal	Year 2 of 4

	needs, making program connections to support goal attainment, and continuing to provide ongoing support. â €œ		

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:** English, Spanish, • **Additional Target Population Status:** Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
Wrap Around Waltham Collaborative - Waltham Partnership for Youth, Waltham Boys and Girls Club, Childrenâ€™s Charter, The Right To Immigration Institute, Doc Wayne	Not Specified
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. CACâ€™s also provide financial estimates for services. In FY20, NWH CACs contributed to the estimated 75 patient financial counselors that served patients who needed assistance with their coverage.
Program Hashtags	Prevention,
Program Contact Information	Brooke Alexander, Mass General Brigham Community Health

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 FY20, NWH CACs contributed to the estimated 75 patient financial counselors that served patients who needed assistance with their coverage.	Process Goal	Year 3 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

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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 2020, about 374 BPS students had jobs at BWH, MGH, and Faulkner through Mayor Walshâ€™s Summer Jobs Program. In addition, Newton Wellesley Hospital provided 20 summer jobs. The total count for all summer jobs across Mass General Brigham hospitals in 2020 was as follows: Brigham and Womenâ€™s Hospital: 222 Brigham and Womenâ€™s Faulkner Hospital: 13 Massachusetts General Hospital: 112 Newton Wellesley Hospital: 20 North Shore Medical Center: 16
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.	NWH Virtual Summer Jobs program, in partnership with Waltham Partnership for Youth and Mass Bay Community College, focused on career exploration, virtual classes to enable interns to obtain college credits, and skills building workshops.	Outcome Goal	Year 4 of 4
Provide students with meaningful summer job experiences and mentoring.	Hired 20 Waltham High School students through the Waltham Partnership for Youth Summer Internship program with the goal of providing paid opportunities that cultivate professional skills and allow for the exploration of future career interests. This was the largest number of students sponsored by one organization.	Outcome Goal	Year 3 of 3
Provide students with meaningful summer job experiences and mentoring.	The format of the program was innovatively re-designed due to Covid-19 . Through a partnership with MassBay Community College, students were enrolled in an on-line biology course with lab. All 20 students completed the course and received college credit and were paid at $15 per hour for 32 hours per week.	Outcome Goal	Year 1 of 3

Provide students with meaningful summer job experiences and mentoring.	Over the 6 weeks, the students attended weekly hospital career focused sessions with panelists from all different areas of Newton-Wellesley Hospital. A total of 25 NWH staff participated in the career exploration sessions.	Outcome Goal	Year 1 of 3
Provide students with meaningful summer job experiences and mentoring.	An alumni intern was selected to serve in a leadership role as a peer mentor for the cohort of students.	Outcome Goal	Year 1 of 3
Provide students with meaningful summer job experiences and mentoring.	Continued sponsorship for the Youth Intern Coordinator position at the Waltham Partnership for Youth. The position is responsible for the placement, training, and development of over 60 summer interns in the City of Waltham.	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:** Suburban, • **Gender:** All, • **Age Group:** Teenagers, • **Race/Ethnicity:** All, • **Language:** English, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Mass Bay Community College	https://www.massbay.edu/
Waltham Partnership for Youth	https://www.walthampartnershipforyouth.org/

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 $7.0 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	Community Health Center Partnership, Health Professional/Staff Training, Prevention, 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
	In 2019, RIZE launched Together in Recovery: Supporting Informed Decisions (TiR) to address the philosophical divides that arise in OUD treatment. The main goals are to		

Partner with relevant organizations to inform state and local actors and other stakeholders to align thinking and approaches to SUD policy and services.	foster an accessible, integrated treatment and recovery community in Massachusetts that champions evidence-based approaches, supports multiple pathways of recovery, and puts people in charge of their treatment choices. Through a Change Team of diverse influencers, RIZE convened eight regional and one statewide meeting to examine the many challenges associated with OUD treatment. We heard about the barriers that exist for both people seeking treatment and those in long-term recovery from advocates, providers, parents, and school administrators, among others. We then took the data gathered across the state to finalize a Priorities for Action document that embraces a unified vision representing varied perspectives of treatment. One of these priorities is to create and disseminate a Your Rights in Recovery toolkit. The toolkit is a turnkey, digital educational tool and resource individuals and families can access on RIZEâ€™s website. It addresses issues such as rights related to recovery pathways, family resources, housing, education, employment, and the criminal justice system. The content is available in both English and Spanish and was launched at a live webinar with Attorney General Maura Healey on April 8, 2021.	Outcome Goal	Year 2 of 4
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 $7 million in grants to more than 60 Massachusetts organizations. To further advance our racial equity agenda, RIZE implemented our Innovations in Anti-Racism to Address the Overdose Crisis program. This program provides grants to four Massachusetts organizations creating meaningful results in fighting racism and improving access to evidence-based addiction treatment by reducing the stigma and structural barriers faced by Black, Indigenous, People of Color (BIPOC). We also partnered with the Cambridge Health Alliance Health Equity Research Lab (HER Lab) to perform the evaluation for this program.	Outcome Goal	Year 4 of 4
COVID-19 Rapid Response Grants	In response to these challenges, we partnered with the Boston Resiliency Fund, a COVID-19 related philanthropic rapid response effort, and were awarded a grant of $250,000 that we matched in-full. RIZE is working closely with the city of Boston Mayorâ€™s Office of Recovery Services to help front-line health care workers that serve people with OUD. Support was given to residential programs and organizations assisting with outdoor comfort stations that provide harm reduction services, screening for COVID-19, and connections to care and treatment for individuals experiencing homelessness. These community contributions are in addition to rapid response grants RIZE awarded to our frontline community partners in March. These two funding initiatives total $705,000.	Outcome Goal	Year 1 of 1

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
Access, Harm Reduction, Overdose Prevention and Education (AHOPE)	Not Specified
Boston Medical Center	Not Specified
Casa Esperanza, Inc.	Not Specified
City of Malden Health Department	Not Specified
Community Action Programs Inter-City, Inc.	Not Specified
Fishing Partnership Support Services	Not Specified
Gavin Foundation	Not Specified
Granada House	Not Specified
Hope House, Inc.	Not Specified
Interim House	Not Specified
Learn to Cope	Not Specified
Massachusetts Organization for Addiction Recovery	Not Specified
Metropolitan Area Planning Council	Not Specified
Middlesex Human Service Agency	Not Specified
New England Culinary Arts Training	Not Specified
New England Usersâ€™ Union	Not Specified
North Suffolk-Meridian House	Not Specified
Ostiguy High School	Not Specified
People's Harm Reduction Alliance	Not Specified
Phoenix House	Not Specified
Prisoners' Legal Services	Not Specified
Rehabilitation and Health, Inc.	Not Specified
St. Francis House	Not Specified
The Dimock Center	Not Specified
The Phoenix	Not Specified
The Resource and Reclamation Center	Not Specified
Victory Programs, Inc.	Not Specified
Volunteers of America	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,
Program Contact Information	Tavinder Phull, MPH MBA, Mass General Brigham Community Health

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. Leagueâ€™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 4 of 4
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 4 of 4

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Mental Illness and Mental Health,
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, Somerville • **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	**$2,854,843.00**

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	$1,978,853.00	$361,955.00
Access/Coverage Supports	$875,990.00	$255,938.00
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	$93,142.00
Mental Health/Mental Illness	$617,767.00
Housing/Homelessness	$11,825.00
Substance Use	$673,101.00
Additional Health Needs Identified by the Community	$1,459,008.00

Other Leveraged Resources	$1,705,827.00

Net Charity Care Expenditures	Total Amount
HSN Assessment	$6,035,676.00
HSN Denied Claims	$66,923.00
Free/Discount Care	$584,070.00
Total Net Charity Care	$6,686,669.00

Total CB Expenditures:	$11,247,339.00

Additional Information	Total Amount
Net Patient Service Revenue:	$469,408,000.00
CB Expenditure as Percentage of Net Patient Services Revenue:	2.40%
Approved CB Program Budget for FY2021: (*Excluding expenditures that cannot be projected at the time of the report.)	$11,247,339.00
Comments (Optional):	Not Specified

Optional Information

Hospital Publication Describing CB Initiatives:	Not Specified
Bad Debt:	Not Specified
Bad Debt Certification:	Not Certified
	Mass General Brigham (MGB) System Commitments: In addition to commitments made by the member hospitals, Mass General Brigham makes system investments aimed at:

â€¢ Leveraging our business practices around inclusive local hiring and workforce development, local and diverse sourcing and place-based investing to tackle underlying causes of poor health outcomes in the communities we serve.
â€¢ 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).
â€¢ Ensuring access to primary care close to home. MGB 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.
â€¢ Ensuring access to care for our low income community residents by supporting state program enrollment. MGB 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.

While some of the programs below are in areas not included in our current CHNA priority areas, they represent work in priority areas identified in other or prior processes.
1. Interpreter Services â€" provides equitable access to healthcare services.
2. Corporate Contributions are evaluated and decision for support is given only after a link to priorities in the Implementation Strategy is identified.
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.

Substantial engagement has occurred during Covid-19. The presence of already established relationships were instrumental in timely communication and addressing community challenges. As a result, these partnerships were deepened and were critical to working collaboratively in response to issues related to the pandemic. Additionally, several new collaborations formed over this time that did not exist previously. For NWH, the engagement with the community stemmed from an overarching mentality that there needed to be reliance on collective action, on both a large and small scale.

During Covid-19, Newton-Wellesley Hospital has served a critical role in being a resource and trusted partner for the general community. This involved being transparent in relaying real-time Covid-19 details and practices, offering clinical expertise and consultation when needed, and providing financial and material supports. Becoming this key point-resource for community organizations was welcomed and has been relied upon quite heavily over the past year.
Examples of on-going forms of NWH community engagement during Covid-19 include:
- Local Departments of Public Health
- Higher Educational Institutions in our area
- Interagency Networks â€" the engagement with 40 plus Waltham agencies on a weekly basis since the start of the pandemic.
- Faith-based community engagement was enhanced by providing Covid-19 Care Kits and language appropriate informational materials. This connection was critical with immigrant and multi-cultural churches in Waltham as many of the parishioners in the congregations are essential workers.
- Connecting with the business community in responding to the needs of their employees living and working in the community.
- Engagement with the community through various platforms has been helpful in the identification of relevant and timely community programming (virtual). Through connections and input from community members, topics such as addressing isolation, coping with loss, utilizing telehealth and others were identified and offered to the community with expert panelists.
- The Resilience Project team engagement with the school community helped to identify and work collaboratively to meet the mental health needs of students and their parents at this particularly challenging time in education.
- The NWH Domestic and Sexual Violence Program relied on their current partnerships with the local organization and shelter communities to meet a growing landscape of DSV victims and respond with emergency assistance.
- More frequent engagement with the Community Benefits Committee and conducting Open Forums and two community town halls allowed us to hear directly from those in the community.
- The Collaborative for Healthy Families and Communities continued to convene and engage with the 150 council members, 75% of whom are members of the community from various sectors and neighborhoods. The programmatic and initiative work of these 8 councils took on an added level of urgency given the areas of focus. These include

substance use, domestic and sexual abuse, youth mental health, elder care, maternity care, work force development, palliative care, and cardiovascular health. The on-going and frequent engagement of the community in these efforts has continued to help inform and ultimately direct the hospitalâ€™s efforts in each of these health priority areas.
- NWH Community Health Workers were instrumental in outreach related to SDOH and engaged with many community members to provide resources and address compelling challenges highlighted as a result of the pandemic. Through this work a comprehensive Covid-19 Resource Guide was created and updated every other week. The Guide is shared widely among community partners.
- A new engagement opportunity presented itself among the Assisted Living Facilities/Independent Living Facilities. Starting the collaboration has allowed for enhanced communication among all entities and a broader awareness of challenges, as well as the sharing of best practices. This exchange will continue through a Senior Living Community Forum which will be held on a quarterly basis.
- Hands-on community engagement (i.e., at the NWH flu clinics, and the Waltham mobile food market) we heard from and witnessed first-hand the needs of community residents.

Optional Supplement:

Within the first month of the pandemic a NWH COVID Equity and Community Health Work Stream was formed. This multidisciplinary team of 25 individuals includes representatives from across the institution and met on a bi-weekly basis. The efforts of the workstream served to identify challenges and action steps to address issues being experienced by our broader community, to include patients and families. These obstacles as well as solutions were brought forward to various levels of leadership to weave into the overall Covid response. The workstream continues to meet regularly and has used prior learning to advance action in response to the second surge.

Covid-19 has created various means for collaborations among all of our community partners. As a hospital, this work has enabled NWH to understand and engage the community â€“ itâ€™s residents and organizations - in a much deeper and meaningful way.

COVID Response
During Covid-19 there was a shift in how community engagement took place and therefore created changes in the approach to NWHâ€™s community benefits programming.
Despite having to do things differently, we realized that engagement was critical in effectively reacting to the needs of the community.
Aspects that became imperative for consideration were:
1. Access to information - how information was being obtained; and level of digital accessibility across our communities.
2. Language barriers â€“ in all programming, but specifically related to Covid-19 information.
3. Shift in prioritization â€“ an elevated focus on NWH community benefits programs relating to food access, housing, mental health, substance use, socialization, economic stability.
4. Creating programming specific to Covid-19 resources, support and access.
5. Equity - a heightened concentration for viewing all programs through an equity lens. Engaging with the community for input and assistance in adapting programs, as needed.
6. Leveraging established community relationships - critical to working collaboratively in response to issues related to the pandemic and re-directing NWH community benefits programs. These included NWH consistently convening and participating with community partners such as our local departments of public health, higher education institutions, business chambers, senior service agencies, social service agencies specifically related to food, housing, youth, and others.
7. Creation of new partnerships - in faith-based communities, specifically those in immigrant and multicultural communities; among senior living communities; and others.

Some specific examples for community engagement that determined how we responded through community benefit programming included:
- Engaged in partnership to provide clinical expertise to schools, business and other community partners.
- Served as the consistent key provider of Covid-19 related data, health information, and expertise throughout the pandemic to key community organizations and groups.
- The approach for clinical services within the community benefits scope, such as substance use, child psychiatry, and perinatal mood and anxiety disorders, shifted to virtual platforms for visits. In addition, virtual support groups were held for patients and families.
- Programming for NWH Fall Prevention, i.e., Matter of Balance Program was shifted to Tai Chi classes which were held an online Zoom platform. In addition, through a

collaboration with Population Health the SMART program was introduced to address stress in seniors and promote/teach resiliency. The program was held virtually and through connections with senior centers.
- Those NWH community benefits programs that focused on addressing isolation saw a shifted from on-site senior interactive events to a successful Senior Webinar Series that provided both health education as well as socialization. Programs were attended by 100-200 seniors per session. Engagement with this population determined future topic areas.
- The Resilience Project team engaged with the school community and helped to identify and work collaboratively to meet the mental health needs of students and their parents at this particularly challenging time in education.
- The NWH Domestic and Sexual Violence Program relied on their current partnerships with the local organization and shelter communities to meet a growing landscape of DSV victims and respond with emergency assistance, all of which were made more prominent by Covid-19.
- More frequent engagement with the Community Benefits Committee, conducting Open Forums, and holding two community town halls enabled NWH to hear directly from those in the community. These conversations and discussions both reinforced our current community benefits work as well as re-directed the hospital to new areas of need in reaction to the pandemic.
- The Collaborative for Healthy Families and Communities continued to convene and engage with the 150 council members, 75% of whom are members of the community from various sectors and neighborhoods. The programmatic and initiative work of these 8 councils took on an added level of urgency given the areas of focus. These include substance use, domestic and sexual abuse, youth mental health, elder care, maternity care, work force development, palliative care, and cardiovascular health. The on-going and frequent engagement of the community in these efforts has continued to help inform and ultimately direct the hospitalâ€™s efforts in each of these health priority areas.
- NWH Community Health Workers were instrumental in outreach related to SDOH and engaged with many community members to provide resources and address compelling challenges highlighted as a result of the pandemic. Through this work a comprehensive Covid-19 Resource Guide was created and updated every other week. The Guide is shared widely among community partners.
- Relationships with community organizations enabled NWH to partner on outreach efforts such as flu clinics, and Covid-19 vaccine outreach. For the latter, NWH collaborated with Healthy Waltham at the mobile food pantry. Bi-lingual hospital staff took part on several occasions to engage with a predominately immigrant community base.
- NWH Covid-19 Equity and Community Health Work Stream was formed to bring together an internal multidisciplinary team of 25 individuals all of whom had roles that touch the community NWH serves in some capacity. The Work Stream met on a b-weekly basis to identify challenges and action steps to address issues being experienced by our broader community. These obstacles as well as solutions were brought forward to various levels of leadership to weave into the overall Covid-19 response.