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:	Senior Director
Contact Department (Optional):	Community Health
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:	Mass General Brigham
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 at-risk 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 resources to address unmet needs of the community. Further explained:

- 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 hospital'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, Community Health Needs Assessment
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, Community Health Needs Assessment
Immigrant Populations	Community Health Needs Assessment; Departments of Public Health data
Residents experiencing housing and food insecurity	Covid-19 state data; Greater Boston Food Bank Food Access Report; local food pantry data; local and regional housing authority data; US Census (2019); local community assessments

Publication of Target Populations:

Marketing Collateral, Annual Report, Website

Community Health Needs Assessment:

Date Last Assessment Completed:

2021

Data Sources:

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

Health, MetroWest Health Foundation, the Massachusetts Department of Elementary and Secondary Education, and the Federal Bureau of Investigation

CHNA Document: NWH 2021 CHNA REPORT FINAL.PDF

Implementation Strategy:

Implementation Strategy Document: NWH 2021 CHIP FINAL.PDF

Key Accomplishments of Reporting Year:

- Among community dwelling elders, fall-related injuries are the most common type of injury. In FY21, 40 elders participated in the Matter of Balance program, bringing the total number of participants since the program inception in 1997 to 1,875. In addition, Strength and balance classes were held virtually twice per week with 25 seniors attending per class.
- The NWH Wellness Center shifted all exercise and wellness programming to be free of charge to the community over a virtual platform. All programs are specifically geared to the senior community. Six classes are offered per week. Approximately 150 class participants per week.
- Tai Chi has also been identified to improve balance and well-being among elders. In collaboration with Newton Senior Services, 25 seniors per week took part in virtual Tai Chi sessions with an overwhelmingly positive response for balance, socialization, and a feeling of wellness.
- In FY21, the Domestic Violence/Sexual Assault Program at NWH provided free, voluntary, and confidential services to over 778 survivors of domestic, family, or sexual violence (a 48% increase over FY19).
- Provided a $50,000 grant to REACH Beyond Domestic Violence to better serve the over half client population who are of Latina descent.
- Program staff facilitated Transforming Trauma Support Group, a skill-building group for survivors of violence abuse that offered psychoeducation regarding the impact of trauma on mind, body, and spirit as well as opportunities to practice mindfulness, embodiment, and grounding exercises.
- Created culturally and linguistically specific services and resources for survivors in written information and electronically.
- Facilitated the SANE Tele-nursing Center at NWH served 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. Provided technical assistance and education to ten Massachusetts hospitals using TeleSANE services.
- In FY21, 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.
- In FY21, facilitated 1427 rides through the Modivcare/Lyft platform for ease of access to and from hospital care.
- Provided assistance to 155 patients (a 19% increase over FY20) 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:
- the NWHs local Departments of Public Health; and
- in collaboration with Population Health, quarterly Senior Living Forums were conducted with local ALFs/ILFs
- Expanded the presence of NWH Community Health Workers in the communities of Waltham, Newton, Needham, Natick, Weston, and Walpole. This was in response to a recognized need to provide support to patients in the areas related to SDOH.
- In FY21, NWH administered 556 flu vaccines at a variety of community locations to include the Waltham mobile food market.
- In FY 21, NWH representatives spoke at and took part in NWH-hosted and community-hosted events/sessions promoting health, wellness, and safety.
- In FY21, NWH continued to provide numerous education and opportunities for engagement on the topic of Covid-19. This included audiences of businesses, school personnel, social service agencies, and others.
- In FY21, held a mental health summit (virtually) with 130 attendees (principals, school nurses, social work, guidance staff and therapeutic staff) from high schools, middle schools, private schools, and youth-based organizations from the NWH primary service area.
- In FY21, held 5 virtual senior events with focuses on exercise, staying healthy and safe and home, dealing with loneliness and loss, and navigating the Covid-19 pandemic. 445 seniors attended. A robust and successful Senior Webinar Series continued to inform seniors on topics such as cardiovascular health, telehealth, and others.
- In FY21, 4500 children were seen in the Child and Adolescent Clinic (a 17% increase over FY20). The outpatient clinic also saw a doubling in new patient referrals, including referrals from pediatricians and from schools participating in The Resilience Project.
- In FY21, 735 children were seen for mental health care in the Emergency Department. This is a 102% increase over FY20. Young teens aged 13 and 14 represent the highest proportion of such ER visits.
- Had 140 parents take part in the Parenting Series and added an Alumni Drop-In Group option. Held 10 programs in the Building Resilience educational series.
- Provided training and clinical consultation to more than 450 educators throughout the school year; 62 percent of these programs were delivered to middle school personnel, and 38 percent were delivered to high school personnel.
- In FY21, NWH distributed 174 doses of Narcan to community agencies/partners. NWH dispensed 54 naloxone kits to patients in the NWH Emergency Department with diagnosis of opioid overdose.
- Substance Use Service clinicians completed 2465 patient visits, with referrals from primary care, inpatient and the Emergency Department.
- SUS Recovery Coach conducted twice weekly group support sessions (one virtual, one in-person). 88 groups have been held in FY21. There is, on average, 10 people per group who are between the ages of 25 to 83 years old.
- Collaborated with SOAR Natick on efforts to reduce stigma and promote engagement and discussion on the issue of addiction. Displayed the Opioid Art Project and the Purple Flag Project at NWH with an additional presence during the Boston Marathon.
- The hospital continued its partnership with the Middlesex District Attorneys Office in the Charles River Regional Opioid Task Force, taking part in monthly education and discussion sessions.
- Further develop partnerships with local food and nutrition organizations. Through MGB Community Health helped increase food access with $100,000 in grant funding to the Newton Food Pantry, Healthy Waltham and the Waltham Boys and Girls Club.
- Sponsored the Waltham Partnership for Youth Language Access for Civic Engagements (LACE) Program. 12 new bilingual teens were trained as interpreter liaisons by Cross Cultural Communications, Inc. Both Spanish and Haitian-Creole. A total of 15 teens were hired at 10 events throughout the year.
- Hired 18 Waltham High School students through the Waltham Partnership for Youth Summer Internship program (the largest number of students of any participating organization). Program was held virtually during Covid-19. In partnership with Lasell University, student employment included a college credit courses: Health Psychology or Foundation Health Professions.
- Continued to engage with community and school-based youth and adult vocational programs to adapt participation during Covid-19. The opportunities provide a work- based learning environment to develop and build employment skills.
- Held a career event over two nights (virtually due to Covid-19). 55 attendees each event. Wide array of careers with a variety of educational and financial commitments required. The program also included careers requiring a two-year degree, certificate programs. or alternative training. 10 staff served as panelists.
- To address maternal mental health, grew the Post-Partum Mood and Anxiety Disorder Program with 1000 patients referred since the program began in May 2019. Between 28-50 new patients are referred weekly.
- Held 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 Covid preparedness.

- NWH was involved as a key contributor in the planning for the October 2021 Boston Marathon.
- Provided 12,974 completed Interpreter Service requests, including face-to-face, telephonic, video, ASL. A 20% increase over FY21.
- Continued to evolve the NWH Community Collaborative with 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 has leadership from the community and the Hospital. The Collaborative 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 advocacy.
- 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.
- 22 of the 26 Wrap Around students who were active in Spring/Summer 2021, advanced to the next grade level at the end of the academic year, and 3 of the 26 Wraparound students who were active in Spring/Summer 2021, graduated at the end of the academic year.
- Carried out the Community Health Initiative phase of the NWH Determination of Need. Created community-based Advisory and Allocations committees to select health priority for funding the Committee identified which will address housing insecurity with an additional focus on mental health and self-sufficiency components as the priority.
- Disbursed $708,084 of DON funds into the Statewide Initiative Fund.
- Continued to respond to and shifted programs, resources, and outreach in reaction to Covid-19.

Plans for Next Reporting Year:

In addition to the hospitals ongoing program and those in partnership with other organizations, the hospital will be carrying out the goals outlined in the most recent 2021 CHNA/CHIP: addressing needs for specific populations (youth, seniors, low income, immigrants, and food/housing insecure residents.) and priority areas of access to care and overall health, to include those related to SDOH; chronic disease prevention and management; and a focus on mental health, and substance use. These identified populations and specific priorities are viewed as critical and have a growing need for more focused attention, resources, and collective action. NWHs efforts in all priority areas emphasize improvement in health status and working collaboratively within and across its communities.
The monitoring and evaluation 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 the NWH Community Collaborative.
Newton-Wellesley Hospital will also begin the process to conduct another community health needs assessment in 2022. This work will assist the hospital in capturing and understanding the needs of the community post-covid as well as to be on the same assessment cycle as other entities in the Mass General Brigham healthcare system.

In 2021, through the Determination of Need process, Newton-Wellesley Hospital (NWH), awarded a $1.9 million grant to WATCH Community Development Corporation (WATCH CDC) and MetroWest Collaborative Development (Metro West CD) to address housing insecurity in the communities surrounding the hospital. WATCH CDC, located in Waltham, and Metro West CD, located in Newton, will collaborate to reduce inequities in housing security of low-income tenants, particularly among communities of color and immigrant communities in Natick, Needham, Newton, Waltham, Wellesley, and Weston. NWH identified housing insecurity as the focus of its Community-Based Health Initiative (CHI) following a comprehensive review of critical needs in the area, in collaboration with an Advisory Committee comprised of key community stakeholders.
Through this four-year grant, beginning in October 2021, NWH will invest $1.9 million into the WATCH CDC and Metro West CD collaborative, which will build on existing case management-based housing clinics, with particular emphasis on reaching out to and serving low-income and immigrant tenants. The collaborative will also heighten awareness of the mental health needs of clients experiencing housing insecurity, with the assistance of a mental health consultant, and provide emergency financial assistance at its clinics. In addition, the collaborative will hire a Job and Financial Planning Coordinator to mentor clients to greater financial self-sufficiency. Both organizations will work to expand the stock of affordable housing and increase protections for tenants through community organizing and advocacy.
Given the DON process timeline, funding is not being disbursed until FY22.

Self-Assessment Form: Hospital Self-Assessment Form - Year 1

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 to care issues, NWH develops transportation resource outlets to facilitate client access to needed healthcare. NWH also works with and supports various community agencies with transportation options. Community Health Workers facilitate healthcare access and support services through direct referrals and community connections. NWH provides resources for timely school immunizations for Waltham youth.
Program Hashtags	Community Education, Prevention,
Program Contact Information	Lauren Lele, Senior Director, Community Health 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 1427 rides through the Modivcare/Lyft platform (previously Circulation) for ease of access to and from hospital care. Among areas using this service are the Emergency Department, Cancer Center, and Integrated Care Management Program.	Outcome Goal	Year 1 of 3
Provide primary care to children and adolescents who are uninsured or present other challenges interfering with accessing primary care.	In FY21, provided care to pediatric uninsured patients while they were in the application phase for Mass Health so as not to delay school entry. Volume was significantly lower this year for children served.	Process Goal	Year 1 of 3
Provide Community Health Worker support to patients and linkages to the community.	Expanded communities served by NWH Community Health Workers to now include: Waltham, Newton, Needham, Natick, Weston and Walpole. CHW's provide navigate access to necessary services both clinical related, but predominantly within the areas of the social determinants of health. Those areas of greatest need are education/employment, food access, and	Process Goal	Year 1 of 3

	housing insecurity. CHW are educated and have successfully formed partnerships with local community service organizations.		

EOHHS Focus Issues	N/A,
DoN Health Priorities	N/A,
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:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Domestic Violence History, Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
Circulation	Not Specified
Waltham Public Schools	Not Specified

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, Support Group,
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 FY21 through increased patient volume, enhanced school collaborations, and expansion of offerings and participants attending community and parent programs.	Process Goal	Year 1 of 3
Create a regular platform for parent and community education and awareness on the topic of mental health.	Pivoted to a fully virtual format to continue providing The Resilience Project's Building Resilience series, which are free educational outreach programs for educators and community members. During this school year alone, this series offered 10 webinars to date. Examples of topics covered included promoting resilience and wellbeing for children and adolescents, dialectical behavior therapy and acceptance and commitment therapy-informed tools, how to have difficult conversations with children and teens, supporting students with special needs during COVID-19, how to talk with kids about racism, inclusion and social justice, and preparing students for the transition to college/post-secondary education.	Outcome Goal	Year 1 of 3
Address parenting education and the development of skill-building tools for mental health and resilience.	Expanded the number of workshop cycles' from two to three sessions per year of Raising Resilient Teens, a popular offering for parents. This psychoeducational, seven-week workshop for parents and caregivers of teens, is led by a child and adolescent psychiatrist and a clinical psychologist. The group also offers an Alumni Drop-In Group for parents and caregivers who have completed the workshop but would like an ongoing connection with other parents and support from the workshop facilitators. Each session was at capacity with a waiting list. More than 140 parents have participated in these sessions since the program was launched in 2017.	Process Goal	Year 1 of 3
Create school-specific mental health programming to include a clinical consultation service and training.	Provided training and clinical consultation to more than 450 educators throughout the school year; 62 percent of these programs were delivered to middle school personnel, and 38 percent were delivered to high school personnel. Attendees to these trainings included school administrators, teachers, school nurses, guidance counselors, school-based speech and language pathologists, school nurses, special educators, school psychologists, social workers and school adjustment counselors.	Outcome Goal	Year 1 of 3

Provide Educator Training Sessions, Professional Development and Clinical Consultation Programs	Provided 27 training sessions, professional development and clinical consultation programs to educators. Examples of this outreach included consulting schools on interventions to support students who were experiencing school refusal behaviors and managing educator stress while also generating and delivering new professional development content on topics such as educating students with special needs during COVID-19 and supporting students and staff with school re-entry in the context of the pandemic. One of the most popular and well-received talks this school year was entitled Resilient Schools: Supporting Staff Self-Care, Pivoting in Times of Change and Building Engagement with Students in a Virtual World.	Outcome Goal	Year 1 of 3
Provide specific outreach to Newton and Waltham Public Schools.	Accommodated specific school requests, including presenting talks on youth mental health and resilience at school-based forums on social-emotional development for families in the Newton Public Schools and the Waltham Public schools, with attendance reaching nearly 90 participants combined. During 2020-2021, The Resilience Project had 14 touchpoints with the Newton Public Schools, spanning their middle and high schools, with 50% of those touchpoints happening in middle schools. During 2020-2021, The Resilience Project had 18 touchpoints with the Waltham Public Schools, spanning their middle and high schools.	Outcome Goal	Year 1 of 3
Provide opportunity for collaboration with middle and high schools on the issue of mental health.	Organized and presented the fifth annual educational summit, The Compassionate Classroom: Balancing Emotional Health and Academic Success, on October 2 (provided in a virtual format). Featured speakers included Jonathan Kleiman, Senior Program Director at Challenge Success, who presented The Well-Balanced Student: Avoiding Stress and Overscheduling During the Pandemic and Beyond, Richard Weissbourd, EdD, Senior Lecturer, Harvard Graduate School of Education and Co-Director, Human Development and Psychology Program, Kennedy School of Government, presented Cultivating Caring, a Commitment to Justice and Wellbeing in Children. The session was attended by nearly 130 school staff members.	Outcome Goal	Year 1 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 1 of 3
The Resilience Project Council (youth mental health), within the Newton-Wellesley Community Collaborative, is an innovative school-and community-based initiative designed to promote the mental health and well-being of adolescents.	The Resilience Council, comprised of 22 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 1 of 3
Provide mental health care services to patents in the Child and Adolescent Clinic and in the Emergency Department.	In FY21, 4500 children were seen in the Child and Adolescent Clinic (a 17% increase over FY20). The outpatient clinic also saw a doubling in new patient referrals, including referrals from pediatricians and from schools participating in The Resilience Project. In FY21, 735 patients were seen for mental health care in the Emergency Department. This is a 102% increase over FY20. Young teens aged 13 and 14 represent the highest proportion of such ER visits.	Outcome Goal	Year 1 of 3
Conduct the PACT (Parenting At Challenging Times) Program with individual consultations and follow-up parent guidance visits to patients receiving cancer treatment or care at the Mass-General Cancer Center at Newton-Wellesley Hospital who are parents to children age 24 and under.	PACT services are provided by child and adolescent psychiatrists, psychologists, and clinical social workers with expertise in child development, family communication, and coping. PACT clinicians provide guidance to patients on topics such as: - Supporting comfortable, honest, and child-centered communication, including about the patientls diagnosis and treatment - Addressing common parenting concerns and questions - Promoting resilience of the whole family, such as protecting family time, minimizing disruption to a child's routine, and shoring up additional family supports - Implementing practical strategies to manage common challenges including hair loss, hospital visits, and communication with children's schools In FY21, PACT provided 232 free individual consultations and 51 group therapy visits for 92 patients. PACT has also expanded its clinical team from two to four clinicians to continue to meet the growing need for support and guidance for parents with cancer.	Outcome Goal	Year 1 of 3

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	N/A,
Health Issues	Health Behaviors/Mental Health-Mental Health, 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:** Children, Teenagers,

	• **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

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

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	Prevention,
Program Contact Information	Sid Allendinger, Manager, Emergency Preparedness

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 1 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 1 of 3
Serve as key convener for Boston Marathon preparation and planning. Conduct functional planning exercises.	Successful preparation and completion of Marathon Event. Conduct an After Action review.	Process Goal	Year 1 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 1 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 (every six weeks - 6/8 times per year), first responders, and others. As a hospital served as a content expert to multiple agencies and in many forums.	Process Goal	Year 1 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	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
Boston Athletic Association	Not Specified

Community Health Needs Assessment (2021)

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	Conduct the tri-annual community health needs assessment as required by the Massachusetts Attorney General to gain a comprehensive review of unmet health needs of the community, including negative health impacts of social and environmental conditions, by analyzing community input, available public health data, and an inventory of existing programs, which should facilitate regional collaboration.
Program Hashtags	Community Education, Health Professional/Staff Training, Health Screening, Mentorship/Career Training/Internship, Prevention,
Program Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Conduct community health needs assessment.	Collected primary and secondary data (both quantitative and qualitative) to identify unmet health needs in the six NWH service communities (Natick, Needham, Newton, Waltham, Wellesley, Weston) from a variety of sources and inventory programs currently available to address those needs. Process considered health needs broadly and include data and analysis on social, behavioral, and environmental factors that impact health in the community. Special emphasis during the community health needs was placed on identifying health disparities, and particular types of health differences that are closely linked with economic, social, or environmental disadvantage.	Process Goal	Year 1 of 3
Create a Community Health Implementation Plan (CHIP) after the community health needs assessment is complete. The CHIP supports, specific programs or activities that are associated with significant needs identified in the Community Health Needs Assessment, and establishes measurable short and long-term goals for each program or activity.	Created a Community Health Implementation Plan with four target populations identified. Four distinct priorities were established with four Goals. Four sub-priorities are listed specifically under the SDOH priority. Twenty- six strategies were established along with specifics success measures. In addition, community partnerships were identified to complete the priority and time lines were outlined.	Process Goal	Year 1 of 3
Demonstrate active involvement and as a key decision maker by the Hospital's Community Benefits Committee and all required sector representation throughout the entire CHNA and CHIP process.	Three meetings were held throughout the process for active engagement on sources of primary and secondary data and identification of key stakeholders. In addition, to present and solicit input on key findings. Significant engagement took place on the development of the CHIP to include priority areas and target populations. The Committee has community representation with members who are racially, culturally, and ethnically diverse. In addition, the composition of hospital leaders and staff are from a number of different operational groups, as well as clinical and non-clinical areas.	Process Goal	Year 1 of 3
Demonstration by hospital leadership for support for the Implementation Strategy.	CHNA was presented at the July 2021 Board of Trustee meeting. CHIP was presented at the December 2021 Board of Trustee meeting. Board members asked questions and gained a better understanding of the process and the content of the findings. The Board fully endorsed the Implementation Plan.	Process Goal	Year 1 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	Social Environment,
Health Issues	Cancer-Breast, Cancer-Colorectal, Cancer-Lung, Chronic Disease-Cardiac Disease, Chronic Disease-Overweight and Obesity, Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Physical Activity, Injury-Other, Maternal/Child Health-Reproductive and Maternal Health, Other-Cultural Competency, Other-Emergency Preparedness, Other-Senior Health Challenges/Care Coordination, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Education/Learning, Social Determinants of Health-Homelessness, Social Determinants of Health-Income and

	Poverty, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Nutrition, Social Determinants of Health-Public Safety, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of Health-Violence and Trauma, Substance Addiction-Alcohol Use, Substance Addiction-Opioid Use, Substance Addiction-Smoking/Tobacco Use, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** All, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Disability Status, Domestic Violence History, LGBT Status, Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
Health Resources in Action	www.hria.org

Determination of Need - Community Health Initiative

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	Determination of Need: Establish plans for addressing state-defined Health Priorities through Community-Based Health Initiatives (CHIs). Plans include creation of the an appropriately community-represented Advisory and Allocation Committees, setting health priority for funding, and funding distribution.
Program Hashtags	Prevention,
Program Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
The Community Statewide Initiative extends the CHI program across the Commonwealth, addressing the historic realities that availability of CHI resources is uneven throughout the Commonwealth. The three primary purposes: 1. To provide local grants for Health Priority strategies and policy action in areas of the Commonwealth historically underserved by DoN CHI resources; 2. To provide support for regional and collaborative CHIP) processes across the Commonwealth; and, 3. To fund tools and resources to support system-wide and local evaluation of CHI programs.	According to DON-CHI requirements, $708,084. was disbursed into the statewide initiative fund.	Process Goal	Year 1 of 3
The Hospital and engaged-community, participate in a transparent and public process in selecting and distributing DON-CHI funds	Newton-Wellesley Hospital (NWH), awarded a $1.9 million grant to WATCH Community Development Corporation (WATCH CDC) and MetroWest Collaborative Development (Metro West CD) to address housing insecurity in the communities surrounding the hospital. WATCH CDC, located in Waltham, and Metro West CD, located in Newton, will collaborate to reduce inequities in housing security of low-income tenants, particularly among communities of color and immigrant communities in Natick, Needham, Newton, Waltham, Wellesley, and Weston. NWH identified housing insecurity as the focus of its Community-Based Health Initiative (CHI) following a comprehensive review of critical needs in the area, in collaboration with an Advisory Committee comprised of key community stakeholders. Through this four-year grant, beginning in October 2021, NWH will invest $1.9 million into the WATCH CDC and Metro West CD collaborative, which will build on existing case management-based housing clinics, with particular emphasis on reaching out to and serving low-income and immigrant tenants. The collaborative will also heighten awareness of the mental health needs of clients experiencing housing insecurity, with the assistance of a mental health consultant, and provide emergency financial assistance at its clinics. In addition, the collaborative will hire a Job and Financial Planning Coordinator to mentor clients to greater financial self-sufficiency. Both organizations will work to expand the stock of affordable housing and increase protections for tenants through community organizing and advocacy. Given the DON process timeline, funding is not being disbursed until next fiscal year.	Outcome Goal	Year 1 of 3
"Foster a successful CHI process that	Established an Advisory Committee and Allocations Committee that was diverse so as to reflect the larger community. Many members included those on the NWH Community Benefits Committee as well as the DPH required sectors were		

includes robust community engagement, transparency in decision-making, accountability for planned activities, and demonstrable community health impact. "	represented. The combined work of these committees established the CHI health priority and strategy. In making these decisions, the committee reflected and incorporated what had been identified in the most recent NWH CHNA and NWH CHIP. They also considered the DON Health priorities and the EOHHS/DPH Focus Issues. The Committee developed funding parameters and processes, reviewed proposals and made the final selection for a grantee. The Committees met for a total of seven times during the process.	Process Goal	Year 1 of 3

EOHHS Focus Issues	Housing Stability/Homelessness,
DoN Health Priorities	Housing,
Health Issues	Health Behaviors/Mental Health-Mental Health, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Income and Poverty, 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
Umass Donahue Institute	www.donahue.umass.edu
Massachusetts DPH	Not Specified

Direct Outreach/Health Navigation

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	No
Program Description	NWH facilitates access to providers and resources for patient needs. NWH regularly convenes community health departments, community agencies and higher education institutions to engage in discussion and strategy development for improved access to healthcare.
Program Hashtags	Community Education,
Program Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Convene a Senior Living Community Forum for local assisted living and independent living, and as appropriate, long term care facilities. Provides an opportunity to share content expert information, relay best practices and align services.	Four Senior Living Forums were held this year with approx. 25 attendees at each Forum. Forum has multidisciplinary leadership with the Chief Medical Officer, Medical Director, Physician Health Organization, Case Management, Population Health, and Community Benefits. Topics have included Guardianship, and Delirium in Older Adults.	Process Goal	Year 1 of 3
Make appointments for those in need of accessing clinical services for either primary or specialty care.	In FY21, the hospital's Care Finder program facilitated scheduling appointments for patients in need of a physician or hospital service. Total year end call volume was 9012 calls (a 20% increase over FY20).	Outcome Goal	Year 1 of 3
Provide resources for assistance with basic needs related to patients' medical condition when no alternative option is accessible.	Provided assistance to 155 patients in the categories of food, lodging, technology, safety, and others. This was a 19% increase over FY 20 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 1 of 3
Collaborate with local health departments and other community agencies.	NWH convenes eight meetings per year with local health departments. Goals are to communicate challenges, share best practices, review services, and strategize solutions on access and types of care, in hospital and in community. Other community agencies are invited, as needed. Topics discussed include substance use, behavioral health, Covid-19 protocols, and safety. Having the structure already in place helped to facilitate ease of communication and solution building during the many Covid-19 surges. NWH Emergency Department data is provided on a quarterly basis to a wide array of community partners in the areas of top five diagnosis, overdose, and behavioral health to a wide array of community partners.	Process Goal	Year 1 of 3
Direct Newton-Wellesley Hospital engagement with community networks and coalitions for the purpose of information sharing and providing a hospital liaison.	Consistent clinical and administrative hospital leader representation and active engagement at the Waltham Interagency Network, Needham Community Crisis Intervention Team, Waltham Homeless Assistance Coalition, Waltham and Newton Chambers of Commerce and others. This was of particular importance over the past few years in order to inform of Covid-19 trends and protocols . On the reverse, the hospital was successfully able to more fully understand the challenges	Process Goal	Year 1 of 3

	being experienced in the community. It was often sited that for the hospital to be present in this way was impactful in furthering and developing relationships with the community.		

EOHHS Focus Issues	N/A,
DoN Health Priorities	N/A,
Health Issues	Health Behaviors/Mental Health-Mental Health, Other-Senior Health Challenges/Care Coordination, 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:** Disability Status, Domestic Violence History, Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
2Life Communities	Not Specified
Benchmark Senior Living	Not Specified
CareOne	Not Specified
LaSell Village	Not Specified
Natick Department of Public Health	Not Specified
Needham Police Department	Not Specified
Needham Public Health	Not Specified
Newton Health and Human Services	Not Specified
Newton-Needham Chamber Commerce	Not Specified
Scandinavian Living Center	Not Specified
Waltham Health Department	Not Specified
Waltham Police Department	Not Specified
Waltham West Suburban Chamber of Commerce	Not Specified
WATCH CDC	Not Specified
Wellesley Health Department	Not Specified
Weston Health Department	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 service and resources to City of Newton employees.
Program Hashtags	Prevention, Support Group,
Program Contact Information	Amy Ryals, Director, Human Resources

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 1 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 1 of 3

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	N/A,
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:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
CMG Associates	www.cmgassociates.com
Newton Health and Human Services	Not Specified

Fall Prevention Among Community Seniors

Program Type	Direct Clinical Services
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 FY21, the The Matter of Balance Program served 40 participants for a total of 1,875 since inception in 1997.	Outcome Goal	Year 1 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.	Strength and Balance classes held twice per week with 25 attendees per class. Held virtually and open to the whole community. Build confidence and tools for maintaining balance. Class creates a level of socialization and engagement among attendees.	Process Goal	Year 1 of 3
Conduct Tai Chi classes to promote balance. Provide an outlet for group interaction and socialization among seniors through Tai Chi.	Tai Chi class held once per week, virtually, open to the whole community. 25 attendees per class. Continued positive feedback from program participants. Has enable patients and caregivers to interact in new ways despite disease related conditions.	Process Goal	Year 1 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	N/A,
Health Issues	Chronic Disease-Alzheimer's Disease, Chronic Disease-Osteoporosis, Health Behaviors/Mental Health-Physical Activity, Injury-Other,
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
Waltham Council on Aging	Not Specified
Needham Council on Aging	Not Specified
Watertown Council on Aging	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
Wellesley Council on Aging	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	Community Education, Health Professional/Staff Training, Prevention,
Program Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide Interpreter Services to the Newton-Wellesley Hospital patient population.	Provided 12,974 completed Interpreter Service requests, including face-to-face, telephonic, video, ASL. A 20% increase over FY20.	Outcome Goal	Year 1 of 3
Ensure that Interpreter Services are available in all areas of the hospital.	Introduced a mobile video platform for interpreter services expanding access and efficiency of service. Increased the number of devices to 30. Also provides a video option for American Sign Language. Overwhelming positive feedback form the staff, providers, patients, and families. The top five hospital departments utilizing interpreter services were Emergency (3756 - completed interpreter requests), Medicine, Surgery, Cardiology and Urgent Care Walk-In.	Process Goal	Year 1 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.	Nursing Education continued to train all new staff in the areas of interpreter resources. Implementation and training for staff on New Audio/Video IPAD technology for patients took place in all patient care areas, inpatient and ambulatory, as well as off-site locations. Reference and resource materials were provided to areas.	Process Goal	Year 1 of 3
Provide patient information documents in translated languages.	Provided translated documents for: discharge instructions, patient rights, menus, patient education, and patient guidebook. Through system-wide efforts, the patient portal has also been made available in multiple languages. Assessment in clinical areas with high multi-lingual patient populations is on-going to translate needed patient materials. NRC Patient Satisfaction Surveys, currently sent out in the following languages: English, Spanish, Khmer, Arabic, Haitian Creole and Chinese. In December 2021, two interpreter questions were added to all of Mass General Brigham's patient experience surveys: (1) Patients will first be asked if they needed an interpreter, and then (2) If they got an interpreter when they needed it. For the community, materials on Covid-19 and flu were translated in to multiple languages.	Process Goal	Year 1 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	N/A,
Health Issues	Social Determinants of Health-Access to Health Care, Social Determinants of Health-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/
Language Line Solutions	www.languageline.com

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	Community Education, Prevention, Support Group,
Program Contact Information	Buffy Sheff-Ross, Clinical Social Worker, LICSW

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. Over 1000 patients have been referred to the PMAD social worker since the program began in May 2019. On average, receiving 28-50 new patients monthly, communicating with 30 plus patients a week. Successfully shifted to virtual visits during Covid-19 and has returned to hospital-based office in October.	Outcome Goal	Year 1 of 3
Extend the post-partum screening tool further after pregnancy.	Collaboration with 3 OB practices using The Edinburgh Postnatal Depression Scale to screen pregnant and postpartum patients between 24-28 weeks prenatally, 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 28 hours.	Process Goal	Year 1 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. Reason for referral are not just for anxiety and depression, but also include fetal demise, elective termination, substance use, domestic violence, homelessness, unplanned pregnancy, and traumatic delivery. Expanded relationship with community partners for collaboration of resources and support services.	Outcome Goal	Year 1 of 3
Provide on-going methods of support for maternal patients.	Group support sessions conducted twice per week (virtually during Covid-19) for new moms. Held by NWH mid-wife. Open and general discussion as well as specific topic areas with content experts, i.e., pediatric dentistry, sleep deprivation, nutrition, etc. Approx. 11 new moms attend each session. Extremely positive feedback from participants for the impact of having a support resource. "Having a virtual community of moms that are sharing what they are going through helped me survive mentally when I was isolated with a newborn in a pandemic. It gave me community, comfort, helpful advice, and something to look forward to each week as a new mom in the trenches with a new baby.	Outcome Goal	Year 1 of 3
The Maternity Services Council, within the Collaborative for Healthy Families & Communities (CHF&C), is focused on improving Maternity Services during pregnancy and after delivery with a special mission to increase awareness and improve treatment of pregnancy-related depression.	The Maternity Services Council is comprised of 25 hospital and community members and meets 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 1 of 3
Provide opportunities for community education on post-partum depression and maternal wellness.	Held three community-wide webinars. 112 attendees. The Collaborative Council continued to expand presence on the web for on-going education and information sharing.	Process Goal	Year 1 of 3

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	N/A,
Health Issues	Health Behaviors/Mental Health-Mental Health, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy,
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:** Not Specified

Partners:

Partner Name and Description	Partner Website
Jewish Family & Children's Services	https://www.jfcsboston.org/
MCPAP	https://www.mcpapformoms.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. CACs also provide financial estimates for services.
Program Hashtags	Not Specified
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 FY21, 2 NWH CACs contributed to the estimated 65 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

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	Mayor Walsh's Summer Jobs Program provides jobs to BPS students at BWH, BWFH, MGH, NWH, and SLM.
Program Hashtags	Not Specified
Program Contact Information	Lauren Lele, Senior Director, Community Health 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 Lasell University, focused on career exploration for healthcare careers the included clinical and non-clinical positions, and those with varied levels of education and financial commitment. The interns also had an on-site tour and interactive session in the NWH Simulation Center, Fitness Center, and a Q&A with hospital leadership. The program also included enrollment in a choice of two courses that were held virtually, enabling the interns to earn college credits. The third component of the program was a series of skills building workshops.	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:** Waltham, • **Environments Served:** All, • **Gender:** All, • **Age Group:** Teenagers, • **Race/Ethnicity:** All, • **Language:** English, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Lasell University	www.lasell.edu
Waltham Partnership for Youth	https://www.walthampartnershipforyouth.org/

Nutrition Security and Equity

Program Type	Total Population or Community-Wide Interventions

Program is part of a grant or funding provided to an outside organization	No
Program Description	According to the Greater Boston Food Bank, food insecurity across Massachusetts increased by 55% from 2019 to 2020. The connection between food security and nutrition-related chronic diseases is the reason Mass General Brigham system institutions will create food security partnerships for capacity building. Since the pandemic the numbers of households being served through local food pantries and partnership efforts in the Newton-Wellesley service area have doubled, and tripled in need. These include to low-income households and ethically diverse residents, and to many of Newton-Wellesley's target populations of youth, seniors, and recent immigrants.
Program Hashtags	Community Education, Prevention,
Program Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Convene community partners on aspects of nutrition security and equity. Representation on community organizations focused on food access.	Representation on the Newton Food Pantry Advisory Board. Began discussions with the Newton Health and Human Services to convene a food access work group. On-going partnership with Healthy Waltham.	Process Goal	Year 1 of 3
Focus on the following three goals: 1. Support and expand existing commitment to food access 2. Build and support capacity and partnerships with internal and external organizations working to expand food access 3. Improve geographic reach of food access partnerships	A total of $100,000 grant funding awarded by Mass General Brigham Community Health to organizations in the local Newton-Wellesley hospital service area. 1. Waltham Boys and Girls Club: Year long meals and weekend packs for 1,200 youth during school, breaks, summer 2. Heathy Waltham: Provision of food for 2,000 families for Summer 2021 3. Newton Food Pantry: Gift card program (groceries, diapers, kid friendly snacks) for 500 households	Outcome Goal	Year 1 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	Social Environment,
Health Issues	Chronic Disease-Cardiac Disease, Chronic Disease-Diabetes, Chronic Disease-Hypertension, Chronic Disease-Overweight and Obesity, Health Behaviors/Mental Health-Mental Health, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Income and Poverty,
Target Populations	• **Regions Served:** Newton, Waltham, • **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
Centre Street Pantry	Not Specified
Healthy Waltham	Not Specified
Newton Community Senior Center	Not Specified
Newton Food Pantry	Not Specified
Newton Health and Human Services	Not Specified
Waltham Boys and Girls Club	Not Specified
Waltham Public Schools	Not Specified

NWH Community Collaborative

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 NWH Collaborative works within communities. Grounded in an ongoing assessment of priority needs, it brings an unrelenting focus to lessening healthcare disparities, strengthening the social fabric of support, and empowering residents to lead healthier lives. Its extensive programs are led by eight strategic councils, each dedicated to addressing community needs and the underlying social determinants of health. Their work embraces education, advocacy, engagement, and targeted programmatic initiatives. From the start, the Collaborative's success has grown from the leadership of passionate volunteers, the expertise of NWH staff and community partners, and the generosity of our community of donors.
Program Hashtags	Community Education, Health Professional/Staff Training, Health Screening, Mentorship/Career Training/Internship, Prevention, Support Group,
Program Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330

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 Community Collaborative. The multi-pronged approach includes the development of a community-oriented clinical programs, community educational programming, and community engagement through council involvement. The Collaborative leadership includes a Director, and a program outreach manager. Council leadership is a dyad model with a community champion and a hospital-based clinical champion. All 8 councils have community champions. Six of the eight councils have well-established clinical champions. Two councils are in the process of establishing their champions.	Process Goal	Year 1 of 3
Established Community Collaborative Councils that address identified health needs.	Maintain 8 community-focused councils: Cardiovascular Council, Domestic and Sexual Abuse Council, Elder Care Council, Maternity Services Council, Palliative Care Council, Resilience Project Council, Substance Use Council, Workforce Development Council.	Process Goal	Year 1 of 3
Involve community in the NWH Community Collaborative.	Each council has approximately 20 members with a total of 160 community members involved across all 8 councils. These community members include those who have expertise on the subject for their council as well as those passionately engaged on the focus area. Chairs or Co-Chairs for each of the councils are community members. Each Council meets four time per year.	Process Goal	Year 1 of 3
Provide community programming and education through the Community Collaborative.	Each Council conducts community programming to provide 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 22 events held with over 1440 individuals who attended the Council programs.	Outcome Goal	Year 1 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 expansion of access to palliative care in inpatient and 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 access to supports for victims of abuse; the Elder Care Services Council focused on addressing fall prevention and social isolation; 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 1 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	Social Environment,
Health Issues	Chronic Disease-Cardiac Disease, Health Behaviors/Mental Health-Mental Health, Maternal/Child Health-Reproductive and Maternal Health, Other-Senior Health Challenges/Care Coordination, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Education/Learning, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Violence and Trauma, Substance Addiction-Opioid Use, 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:** Domestic Violence History, LGBT Status, Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

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 preventive health initiatives through webinars, in-person events, fairs, and screenings. The topics and events are often within the scope of the 8 councils of the Community Collaborative. Many of the health awareness programs are conducted in partnership with community organizations. Additional health promotion education is conducted on topics such a senior living, health and sports, heart health, cancer, nutrition, diet and other topics. **Program Hashtags** Community Education, Health Screening, Prevention, **Program Contact Information** Kim Gerard, Manager, Community Outreach; 617-243-6792 **Program Goals:**

Goal Description	Goal Status	Goal Type	Time Frame
Conduct community flu clinics.	In FY21, NWH administered 556 flu vaccines. Six clinics were held at flu clinics held at the NWH Ambulatory Care Center, 159 Wells Ave Newton, and 2 clinics were held at the Healthy Waltham Food Pantry on-site location. Promotion of the flu clinics located in Waltham were communicated in Spanish.	Outcome Goal	Year 1 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	Process Goal	Year 1 of 3

	agencies.		
Support local initiatives that promote health and wellness.	NWH had various levels of staff participate in education and wellness programs held by community organizations. Topics ranged from mental health, Covid-19, senior wellness, and others.	Process Goal	Year 1 of 3
Provide a source of health education and socialization for local seniors in the community.	Held 5 virtual senior events with focuses on exercise, staying healthy and safe and home, dealing with loneliness and loss and navigating the Covid-19 pandemic. 445 seniors attended. Also held ongoing virtual group fitness classes including tai chi, stretch and strengthen and balance classes. 115 participants.	Outcome Goal	Year 1 of 3
Provide health awareness and disease prevention programs.	In FY21, NWH conducted 3 virtual screening education events for the community, including breast cancer, lung cancer and skin cancer screening events. In-person screening events were not held due to Covid-19. Covid-19 specific educational forums were held for community seniors, parents, and others to inform them about the pandemic, explain proper protocols, and to explore next steps. Post- sessions, resource materials were sent to program attendees for further detail on follow up care.	Outcome Goal	Year 1 of 3

EOHHS Focus Issues Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, **DoN Health Priorities** N/A, **Health Issues** Cancer-Other, Chronic Disease-Cardiac Disease, Chronic Disease-Diabetes, 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-Homelessness, 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:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Natick Department of Public Health	Not Specified
Natick Senior Ceneter	Not Specified
Needham Council on Aging	Not Specified
Needham Public Health	Not Specified
Newton Community Senior Center	Not Specified
Newton Health and Human Services	Not Specified
Newton Public Schools	Not Specified
Waltham Council on Aging	Not Specified
Waltham Health Department	Not Specified
Waltham Public Schools	Not Specified
Wellesley Health Department	Not Specified
Wellesley Senior Center	Not Specified
Weston Health Department	Not Specified

Program Type Total Population or Community-Wide Interventions **Program is part of a grant or funding provided to an outside organization** No **Program Description** As a community hospital, we view our investment in research as an investment in our patients and that of greater community. Our ability to engage in innovative, cutting-edge research means that we are able to offer access to an array of clinical trials, which helps advance the practice of medicine and improve overall care and outcomes. **Program Hashtags** Research, **Program Contact Information** Maureen Dwyer, Director, Office of Clinical Research **Program Goals:**

Goal Description	Goal Status	Goal Type	Time Frame
Conduct research studies related to Covid-19 to explore the safety, effectiveness of treatments.	Conducting 7 research studies related to Covid-19. Various treatment are being explored through the studies as well as studies related to the rate of disease progression for Covid-19 patients.	Process Goal	Year 1 of 3
Conduct research in the area of innovation in health.	Research to determine if education and exercise for joint replacement surgery remotely guided by the mymobility mobile telehealth application paired with the Apple Watch is just as good, or better, than current standard education and outpatient physical therapy after joint replacement.	Process Goal	Year 1 of 3
Conduct research related to chronic diseases.	Study being conducted to look at if adding another drug to the medical care that people with heart failure are already receiving could better control heart failure.	Process Goal	Year 1 of 3

EOHHS Focus Issues Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, **DoN Health Priorities** N/A, **Health Issues** Chronic Disease-Cardiac Disease, Health Behaviors/Mental Health-Mental Health, Infectious Diseaseâ€"COVID-19, **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
Not Specified	Not Specified

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, Prevention, **Program Contact Information** Lauren Lele, Senior Director, Community Health and Volunteer Services; 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.	Transitioned senior socialization outlets to occur virtually. Created a "community" for those who attended to ask questions and have conversation around health topic areas. In FY21, program topics included home safety, nutrition, neurological changes, heart health, and Covid-19.	Process Goal	Year 1 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. Transitioned to virtual and expanded access to a larger number of individuals to participate. The Matter of Balance Program resumed this year. Tai Chi session held once a week. All seniors in any of the six NWH communities had the opportunity to participate. Promoted through the Senor Centers.	Process Goal	Year 1 of 3
Provide opportunities for physical exercise and wellness.	The NWH Wellness Center shifted all exercise and wellness programming to be free of charge to the community over a virtual platform. All programs are specifically geared to the senior community. Six classes are offered per week. Approximately 150 class participants per week.	Process Goal	Year 1 of 3
The Elder Services Council, within the Newton-Wellesley Community Collaborative, is focused on the socialization of elders as well as falls prevention.	The Elder Care Council is comprised of 23 hospital and community members. The Council was able to expand its community representation on the council and 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
Partner and support community efforts focused on Senior Wellness.	Collaborated with local senior centers, YMCA's, housing complexes, and others on health education and senior wellness activities. Focused on nutrition, mental health, advanced care planning, heart health and others.	Process Goal	Year 1 of 3

EOHHS Focus Issues N/A, **DoN Health Priorities** 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:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Natick Senior Ceneter	Not Specified
Newton Community Senior Center	Not Specified
Community Housing Facilities: 2lifecommunities; Newton Housing Authority	https://www.2lifecommunities.org/live-here/our-campuses/golda-meir-house; www.newtonhousing.org
Needham Council on Aging	Not Specified
Waltham Council on Aging	Not Specified
Wellesley Council on Aging	Not Specified
Weston Community Senior Center	Not Specified
YMCA of West Suburban - Newton Branch	www.wsymca.org

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, Support Group, **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	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		

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.	to our community partners to support their efforts of dealing with the opioid crisis. In FY21, NWH provided 174 doses of Narcan to local community partners, police and fire, public health, schools and shelters. Provided training to community partners, as necessary.	Outcome Goal	Year 1 of 3
Provide preventive substance use resources to ED patients and families.	In FY21, NWH dispensed 54 naloxone kits to patients in the Emergency Department with diagnosis of opioid overdose.	Outcome Goal	Year 1 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 1 of 3
Provide education on various forms of substance use.	Conducted two community wide lectures on alcohol use, impact with Covid-19, and the intersection of substance use and mental health 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. Additional education forums were provided to various organizations in the community. Numerous clinicians provided education to school programs with virtual audiences of youth, parents and educators.	Process Goal	Year 1 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. An annual substance use NWH medical grand rounds was held and open to the medical community. Additionally the following clinical education was presented: Medical Management of Addiction: a Pain Management Perspective; Co-managing Pain and Addiction: A Practical Approach for the Pain Care Provider; Care Considerations for our Patients with Opioid Use Disorder. NWH continues to offer Suboxone waiver trainings for Newton-Wellesley medical staff. The trainings are committed to helping clinicians to identify when Suboxone is appropriate and to help them to initiate, monitor and maintain treatment. The sessions are now being held four times a year, virtually, and include lectures, interactive case-based discussions, and patient presentations on their road to recovery. Since 2017, 273 care providers have participated in these waiver trainings.	Outcome Goal	Year 1 of 3
Provide resources to community partners for needed substances.	Provided 100 doses of Epipens to local fire departments and colleges.	Process Goal	Year 1 of 3
Use the hospital as a site to increase public awareness on the opioid epidemic and decrease stigma around substance use.	For the third 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. The Purple Flags were on display during September and October 2021 and coincided with the Boston Marathon which takes place in front of NWH. In addition to the annual remembrance event, this brought additional awareness to the need for reducing stigma associated with substance use. Two of the SUS CLinic clincal leaders ran the marathon in support of raising awareness for substance use.	Process Goal	Year 1 of 3
Provide care to substance use patients in the SUS clinic.	SUS front-line clinicians (MD's, PA, Recovery Coach and Social Worker) completed 2465 patient visits (5x the number seen in 2018). Patients were referred by NWH primary care (31%), inpatient Hospitalist service, and emergency department (60%) clinicians. Patients presented with alcohol disorder (70%), opioid disorder (13%).	Outcome Goal	Year 1 of 3
Collaborate with various local multi-community, and state-wide agencies to address the opioid crisis.	In FY21, 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 Attorneys 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 1 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 20 community and hospital members, represent both clinical and societal perspectives. The Council meets four times per year and focuses on key initiatives that further ways to provide critical services at the time of greatest impact. These initiatives currently include expansion of recovery coaches and psychiatry clinical expertise, and embedding treatment and preventive care throughout our community with enhanced primary care provider support and training.	Process Goal	Year 1 of 3

Increase resources for primary care physicians to address substance use issues in patients.	Numerous hospital-wide efforts continue around safe opioid prescribing under the direction of medical leaders and are championed within Primary Care leadership. These activities include the NWH Opioid Advisory Committee which works to monitor opioid prescribing patterns to help identify and support NWH clinicians needing additional support, standardized post-surgical opioid prescribing guidelines, and one-on-one PCP outreach to support chronic pain and substance use patients with physician-led support.	Process Goal	Year 1 of 3
Provide support options for those experiencing substance use addiction.	Recovery Coach conducted twice weekly group support sessions (one virtual, one in-person). 88 groups have been held in FY21. There is, on average, 10 people per group who are between the ages of 25 to 83 years old.	Outcome Goal	Year 1 of 3

EOHHS Focus Issues Substance Use Disorders, **DoN Health Priorities** N/A, **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
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
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 Public Schools	Not Specified
SOAR Natick	www.soarnatick.org
West Suburban YMCA	https://www.wsymca.org
Natick Public Schools	Not Specified

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. **Program Hashtags** Prevention, **Program Contact Information** Jospehine Pang, Manager, DSV Program **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 FY21, the program served over 778 distinct survivors of violence and abuse. This is a 48% increase from FY19 and shows consistent increases in the demand for services from FY20. Staff not only saw a significant increase in demand for direct services, but also in complexity, lethality, and acuity within the demand.	Outcome Goal	Year 1 of 3
Expand Domestic Violence services in the community and to Spanish-speaking, immigrant survivors of partner abuse.	In FY21, NWH was able to resume providing REACH Beyond Domestic Violence with a $50,000 grant to better serve Latinx survivors of abuse and their children. Of the 300-400 families that REACH works with per year, approx. 100 are new in any given year. More than half of the total number of survivors/heads of household are Latina most with relatively recent and extremely traumatic immigration experiences.	Process Goal	Year 1 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 FY21, 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 1 of 3
	In FY21, the program continued collaboration with REACH Beyond Domestic Violence and Greater Boston Legal Services to directly serve over 175 Latinx survivors in Waltham. In addition,		

Grow accessibility for Latin, Spanish-speaking, and, in particular, undocumented survivors (who are disproportionately at risk).	the partnership assisted over 60 survivors to apply for U Visas and Asylum based on violence they experienced in their home countries or while in the US while also ensuring that families received emergency rental assistance, relocation assistance, utility assistance, and assistance with other basic needs such as food. 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. Additionally, with the generous support of NWH Community Benefits program, the DVSA program has continued to expand upon outreach efforts that began in FY19, when NWH provided $17,000 in emergency funding to victims for basic needs such as housing, rent, utilities, and food as well as Covid-19 self-care informational materials in multiple languages.	Process Goal	Year 1 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. In FY21, 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. During FY 21 NTC staff/MA SANE has applied to be on a DOJ/OVC Technical Assistance (TA) grant to support the development of 10 new national SANE Programs that will also be funded by DOJ/OVC. Ten MA Hospitals that are currently receiving TeleSANE services: 1. Marthas Vineyard Hospital, 2. Nantucket Cottage Hospital 3. North Shore Medical Center 4. Baystate Franklin Medical Center 5. Good Samaritan Medical Center 6. Metrowest Medical Center 7. Athol Hospital 8. Sturdy Memorial Hospital 9. Beverly Hospital 10. Saint Annes Hospital NTC is still in a partnership with Hopi Health Care Center, although their SANE Program has not been operational during the the Covid-19 pandemic.	Process Goal	Year 1 of 3
	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 because of COVID. Program staff facilitated Transforming Trauma Support Group, a skill-building group for survivors of violence abuse that offered psychoeducation regarding the impact of trauma on mind, body, and spirit as well as opportunities to practice mindfulness, embodiment, and grounding exercises. Program Staff supported the work of FORGE (national anti-violence organization that offers education and technical training to address the needs of transgender and non-binary individuals) and MenHealing (national organization providing help for male survivors of sexual assault, sexual abuse, and sexual trauma during childhood or as adults) to launch Voices of Healing: Trans & Nonbinary Survivors SPEAK OUT. The event will utilize expressive arts to showcase diverse stories of survivorship and healing from trans and nonbinary survivors who have experienced any kind of sexual victimization. DVSA program partnered with TSS to offer two online nutrition groups in in the community one for trauma survivors, and another for trauma workers. DVSA program partnered with TSS to offer a 6-month trauma-informed yoga group for survivors of violence, abuse, and trauma in the community. 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		

Work to build options for support and empowerment groups through alternative modalities.	mothers with substance use disorders. Approximately 90% of the participants there have experiences of severe violence and abuse. Program staff co-facilitated a 5-week, Spanish-language Expressive Flamenco pilot group using body modalities to address immigration trauma, racism, partner and sexual abuse with the Latinas Know Your Rights Project. Program staff co-facilitated a 10-week, Spanish-language virtual leadership and empowerment workshop for survivors of domestic abuse. Topics included: What is a Leader?, DV: What is it? And What Can You Do to Help?, DCF: Who Are They and What Do They Do?, Employees Rights, Legal Systems and the Courts, Immigration Update: DACA, Immigration Remedies for Survivors of Violence & Abuse, Family Courts and Public Benefits, Parenting and Coping with Stress. Program staff became trained as a Men Healing clinical team member and joined The Weekend of Recovery (WOR) and Day of Recovery Facilitator Team. WOR clinicians are highly skilled trauma clinicians, utilizing current ethical and best practice evidence-based standards of trauma treatment. Weekend of Recovery retreats are three-day healing workshops for male survivors of sexual abuse, sexual assault, or sexual trauma as a child or as an adult. DVSA program supported MenHealing with obtaining $2,500 grant from NWH Community Benefits to fund a pilot program to support programming and curriculum building aimed to support partners, family, and friends of male survivors. 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 1 of 3
The Domestic and Sexual Abuse Council, within the Community Collaborative, is focused on enhancing access for survivors who face linguistic and cultural barriers and providing increased awareness and education on domestic and sexual abuse.	The Domestic and Sexual Abuse Council, comprised of 20 members, meets four times per year. The Council has been instrumental in disseminating emergency resources to victims of abuse and reacting to partner needs.	Process Goal	Year 1 of 3

EOHHS Focus Issues N/A, **DoN Health Priorities** Violence, **Health Issues** Health Behaviors/Mental Health-Mental Health, Injury-Other, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Violence and Trauma, Substance Addiction-Alcohol Use, **Target Populations**

- **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston,
- **Environments Served:** Suburban,
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Additional Target Population Status:** Domestic Violence History, LGBT Status, Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
Boston Area Rape Crisis Center	http://www.barcc.org/
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/
Massachusetts DPH	Not Specified

Program Type Total Population or Community-Wide Interventions **Program is part of a grant or funding provided to an outside organization** Yes **Program Description** Cultivating and developing job skills and providing access to employment can lead to opportunities for economic growth and individual and community well-being. 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, Senior Director, Community Health and Volunteer Services; 617-243-6330 **Program Goals:**

Goal Description	Goal Status	Goal Type	Time Frame
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. Focused on both clinical and non-clinical roles and innovation in healthcare. Held virtually due to Covid-19. 220 student volunteers attended the sessions each week.	Outcome Goal	Year 1 of 3
	Hired 18 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.		

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.	The format of the program was innovatively re-designed due to Covid-19 . Through a partnership with Lasell University the students were enrolled in one of two courses: Health Psychology and Foundation Health Professions . All 18 students 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. For the entire WPY intern program (100 interns), 43% were from low or lower income households, and 65% were of non-white race and ethnicity.	Outcome Goal	Year 1 of 3
Support on-going youth work force development initiatives in the community.	Continued sponsorship for the Career Exploration and Training Coordinator at the Waltham Partnership for Youth. Position is responsible for the placement, training, and development of over 100 summer interns (a 56% increase over FY20) in the City of Waltham as well as conducting the Teaching for Social Justice curriculum and additional youth development initiatives for Waltham youth.	Process Goal	Year 1 of 3
Provide work-skill based opportunities for students and adults through the NWH vocational volunteer program.	Provided structure for individuals, both adult and youth, in vocational programs with separate, on-going, placement opportunities to learn, practice and be exposed to workplace skills. NWH Volunteer Services maintained affiliation with 20 schools and organizations despite the suspension of on-site services due to Covid-19.	Outcome Goal	Year 1 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 55 attendees. Made available to high school students, adult learners, NWH employees, and school guidance counselors. A keynote speaker, and career focused 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. 10 staff participated in the sessions.	Process Goal	Year 1 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 1 of 3
The Work Force Development Council, within the Newton-Wellesley Community Collaborative, focuses on expanding potential career options, through training, education and career development. Providing opportunities for both youth and adults to enhance family financial security and, importantly, provides a ready pool of talent for local businesses. A strong local economy can positively and more broadly impact health and wellness.	The Work Force Development Council, comprised of 25 community and hospital members, meets four times per year and focuses on key initiatives that include Waltham summer youth intern program, student and community exposure to healthcare careers across all levels, and opportunities for building career-based networks. The goal is for the hospital to serve as a career hub, through collaborations and partnerships that can provide opportunities for youth to enhance family financial security. Identified a WFD Community Chair with professional expertise in work force development based in the community college level.	Process Goal	Year 1 of 3
Form partnerships to promote youth development and leadership skills.	Partnered with SparkShare as a community facilitator with a goal of empowering young people to be change agents in their communities and in their own lives by listening, connecting, and building partnerships. Participated in two SparkShare mini-Summits and participated in multiple planning sessions to created content development to optimize youth engagement.	Process Goal	Year 1 of 3
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. 12 new bilingual teens were trained as interpreter liaisons by Cross Cultural Communications, Inc. Both Spanish and Haitian-Creole translation were part of this years program. A translation (writing) training course was also part of the program. The 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 15 teens were hired at 10 events throughout the year. Allows outreach events to occur at locations with culturally and linguistically diverse venues.	Outcome Goal	Year 1 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. From a student participant: R. completed the Interpreter training during the Fall of 2020 during the pandemic and it has been incredible to watch confidence build during such a difficult time. In R. words, "I struggled a bit at first because interpreting is not as easy as it seems, but now I can confidently say that I am ready for anything. The experience has been amazing and I would definitely recommend it!"	Process Goal	Year 1 of 3
Engage with local school districts on opportunities to expand and think innovatively on the intersection of work place/career exposure and academic curriculum.	Newton-Wellesley staff representatives on the Waltham High School Health Assisting Program Advisory Committee Meeting and the Waltham High School School to Career Work Team.	Process Goal	Year 1 of 3

EOHHS Focus Issues N/A, **DoN Health Priorities** Employment, **Health Issues** Social Determinants of Health-Income and Poverty, **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
Waltham Partnership for Youth	www.walthampartnershipforyouth.org
Newton Dept. Health and Human Services	www.newtonma.gov
SparkShare	www.sparkshare.org
Lasell University	Not Specified

Program Type Total Population or Community-Wide Interventions **Program is part of a grant or funding provided to an outside organization** Yes **Program Description** NWH's most recent Community Health Needs Assessment demonstrated that high school graduation rates among Waltham students are lower than that of other communities in the hospital's catchment area and of Massachusetts overall. The dropout rate in Waltham (3%) 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) Community Health Initiative (CHI) processes of Partners HealthCare System, Inc. Massachusetts General Waltham and Partners HealthCare System, Inc. Massachusetts General Physician's Organization Waltham **Program Hashtags** Mentorship/Career Training/Internship, **Program Contact Information** Kaytie Dowcett, Ex. Director, Waltham Partnership for Youth, Liz Homan, Assistant Superintendent, Waltham Public Schools, Lauren Lele, Sr. Director **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.	2021 marks the second year of a four-year grant to Waltham Partnership for Youth (WPY) to implement Wraparound Waltham. Designed as a multi-agency collaborative led by WPY, Wraparound Waltham (WAW) works in partnership with Waltham Public Schools to support newcomer students attending Waltham High School (WHS). Wraparound Waltham aims to: -Support newcomer students who are primarily Spanish-speaking from Latin America -Provide non-academic supports to students fostering community, connection, and belonging -Increase access to mental health support, basic needs supports, legal support, and other resources -Increase high school persistence and graduation among newcomers. Wrap Around Waltham, the Collaborative grantee comprised of five identified community partners (Waltham Partnership for Youth, Waltham Boys and Girls Club, Childrens Charter, The Right to Immigration Institute, Doc Wayne) work collaboratively with Waltham Public Schools for student referrals. Status: - 37 students received WAW services in 2020-2021. 100% of these students were Newcomers, Latin American and Spanish-speaking. - 35 of the 37 had a documented need for non-academic support at the time of referral. - 26 of the students were more fully active in WAW and had on-going connections with the Wraparound Coordinator and to community partners for on-going engagement and support. - Recognizing the importance of working with students as early as possible, 87% of these active students were referred while in 9th or 10thgrade. - Despite the impact of Covid, 100% of the active WAW students met with the Wraparound Coordinator during the Fall 2020 and Spring/Summer 2021. - During the Spring/Summer 2021, $68,000 was secured for Wraparound families to avoid eviction. - Support services received for 2021 were as follows: 39% - food; 42% - housing; 15% - wifi; 100% - community resources; 69% flex funds; 15% hygiene products - 22 of the 26 active WAW students advanced to the next grade level at the end of the academic year.	Process Goal	Year 2 of 4
The Wraparound Waltham student population of interest includes 9thand 10thgrade students at time of referral who are newcomers to the U.S. (did not attend elementary school in U.S.). The expectation is that most referred students are Spanish-speaking English Language Learners (ELL) from Latin America.	All active students during the 2020-2021 academic year were: 100% Newcomers, Latin American, and Spanish-speaking. Recognizing the importance of working with students as early as possible, 87% of active students were referred while in 9th or 10th grade.	Outcome Goal	Year 2 of 4
Referred students are newcomers likely to benefit from mental health supports and/or opportunities to socialize and form positive relationships with peers and adults. Students and their families or caregivers are also likely to face one	The COVID-19 pandemic significantly increased the case management needs of students and their families. Significant efforts were made to assist students and their families with applications for financial assistance for rent, utility bills, and basic needs. These efforts were particularly time consuming for those families that did not qualify for the Emergency Rental Assistance Program. Throughout the 2020-2021 academic year,		

or more of the following: - Housing or food insecurity - Economic pressure to work, - Lack of basic needs or transportation, - Lack of access to healthcare services, - Legal issues related to immigration status	active Wraparound students received housing and financial assistance, as well as assistance accessing food, WiFi and hygiene products. Needs for assistance changed over the course of year as the pandemic wore on. While the need for food and hygiene products declined from fall to spring, the need for housing and flex fund assistance increased, as did the focus on connecting students to community resources. During the Spring/Summer 2021, WPY helped secure $68,000 for Wraparound families to avoid eviction.	Process Goal	Year 2 of 4
Once referred, the Wraparound Coordinator partners with ChildrenÃ¢â‚¬â„¢s Charter, Doc Wayne, Waltham Boys & Girls Club and The Right to Immigration Institute to provide students with non-academic supports, and the Wraparound Case Manager assists students with accessing community resources.	Doc Wayne: -23 of 27 active students in Fall 2020 participated in at least 1 Doc Wayne session -9 of 26 active students in Spring/Summer 2021 participated in at least 1 Doc Wayne session Childrens Charter: -14 of 27 active students in Fall 2020 participated in at least 1 Childrens Charter session -10 of 26 active students in Spring/Summer 2021 participated in at least 1 Childrens Charter session -6 students participated in one-on-one sessions with Childrens Charter in Fall 2020 and Spring/Summer 2021 The Right to Immigration Institute: -6 of 27 active students in Fall 2020 or their families received support from TRII -12 of 26 active students in Spring/Summer 2021 or their families received support from TRII	Outcome Goal	Year 2 of 4
Wraparound Waltham is a collaborative of educators and service providers, led by WPY, working to address disparities in high school graduation and dropout rates among Waltham students by providing individualized supports that address both the academic and non-academic needs of students and families.	22 of the 26 Wraparound students who were active in Spring/Summer 2021, advanced to the next grade level at the end of the academic year. 3 of the 26 Wrap Around students who were active in Spring/Summer 2021, graduated at the end of the academic year.	Outcome Goal	Year 2 of 4
Make impact in the lives of immigrant students and their families.	Wraparounds Holistic Approach to Supporting Advancement: Guidance counselors referred two Guatemalan boys (from a family of six) to Wraparound. They both participated in the virtual Childrens Charter and Doc Wayne support groups. During interactions with the head of the family, a number of critical needs were identified, including a history of domestic violence, unsafe and unstable housing, loss of income due to pandemic, and language and literacy issues. The eldest son, a WHS senior, planned to leave school to help his family. Through Wraparound, the student got individual support from Doc Wayne and the Wraparound Case Manager. The Wraparound Case Manager was able to find the financial resources to help the family with rent; obtain a pro bono lawyer to work with the landlord; got the Waltham Health Department involved to deal with a cockroach infestation; helped the mom get new P-EBT cards and SNAP benefits; and collaborated successfully with another community agency to move the family into public housing. In addition, the Case Manager successfully raised money to help the family buy a new refrigerator. In the end, the oldest child who wanted to quit school to help his mom, graduated from high school in June 2021.	Process Goal	Year 2 of 4
Adapt program in response to Covid-19.	COVID-19 pandemic resulted in school and business closures. This reality greatly affected the early development and implementation of this new initiative. As the pandemic wore on, Wraparound staff, experiencing their own pandemic challenges and stressors, witnessed the needs of students and their families intensify. At the same time, Wraparound partners had to develop strategies to create a welcoming and supportive environment for newcomer students without the benefit of being in space together. This was extremely difficult, particularly for those components of the program that rely on physical activity to build community and connection. As the 2020-2021 academic year continued to be virtual, Wraparound students became increasingly difficult to engage in group programming. In addition to the challenges of engaging and serving youth, Wraparound partners experienced a number of challenges to building a strong collaborative. Specific areas of challenge were: staff turnover and vacancies, means of communication and follow-up, and effective communication.	Process Goal	Year 2 of 4
Beginning in Fall 2021, Wraparound began a new approach to student engagement: the Welcome Class. In this approach, all newcomer students take a class as part of their school schedule. This class is designed to promote connections among newcomers, increase their ability to navigate Waltham High School, and raise awareness of school and community resources.	The Welcome Class accommodates 25 students and lasts eight weeks. During this block, which is co-facilitated by the WHS Academic Case Manager and the Wraparound Community Resource Navigator (formerly the Wraparound Case Manager), students are oriented to the school as a group using a structured and systematic approach. Students are introduced to Wraparound Partners and services through a panel presentation. The Welcome Class serves a vehicle for newcomer students to be referred directly to Collaborative partners and other community partners for services, as needed.	Process Goal	Year 2 of 4

The Welcome Class serves a vehicle for newcomer students to be referred directly to Collaborative partners and other community partners for services, as needed.	The Welcome Class: Increases the overall number of students supported by Wraparound. -Improves coordination with WHS through co-facilitation of the class. -Improves the process for developing Student Success Plans by completing them as part of the class. -Increases student awareness of and connection to community resources and Wraparound supports. -Creates a sense of community by creating -cohorts of newcomer students. The WHS Academic Case Manager completes regular 1-1 check-in meetings with students after they've completed the Welcome Class, to continue relationship building, monitor students' academic and non-academic progress, and refer students back to the Wraparound Community Resources Navigator if the student would benefit from additional services.	Process Goal	Year 2 of 4
Implementation of a Welcome Center at the Middle School.	The Welcome Center, open to students of any grade and their families, is based on a pilot program implemented in Spring 2021. The Center is designed to assist students and their families with navigating the school community and accessing community resources. Staffed by the Wraparound Community Resource navigator and school personnel, the Center offers Spanish-speaking students and their families a physical place to go for assistance with everything from accessing the school's online portal to enrolling in English language classes to obtaining referrals to community resources.	Process Goal	Year 2 of 4
Evaluation and progress monitoring of the Wrap Around Waltham Initiative.	UMASS Donahue Institute provides an annual program summary and on-going progress reports. *2020-2021 available for review.	Process Goal	Year 2 of 4

EOHHS Focus Issues N/A, **DoN Health Priorities** Social Environment, **Health Issues** Health Behaviors/Mental Health-Mental Health, Social Determinants of Health-Education/Learning, Social Determinants of Health-Income and Poverty, **Target Populations**

- **Regions Served:** Waltham,
- **Environments Served:** Suburban,
- **Gender:** All,
- **Age Group:** Teenagers,
- **Race/Ethnicity:** Hispanic/Latino,
- **Language:** Spanish,
- **Additional Target Population Status:** Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
Waltham Public Schools	www.walthampublicschools.org
Children's Charter	Not Specified
Doc Wayne	Not Specified
The Right To Immigration	Not Specified
Umass Donahue Institute Test	Not Specified
Waltham Boys and Girls Club	Not Specified
Waltham Partnership for Youth	www.walthampartnershipforyouth.org

Expenditures

Total CB Program Expenditure **$4,103,681.00**

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	$3,612,239.00	$968,224.00
Access/Coverage Supports	$491,442.00	$196,071.00
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	$228,685.00	
Mental Health/Mental Illness	$738,220.00	
Housing/Homelessness	$6,183.00	
Substance Use	$285,610.00	
Additional Health Needs Identified by the Community	$2,844,983.00	
Other Leveraged Resources	$1,630,436.00	

Net Charity Care Expenditures	Total Amount
HSN Assessment	$7,054,868.00
HSN Denied Claims	$77,459.00
Free/Discount Care	$437,617.00
Total Net Charity Care	$7,569,944.00

Total CB Expenditures:	$13,304,061.00

Additional Information	Total Amount
Net Patient Service Revenue:	$567,519,000.00
CB Expenditure as Percentage of Net Patient Services Revenue:	2.34%
Approved CB Program Budget for FY2022: (*Excluding expenditures that cannot be projected at the time of the report.)	$13,304,061.00
Comments (Optional):	In FY 21, Mass General Brigham and its member hospitals, in collaboration with Beth Israel Leahy Health (BILH), designed, built, and launched a new Community Benefits Reporting Tool (CBRT). The CBRT allows our teams and community partners to more accurately capture, track, and report data related to community benefits programs and initiatives. As part of our design and launch of the CBRT, the MGB and BILH teams undertook a multi-faceted quality improvement project to improve the alignment of definitions and categories for program expenditure reporting across our member hospitals; this may be a contributing driver for differences in trend with AGO reporting categories.

Optional Information

Hospital Publication Describing CB Initiatives:	Not Specified
Bad Debt:	Not Specified
Bad Debt Certification:	Not Certified
Optional Supplement:	As a result of the Needs Assessment findings in 2018 and 2021, NWH has concentrated a significant part of their community benefits initiatives on identified needs in our communities such as substance use and mental health. These have also included, very prominently, all aspects of social determinants of health and have resulted in initiatives and partnerships that address SDOH. For example, employment opportunities for youth with Waltham Partnership for Youth, expanded provider diversity and service with REACH Beyond Domestic Violence, addressing housing insecurity with WATCH CDC, and chronic disease prevention for seniors with our local Councils on Aging. The community engagement work at NWH is being conducted through an equity lens to react to at-risk populations from the perspective of immigrant status, and ethnic and cultural backgrounds. Further analysis of the demographics for who is vulnerable to food and housing insecurity is also a component for how NWH takes an equity approach to shaping community initiatives. For NWH, this has meant on-going concentration in Waltham given the social, economic and health challenges faced by that community over other geographies within the Newton-Wellesley service area. In addition, both Determination of Need grants have been awarded to community collaboratives specifically focused on inequities. Those have been in education - specific to graduation rates of Latino and new immigrant students; and housing with a specific focus on communities of color and immigrant communities. A portion of the funds, of the latter, will be dedicated to addressing upstream issues of housing insecurity rooted in systemic and cultural racism. We recognize that health and wellness concerns are present in all our communities, but in varying degrees. In creating new initiatives, seeking partnerships, and allocating resources, we engage with our community benefits committee and community partners to educate and help provide direction for how to carry out this work. For example, our engagement with the schools helps to direct youth mental health resources; with the public health departments guides our Narcan distribution program; and other collaborations drive food and healthcare access. This close collaboration and communication with our partners, as well as from the Community Benefits Commitee, and NWH Collaborative Councils is critical to the hospital understanding and reacting to make the greatest impact. The Program Narratives and Key Accomplishment sections of the Annual Report highlight the many ways that NWH engages with the community. Here are a few examples of that work: 1. Convening the Departments of Public Health with the goals of communicating challenges, sharing best practices, reviewing services, and strategizing on access. The collaboration has fostered a closer and more fluid relationship with our DPHs. In addition, NWH Emergency Department data is provided on a quarterly basis in the areas of the top five diagnosis, overdose, and behavioral health. 2. The Resilience Project incorporates NWH school teams into area high schools and middle schools for the purpose of consulting, professional development, parent programs, and community outreach. 3. Youth Summer Intern Program is a means for NWH to hire 20 high school Waltham youth into a variety of health care roles. In addition, a career exploration series is conducted for additional exposure. 4. The Community Collaborative - 8 distinct Councils (Cardiovascular, Domestic and Sexual Abuse, Elder Care, Maternity Services, Palliative Care, Resilience (youth mental health), Substance Use, Work Force Development). The Collaborative is grounded in an on-going assessment of priority needs. It brings an unrelenting focus on lessening healthcare disparities, strengthening the social fabric of support, and empowering residents to lead healthier lives.

5. Domestic and Sexual Violence Programs supporting a bi-lingual social worker in the community.
6. Determination of Need community engagement process for the Wrap Around Waltham Collaborative and the WATCH CDC/MetroWest Collaborative Development.
7. Covid-19: Newton-Wellesley continues to be a source for expertise and guidance on Covid-19 information and protocols. NWH, in collaboration with Mass General Brigham, has continued to provide multi-lingual resources for the community. NWH staff serve as a consistent voice on community committees, tasks forces and coalitions to speak to Covid-19 and overall hospital operations.

Newton-Wellesley Hospital has taken the initiative to convene and engage with organizations and individuals. This has allowed for robust exchange of information, sharing of best practices, and identified new opportunities for collaboration. We recognize the need to continue to diversify how we approach our engagement and to bring the community voice into all aspects of our work. Over the past year, we have also seen that compelling SDOH challenges are at the forefront for what the community currently faces (i.e., food, housing, employment). We will continue to partner and engage on these efforts to create advancement in the health and well-being of our communities.