Mass General Brigham
Newton-Wellesley Hospital

FY24 Community Benefits Report to the Massachusetts Attorney General

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@mgb.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):	Not Specified
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 (youth)	CDC Risk Behavior Surveys; MetroWest Youth Risk Behavior Survey; local community Youth Risk Behavior Surveys

Older Adults	Emergency Department data sources; local Senior Center community assessments; Town/City assessments.
Low Income	Community Health Needs Assessment; local Housing Department data; Food and Housing Insecurity data; Greater Boston Food Bank
People affected by domestic, family, or sexual violence	National, state, and local statistics
Substance Use Disorders	National, state, and local statistics; Community Needs Assessment data; Emergency Department data, SUS Clinic data
Immigrant	Community Needs Assessment data; Department of Public Health data, MA DPH, MA ORI, MA EOHS, Interpreter Services DPH report
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; local community assessments
People of color	Community Needs Assessment data; Department of Public Health data
SDOH and Chronic Health Conditions	Census data; DPH PHIT tool; CHEI Data resources, MGB SDOH screening dashboard; MA Disease Registry's

Publication of Target Populations: Annual Report, Website

Community Health Needs Assessment:

Date Last Assessment Completed:

NWH's CHNA was completed and approved by the Hospital Board in November 2022.

Data Sources:

Community Focus Groups, Consumer Groups, Hospital, Interviews, Other, Surveys, U.S. Census Bureau, County Health Rankings, Mass Disease Registry's, the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS), Massachusetts Department of Public Health, Community Foundation of MetroWest, the Massachusetts Department of Elementary and Secondary Education, the Federal Bureau of Investigation, and local community assessments - city/town, food pantry's, senior services, housing corporations.

CHNA Document: NWH CHNA REPORT 2022.PDF **Implementation**

Strategy:

Implementation Strategy Document: NWH STRATEGIC IMPLEMENTATION PLAN (SIP), 2022.PDF

Key Accomplishments of Reporting Year:

-Conducted three Senior Community Living Forums with Assisted Living Facilities and Independent Living Facilities with 25 attendees at each Forum.

-In FY24, the Domestic Violence/Sexual Assault Program at NWH provided free, voluntary, and confidential services to over 109 survivors of domestic, family, or sexual violence.

- Provided a $50,000 grant to REACH Beyond Domestic Violence to better serve the over half client population who are of Latina descent (400 clients served). Support to Men's Healing for program's dedicated to men of color who are survivors of sexual assault; and to Saheli for domestic and sexual violence for South Asian and Arab women.

- In FY24, NWH also launched a Coordinated Community Response (CCR): MetroWest Domestic and Sexual Violence Collaborative, a partnership with Journey to Safety, Newton-Wellesley Hospital Domestic Violence/Sexual Assault Program, Reach Beyond Domestic Violence, and The Second Step, with goals: To foster collaboration and connection among providers; to remove barriers to access to services and enhance effectiveness of services for survivors; and to promote sustainability in the field of domestic and sexual violence.

- Facilitated the SANE Tele-nursing Center at NWH served twelve 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 FY24, facilitated 3956 rides (9% increase) through the Modivcare/Lyft platform for ease of access to and from hospital care.

- Provided assistance to over 100 patients in the areas of food, lodging, safety, and others. A multidisciplinary team ensured linkages to on-going clinical and social services.

-Convened on-going meetings and forums with stakeholder community groups. Expanded opportunities for shared communication, knowledge of resources, collaborations, and improved access to health care services. This included:
-the NWH's local Departments of Public Health (8 meetings held); and Population Health Community Resource Fair with 11 community agencies participating and 50 staff attending.

- Presence of NWH Community Health Workers in the communities of Waltham, Newton, Needham, Natick, Weston, and Walpole. Support, provide resources, and assist with navigation in the areas related to SDOH.

- In FY24, NWH administered 104 flu vaccines at a variety of community locations. Provided interpretation during each clinic.

- In FY 24, NWH representatives spoke at and took part in NWH-hosted and community-hosted events/sessions promoting health, wellness, and safety and included audience of businesses, school personnel, social service agencies, senior centers, and other community members.

- In FY24, held 4 virtual educational programs focused on senior wellness. Topics focused on exercise and wellness, heart health, nutrition, chronic disease, and advanced care planning.

- In FY24, 4456 children were seen for visits in the Child and Adolescent Clinic and 800 consults were provided. The outpatient clinic continued to receive referrals from pediatricians and from schools participating in The Resilience Project.

- Engagement with more than 2,500 participants through educational outreach, clinical consultation, small group programming, and professional development talks. Provided 50 professional development talks and programs to the community partners.

- Continued the Building Resilience Series offered community wide. Conducted four group workshops (Building Resilient Kids and Building Resilient Teens) with 47 family participants.

- The Resilience Project had a presence in 6 school districts - 64 pre-school, elementary, middle and high schools for a total impact of 34,710 students, double that of FY23.

- In FY24, NWH continued distribution of Narcan to community agencies/partners. NWH dispensed 60 naloxone kits to patients in the NWH Emergency Department with diagnosis of opioid overdose.

- Substance Use Service clinicians completed 2500 patient visits. 72% for alcohol use and 9% for opioid use. Referrals were predominantly from the Emergency Department and from primary care.

- SUS Recovery Coach conducted twice weekly group support sessions (one virtual, one in-person) with an average of 35 participants per week. A new Family and Friends Support Group was launched in FY24.

- For the sixth year, collaborated with SOAR Natick on efforts to reduce stigma and promote engagement and discission on the issue of addiction. Hosted the Purple Flag Project at NWH and conducted a public event with Middlesex District Attorney Marian Ryan participating for the second year.

- The hospital continued its partnership with the Middlesex District Attorney's Office in the Charles River Regional Opioid Task Force, taking part in monthly education and discussion sessions.

- Hired 23 Waltham High School students through the Waltham Partnership for Youth Summer Internship program (the largest number of students of any participating organization). Expanded the clinical and nonclinical options for interns. 6 Medical Innovation and Career Exploration Sessions were held for the interns with 25 staff taking part.

- In FY24, the Volunteer Vocational Program affiliated with 10 schools and organizations with 31 volunteers who contributed 1577 hours of service. Participants interacted in a work- based learning environment and develop social skills and built on employment skills.

- Continued programming for exposure to a 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 as well as highlighted high vacancy healthcare positions.

- Newton-Wellesley Hospital continued the Surgical Technology Program pipeline program with Lasell University. The program has a100% completion rate for those in training; 83% job placement rate; and a 100% pass rate on the CRCST exam on the first attempt.

- Created the Shelter to Employment Partnership for New Arrival seeking work placement opportunities. Partnered with MassHire, JVS, and Middlesex Human Service Agency, Inc to conduct ESOL instruction and work readiness training. Six individuals were employed at NWH and 18 hired overall in various employment areas to include retail and hospitality.

- To address maternal mental health, grew the Post-Partum Mood and Anxiety Disorder Program with 3342 patients referred (a 57%increase) since the program began in May 2019. During this past year, there was an increase in patient complexity.

- NWH Nurse Mid-wife held the Post-Partum Mothers Support group two days per week with 11-15 new moms attending each session.

- Sustained and grew participation in the NWH/Community Nutrition Security and Equity Work Group with engaged discussion ont opic areas of space constraints, increased client volume, diverse cultural food selection, and others.

- Held several outreach and educational programs on healthy eating, hypertension, and nutrition for cancer care. An interactive, hands-on program was conducted for youth campers on healthy food options at the Waltham Boys and Girls Club.

- Provided $15,000 grant funding to the Waltham Boys and Girls Club for the Summer Eats Program, serving 55,340 meals. Provided funding for capacity building at the Newton Food Pantry (NFP) and Healthy Waltham.

- In FY24, NWH conducted screenings for the community related to illness to include mammograms, lung cancer screening day, along with educational programming and outreach for increased awareness and detection.

- Continued the Firefighter Heart Health Initiative to focus on a high-risk community population for cardiovascular disease. The multi-part program focuses on assessment, exercise, nutrition, and monitoring. Took place in all six of the NWH community firehouses this past year with 300 firefighters participating.

- The Small Steps Heart Health Program was held at six sites with 200 participants.

- The Walk and Talk Health Program took place at community locations in all six of the NWH towns and cities. 900 individuals participated.

- Partnered with area high schools to provide CPR training and AED demonstration and equipment.

- Continued to serve as a key community contributor and convener in on-going extensive planning for community preparedness (i.e., covid, flu, RSV, hazardous materials, etc.)

- Conducted trainings for community first responders and civic organizations.

- Involved as a lead agency in the planning for the 2024 Boston Marathon.

- Provided 26,960 completed Interpreter Service requests, including face-to-face, telephonic, video, ASL. A 12% increase over FY23.

- Continued to evolve and engage the NWH Community Collaborative with 8 Councils (Cardiovascular Health, Elder Care, Maternity Services, Palliative Care, Youth Mental Health, Work Force Development, Domestic and Sexual Abuse, Substance Use), comprised of a total of 215 community and staff members. Each Council has leadership from a Community Co-Chair and a Hospital Champion. 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 awareness.

- Provided grant funding to organizations within the Newton-Wellesley communities to expand capacity in supporting refugees and immigrants. Developed a partnership with FamilyAid to support the newly open Family Navigation Center for unhoused families.

- Provided sustaining support to the Waltham Welcome Center that served over 143 household in FY24 of new arrivals in the Waltham community and school system.

- Newcomer students and families received referrals and supports for immigration, food access, housing, mental health, school resources, and others through the Welcome Center.

- During the third year of NWH grant to WATCH CDC and MetroWest CD combined to serve 573 client households with more than2,100 housing related documented actions in the hospital's priority communities.

- Provided 223 Tenant Assistance Fund grants for a total of $125,000 to 103 households. 40 households received RAFT grants for more than $220,000. Clients also reported a variety of improved housing conditions as a result of WATCH CDC involvement.

- WATCH CDC and Metro West CD provided housing-related services to 696 housing on the NWH priority communities. Nearly threequarters of the clients served were people of color.

- Over 57% requested non-housing/basis needs assistance with than half reporting not having enough money to buy food.

- During the third year of the grant, WATCH CDC and Metro West CD provided non-housing related case management, including more than 850 actions, to 419 households.

- Job and Financial Planning Clinic services were provided to 405 housing clients. In addition, the clinic provided 42 workshops -- 23 on financial planning topics.

- Through the services of the grant, 51 Back to Work grants were distributed to 43 clients removing barriers to work. A total of 63 clients secured paid employment.

- In the third year of the grant, WATCH CDC referred 25 clients to mental health providers with 21 receiving mental health services. Three-quarters of those receiving services reported reduced anxiety in managing housing challenges.

- Began a new DON/CHI process. Established an Advisory Committee reflective of the diversity of the Waltham community consisting of several NWH CAB members as well as others from required sectors as determined by DPH. Successfully had the health priority approved by DPH.

- Continued to address challenges presented in the 2022 Community Health Needs Assessment and act on priorities identified in the NWH Strategic Implementation Plan. Continued to expand and assess representation on the Community Benefits Committee with community members who reflect the diversity of the populations, sectors and backgrounds present in the community.

Plans for Next Reporting Year:

This coming year, NWH will be conducting a Community Health Needs Assessment. While conducted for the individual entity, the Assessment will be conducted in collaboration with the entire MGB Healthcare System. The timeline for completion is Fall 2025.

Also in 2025, NWH will complete a DON/CHI process and awarded $695,000 to an organization or collaborative in the Waltham Community. The grantee will be addressing systemic barriers to accessing critical healthcare and social services, which negatively impact the health and well-being of under resourced communities across the lifespan in Waltham. Specifically, barriers that contribute to health inequities, to include: Overly complicated processes to access services (e.g., application and administrative complexity); Cultural barriers, including language access, cultural appropriateness, and stigma; Technological barriers, including the lack of devices, internet, and skills to utilize technology; and Transportation barriers. The priority population for the CHI are communities of color, immigrant communities, and recent arrivals to Waltham. Funding will be released in April 2025.

In addition to the hospital's ongoing program and those in partnership with other organizations, the hospital will continue to carry out the goals outlined in the most recent 2022 CHNA/SIP: addressing needs for specific populations (older adults, youth, immigrants, people of color, and food/housing insecure residents.) and priority areas of Housing Affordability, Mental Health and Substance Use, Access to Quality Care (chronic disease prevention and management and wraparound services); and Transportation. These identified populations and specific priorities are viewed as critical and have a growing need for more focused attention, resources, and collective action. NWH's efforts in all priority areas emphasize improvement in health status and working collaboratively within and across its communities. This work is continuously conducted by incorporating the themes identified in the CHNA: health and racial equity, workforce development, and sustained community engagement and empowerment.

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.

The completion of the most recent Newton-Wellesley Hospital community health needs assessment being in conjunction with the needs assessment completed across the Mass General Brigham healthcare system allows common priority areas to be address at a system

level. This will allow for leveraging resources but at the same time adapting action and response to meet the specific needs and challenges being experienced within the NWH communities.

Evaluation of outcomes related to the Housing Initiative DON/CHI will conclude in 2025 and the comprehensive findings will be shared with broader audiences. The Housing Initiative grant is under WATCH Community Development Corporation (WATCH CDC) and MetroWest Collaborative Development (Metro West CD) ($1.9 million grant). The initiative focuses on target populations (immigrant, communities of color, and Latinx) in Natick, Needham, Newton, Waltham, Wellesley, and Weston. Included in this work are aspects to address societal inequities and needs related to the social determinants of health.

Details of outcomes are specified in the Program Goals section of this report.

Plans for next year are to continue to expound upon and further develop all the NWH Community Benefit Program Areas.

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

Community Benefits Programs

Access to Care/Health Navigation

Program Type Total Population or Community-Wide Interventions

Program is part of a grant or funding provided to an outside organization Yes

Program Description To assist with access challenges, NWH develops for and supports various community agencies with transportation support to facilitate client access to needed healthcare. NWH facilitates access to providers and resources for patient needs. NWH regularly convenes community health departments, community agencies, higher education institutions and living communities to engage in discussion and strategy development for improved access to healthcare.

Program Hashtags 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
Number of pieces of equipment provided. Type of equipment provided.	In FY24, provided, over 250 different forms of supplies and equipment.	Outcome Goal	Year 3 of 3
Number of rides provided.	In FY2024, facilitated 3956 rides through the Modivcare/Lyft platform for ease of access to and from hospital care. Among areas using this service are the Emergency Department, ICU, Rehab Services, Cancer Center, and Integrated Care Management Program. A 9% increase over FY23.	Outcome Goal	Year 3 of 3

Grow communities served by Community Health Workers and resources related to social determinants of health (SDOH).	In FY 2024, provided NWH Community Health Workers support/services to the communities of: Waltham, Wellesley, 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 (89% of the patients were screened for the SDOH domains). The most frequent of which are: Food insecurity, Financial Hardship (Utility Bills/Medications), Housing Insecurity, Transportation, Care for Elder/Disabled, and Childcare, Job search/training. and issues with insurance. CHW's are educated and have successfully formed partnerships with local community service organizations. A bi-weekly Resource Guide in the community related to SDOH categories such as food, housing, shelter options, and senior service supports. The Guide includes for details on each of the resources. The Resource Guide is distributed to clinical and non-clinical providers and to broader community partners.	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,

Target PopulationsRegions

- **Served:** Newton,
- **Environments Served:** All,
- **Gender:** All,
- **Age Group:** Adults,
- **Race/Ethnicity:** Hispanic/Latino, White,
- **Language:** English, Spanish,
- **Status:** Not Specified

Additional Target Population **Partners:**

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

Certified Application Counselors

Program Type Access/Coverage Supports

Program is part of a grant or funding provided to an outside organization No

Program Description 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.

Program Hashtags Health Professional/Staff Training,

Program Contact Information Tina Tavares, Project Manager

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.	CACs continued serving 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,

Target PopulationsRegions

- **Served:** All Massachusetts,
- **Environments Served:** All,
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Status:** Not Specified **Partners:**

Additional Target Population

Partner Name and Description	Partner Website
Not Specified	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 provided to an outside organization No **funding**

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, middle schools, elementary schools and preschools 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; 617243-6490

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Increase capacity of the Raising Resilient Teens workshops.	In FY 24, held 4 small-group parent workshops - Raising Resilient Kids (22 families attended) and Raising Resilient Teens (25 families attended). The workshops served dozens of families through education, connection, and community. This psychoeducational, seven-week workshop for parents and caregivers of teens and kids, are led by a child and adolescent psychiatrist and a clinical psychologist.	Process Goal	Year 3 of 3
Number of consultations. Number of group therapy visits. Number of patients in the PACT program.	PACT services are provided by child and adolescent psychiatrists, psychologists, and clinical social workers with expertise in child development, family communication, and coping. PACT help parents with cancer to: -Continue with open communication -Maintain realistic routines -Preserve family time -Engage in self care (parents + child) -Think about legacy leaving. In FY24, PACT provided 92 outpatient consults; 6 inpatient consults and 22 group visits. In addition, PACT team members participate in meetings and regularly communicate with staff at the MGCC at NWH: ISS mental health providers, the greater ISS team, cancer specialty rounds, and palliative care staff/rounds. The PACT team also is involved in teaching NWH students in numerous disciplines, and collaborating with MGH PACT, NWH Collaborative Councils, community mental health providers and pediatricians.	Outcome Goal	Year 3 of 3

Number of professional educator and clinical consultations/trainings.	In FY24, provided nearly 50 psychoeducational and professional development consults and trainings to school personnel in all a variety of roles, parents, and medical professionals. The riels of staff who conducted these sessions were physiatrists, psychologists, social workers, and mental health counselors. 2500 people engaged in the presentations, workshops and fairs. Provided 10 professional development talks to pediatricians and medical students.	Outcome Goal	Year 3 of 3
Number of pediatric mental health patients seen, and types of services provided in the Child and Adolescent Clinic and the Emergency Department.	In FY24, 4456 children were seen for visits in the Child and Adolescent Clinic and 554 consults were provided for a total of 5,010 children being seen in the Clinic. The clinic is fully staffed for the first time since 2019, and patients are currently being seen within two-weeks of referral, a marked shift from the wait times in previous years. The clinic has recently instituted several new initiatives: 1. Systematic approach ensuring all patients are up to date withscreening labs. 2. Vital Signs clinic 3. Urgent follow-up clinic 4. Meeting patients in person at least once per year when possible. 5. Dedicated services for patients with ADHD	Outcome Goal	Year 3 of 3
Number of attendees at the Annual Summit.	Hosted the 8th Annual Educational Summit, a professional development program, for local all-school staff, mental health providers, and community leaders in March 2024. The 2024 Summit was the highest attended to date, with nearly 200 registrants. The 2024 Educational Summit was a full-day, title "When Kids with Big Feelings Have Big Behaviors." Two keynote speakers were part of the curriculum. CEU's for various disciplines were offered.	Outcome Goal	Year 3 of 3
Number of touchpoints with Public and Private Schools. Overall program expansion to lower school age children.	In FY24, the NWH Resilience Project - School Outreach program engaged with over 34710 students in across 6 school districts. In 2024, the Resilience Project expanded into elementary and preschools. Now a total of 64 pre-school, elementary, middle and high schools are part of the programming, increasing the reach of impact to 34,710 students, almost double the FY23 reach of 18000. The program successfully, integrated an early elementary curriculum to expand the reach of service, education, and outreach to younger age groups and expanding the breadth of the Resilience Project impact across the ages. Continued to engage an operational consultant within the Resilience Project team to act on goals identified in the strategic plan for program growth, enhanced marketing, clinical staff recruitment and outreach efforts. Continued to include a mental health counselor as a school liaison clinician to further support local public schools.	Outcome Goal	Year 3 of 3
Participation on external community groups.	In FY24, NWH clinical staff was represented on numerous local committees, and task forces across communities that focus on mental health in adolescents.	Process Goal	Year 3 of 3

Number of Resilience Council members.	The Resilience Council, was officially rebranded as the Youth Mental Health Council in FY24, under new Community Co-chair leadership. Comprised of 31 community and hospital members with an increase of representation of members with "lived experience" and including a teen member of the Waltham community. The Council met three times in FY24 year and continues to focus on key initiatives that include: providing support to students, parents, educators, counselors and communities through collaborating with school personnel, customized educational programming, and improved access to treatment resources.	Process Goal	Year 3 of 3
Expansion of identified program goals.	The Resilience Project is an innovative school and communitybased program that promotes the emotional health and wellbeing of children, teens. and those who support them. 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 and supports. All goals have seen significant growth during FY24 through increased patient volume, enhanced school collaborations (to include lower age levels), additional community partnerships (over 48 community partners), and expansion of offerings and participants attending community and parent programs. Expanded scope beyond high schools and middle schools by piloting services with 2 local elementary schools and 2 preschools in catchment area to meet community need, creating a model for further expansion into FY25.	Process Goal	Year 3 of 3
Number of webinars/programs held.	In FY24, continued with the virtual format for The Resilience Project's Building Resilience series, which are free educational outreach programs for educators and community members. The 4 programs were held as part of the year-long series with a total	Outcome Goal	Year 3 of 3

	of 680 participants. The Series had topics related to mental health, parenting, and educators' professional development. Topics presented included learning about autism and sensory needs, the benefits of enhancing and expanding book sharing with young children, supporting kids and teens through back-to school-related anxiety and avoidance, understanding the pressures of adolescence, supporting students with language based learning disabilities. The Resilience Project offered both virtual and in-person workshops and talks through its 's Building Resilience series, which are free educational outreach programs for educators and community members. The Series welcomed nearly 700 participants. The Series had topics related to mental health, parenting, and current research. Topics presented included a back-to-school blues, supporting the emotional lives of teenagers, supporting students with language-based learning disabilities, and learning about risk and protective factors for mental health from teens in the community. Held a program for clinical providers in inpatient and ambulatory settings, Titled, ""Elevating Youth Voices: An Intimate Roundtable Discussion"". 4 Waltham High School seniors who are also members of the Teen Mental Health Alliance led the discussion centered on the Youth Risk Behavior Survey. Details are: -24 attendees -9 different clinical disciplines/roles represented: pediatrics, emergency pediatrics, inpatient social work, Emergency Department social work, physical therapy, pediatric hospitalists, pain medicine. -Conversation included questions about the YRBS data, students' perceptions and experiences, exploration of modifiable factors, identification of and level of access to trusted adults in school. -Feedback: -I will share the YRBS with my colleagues to create a better understanding of the challenges teens face and increase empathy -Encourage teens I work with to be trained in youth mental health first aid -Such a joy to hear from youth! -Please offer more opportunities for connection and community and youth such as this.		

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 PopulationsRegions

- **Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston,
- **Environments Served:** Suburban,
- **Gender:** All,
- **Age Group:** Children, Teenagers,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Status:** LGBT Status, Refugee/Immigrant Status, **Partners:**

Additional Target Population

Partner Name and Description	Partner Website
High Schools: Natick, Needham, Newton, Waltham, Wellesley, Weston	Not Specified
The Manton Foundation	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 NWH collaborates with other local hospitals, emergency medical systems (EMS), local public safety agencies, and others to prepare for and respond to disasters impacting our community. This collaboration focuses on the critical elements of emergency preparedness, including the development and implementation of disaster plans, communications and notifications, mutual aid, and information sharing. As a proud member of the community, NWH consistently seeks opportunities to further engage with local partners to bolster our collective community preparedness.

Program Hashtags Prevention,

Program Contact Information Sid Allendinger, Manager, Emergency Preparedness

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Level of involvement with community partners for event preparedness, leading up to, and post the marathon.	Host Newton Fire, Newton PD, a BAA medical tent, and a representative from our regional HMCC. Additionally, NWH participates in regional meetings in preparation for the marathon each year, and serves a shelter location during the marathon for the surrounding community.	Process Goal	Year 3 of 3
Level of engagement with community partners and key first responders.	NWH participation in Region 4AB Load Balancing Meetings. Have been occurring at different frequencies since the pandemic (weekly, every other week, etc.) depending on the state of the region. NWH attends each meeting.	Process Goal	Year 3 of 3
Type of engagement to conduct HazMat Incident Planning.	NWH collaborates with Newton Fire to plan for and respond to hazardous materials incidents in the region through quarterly trainings at the hospital.	Outcome Goal	Year 3 of 3
Exercises held for MCI preparedness.	Held a functional exercise focused on preparing NWH to manage an influx of patients to the ED from a mass casualty in the community. This is part of continued work to prepare the hospital to maintain operations during an emergency in the community.	Outcome Goal	Year 3 of 3
On-going participation in Community preparedness planning for New Migrant Arrivals.	NWH, in collaboration with the larger Mass General Brigham, continues to work with state, local, and community organizations to support the surge of new migrant arrivals to the state. From an Emergency Preparedness perspective, we are working with our Emergency Department to ensure we have plans in place to manage an influx of these patients seeking care and/or shelter, to ensure we provide the best possible care and are able to efficiently and effectively connect patients/families with the appropriate community resources. Data reporting occurs with state level agencies.	Process Goal	Year 3 of 3
On-going participation in Community preparedness planning.	NWH Emergency Preparedness/Security are active members of the Waltham Local Emergency Planning Committee and attended the 2024 tabletop exercise held by the LEPC. NWH hosts the majority of the monthly regional HMCC meetings with emergency managers from across the region.	Process Goal	Year 3 of 3

EOHHS Focus Issues N/A,

DoN Health Priorities Violence,

Health Issues Other-Emergency Preparedness,

Target PopulationsRegions

- **Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston,
- **Environments Served:** Suburban,
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Status:** Not Specified **Partners:**

Additional Target Population

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

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 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
Foster a successful CHI process that includes robust community engagement, transparency in decision making, accountability for planned activities, and demonstrable community health impact.	Established an Advisory Committee that was diverse so as to reflect the diversity within the Waltham community. Many members included those on the NWH Community Benefits Committee as well as the DPH required sectors were represented. The work of this committee established the CHI health priority and strategy, outlined below: Improving access to the continuum of Waltham community services that support health and well-being by reducing systemic barriers to care commonly experienced by under resourced communities across the life span. The priority population for the Community Health Impact Funds includes individuals or families facing systemic barriers to essential services and supports, with a focus on communities of color, immigrant communities, and recent arrivals to Waltham. The goal of the Community Health Impact Funding is to increase access to the continuum of Waltham community services that support healthy living, such as increasing access to: Healthy, culturally appropriate food and other basic needs; Community-based social services (e.g., housing, immigration, employment, education, etc.); and mental health care. 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 DPH required policy, systems, or environmental (PSE) change approach, the DON Health priorities, and the EOHHS/DPH Focus Issues. As a result of the robust discussions, a focused expert-led meeting conducted was brought in to lead an additional meeting to specifically share detail on the topic area of transportation. The Committee began to consider and had preliminary discussion on the goals for the Allocations Committee for funding parameters and overall timeline for completion of the process. The Committee met for a total of four times during the process.	Process Goal	Year 3 of 3

EOHHS Focus Issues N/A,

DoN Health Priorities N/A,

Health Issues 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-Education/Learning, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Nutrition,

Target PopulationsRegions

- **Served:** Waltham,
- **Environments Served:** Suburban,
- **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
Umass Donahue Institute Test	Not Specified
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
Number of patients offered assistance.	Provided assistance to over 100 patients in the categories of food, lodging, technology, safety, furniture, supplies, and others. Rent/Housing/Furniture/Cleaning was again the highest use areas. Patients receiving support are at points of crisis and resources provided enable a transition plan to be created. Situations are often in the categories of financial hardship, abusive relationships, caregiving needs, housing hardships, and mental health conditions. The circumstances supported this year had higher complexity than previous years. A component of the program is that patients are linked to on-going clinical and social services. The program is administered through a multidisciplinary team. Specific examples of support included: - for a patient to get groceries delivered to his home when he was discharged after open heart surgery - for infant car seats to safely d/c new mothers & their babies	Outcome Goal	Year 3 of 3
Number of community participant presenters. Number of attendees.	One Community Resource Fair was held in August of 2024. This resource fair was focused on elder resources. At this fair, 11 vendors who support elders in the community presented. At the fair, the organizations shared information on their services and programs and how to refer. Time was provided for participants to ask questions and engage in discussion. The audience for this fair included member of the following teams: iCMP Care Management and Behavioral Health team, Community Health Workers, Transitions Team, IP Case Management, and oncology CRS. 50 employees attended the session. The successful outcome of the fair was the further development of bidirectional relationships among providers and community partners.	Outcome Goal	Year 3 of 3

Number of Senior Community Living Forums held.	Three Senior Community Living Forums were held this year with approx. 25 attendees at each forum. The forum includes multidisciplinary representatives from Newton-Wellesley leadership, including the Associate Chief Medical Officer, Physician Hospital Organization Medical Directors, Case Management leadership, and members of the Population Health, Mass General Brigham Home Care and Community Health teams. Each forum is focused on a specific topic that is applicable to attendees across the continuum. Topics at this year's forum were MGB Home Hospital Program, Isolation and Loneliness in Older Adults, and Protective Services. At each Forum, a NWH clinical provider and a leader from a Senior Living Facility presented information, tips and a case study. Question and Answers followed. Resources and supportive materials were shared with participants after the Forum. The Forum invitees include leadership from Assisted Living Facilities, Independent Living Facilities, Skilled Nursing Facilities, and local public health nurses. As a result of the Forum, relationships with senior living facilities have improved and has now resulted in consistent communication with the hospital. Ideas for future Forums are also solicited from attendees.	Process Goal	Year 3 of 3
Number of times convened with local Departments of Public Health.	NWH convened 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. Publlic health nurses also participate in the meetings and others are invited, as needed. Topics discussed include substance use, behavioral health, capacity, infectious disease protocols, immunizations, home care, housing/shelter needs, school based and senior care, immigrant health, environmental impact, and safety. Having the structure already in place helps to facilitate ease of consistent communication and solution building. Clinical staff serve as presenters and open discussions. 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, behavioral health and falls.	Process Goal	Year 3 of 3
Evidence of active engagement by various levels of hospital leaders with community networks and coalitions.	Consistent clinical and administrative hospital leader representation and active engagement at the Waltham Interagency Network, Needham Community Crisis Intervention Team, Newton Youth Commission, Social Service Collaborative, Newton Coalition for Community Wellness, Natick 180, Waltham and Newton Chambers of Commerce, Waltham and Newton YMCA's, SDOH related Advisory Boards, and others. Post pandemic, participation and presence at these networks continues to be of significant importance for on-going communication and providing a liaison relationship between the hospital and partners within our communities, particularly as health issues continue to persist. This engagement also enables the hospital to more fully understand the challenges being experienced in the community. It is often cited by partners how critical it is for this level of hospital engagement.	Process Goal	Year 3 of 3

Number of Palliative Care Council Members.	The Palliative Care Council is comprised of 19 hospital and community members and welcomed two new members this year. Members are dedicated to advocating for the importance of holding serious illness conversations when discussing care. They are ambassadors and develop opportunities for community education on the topic of advanced care planning and provide support for the training of clinicians on having conversations with patients. The Council's overall goal is to increase access and awareness for palliative care for patients, families, and the community.	Outcome Goal	Year 3 of 3

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 PopulationsRegions

- **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 Wendy Gordon, Interim HR Director

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Types of resources provided.	Provided resources and services that include domestic violence, substance use, work/life wellness, financial assistance resources, etc. Work with CMG when there is an identified increased need due to a trauma. (i.e., a near drowning last summer at the public pool). A customized support plan was developed. There continue to be increases in the volume of services for mental related challenges resulting in leaves of absence. The City of Newton and CMG work together to think innovatively and to expand resources supports for school and city staff.	Process Goal	Year 3 of 3
Level of access for services.	Enabled ease of access to EAP services for City of Newton employees. CMG Associates are very responsive to the needs of Newton employees, and it is an invaluable employee assistance program. 24/7 access is provided which has become a critical component of supporting staff throughout the myriad of stressors.	Process Goal	Year 3 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 PopulationsRegions

- **Served:** Newton,
- **Environments Served:** Suburban,
- **Gender:** All,
- **Age Group:** Adults,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Status:** Not Specified

Additional Target Population **Partners:**

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

Housing Community Health Initiative (DON-CHI)

Program Type Total Population or Community-Wide Interventions

Program is part of a grant or funding provided to an outside organization No

Program Description	Newton-Wellesley Hospital awarded a $1.9 million grant to WATCH Community Development Corporation (WATCH CDC) and Metro West Collaborative Development (Metro West CD) to address housing insecurity in the hospital's priority communities. WATCH CDC, located in Waltham, and Metro West CD, located in Newton, 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.
Program Hashtags	Community Education, 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
Number of client households served. Percent of clients of color and/or of immigrant communities. Percent served per service area.	During the third year of this grant through November 30, 2023, WATCH CDC and MetroWest CD combined to serve 696 households residing in the hospital's priority communities. More than one-half of these client households (55%) included children under the age of 18; more than one-quarter (27%) included children under the age of 5; and 9% included members with special needs. Nearly three-quarters (73%) of the clients served through this grant were people of color. The vast majority (87%) of clients served under this grant reside in Waltham and were provided housing and non-housing case management support services by WATCH CDC. The remainder of clients served through this grant resided in other communities surrounding the hospital specifically, Newton, Natick, Needham,	Process Goal	Year 3 of 3
	Wellesley and Weston -- and were provided housing and non housing case management support services by MetroWest CD. "		

Housing-related case management: Number of housing related documented actions and number of clients served. Amount of funding spent to serve clients. Types of additional housing related actions.	Households working with WATCH CDC and Metro West CD face a multitude of challenges. Overall, 84% experienced housing insecurity, nearly half of which reported being behind on rent. Other challenges reported include needing help with fuel or utility bills, receiving written or verbal notice from landlord to leave, needing to move without being behind on rent, homelessness, living in poor conditions or overcrowding, receiving an eviction notice from court, and experiencing conflicts with their landlord. During the third year of the grant, WATCH CDC and Metro West CD provided housing-related case management, including more than 2,100 housing related documented actions, to 573 households. The wide range of actions can be categorized into the following three categories: provision of information and resources, completing and submitting applications, and providing referrals and advocacy support. These actions resulted in the following financial impacts: -Provided 223 Tenant Assistant Fund (TAF) grants, totaling approximately $125,000, used for utility and rent arrears, emergency housing, and first, last and security deposits to 103 households. The NWH Housing Security CHI grant provided 60% of these dollars. -Submitted Residential Assistance for Families in Transition (RAFT) emergency housing assistance applications. As a result, 40 households received RAFT grants equaling more than $220,000. -Submitted applications resulting in a number of households receiving fuel assistance, first/last month rental assistance and security deposit, and utility bill assistance. In addition to financial impacts listed above, clients reported the following improved housing/living conditions as result of working with WATCH and Metro West CD: -Delayed Eviction -Avoided Eviction -Negotiated with Landlord -Found Emergency Shelter -Fixed Repairs / Code Violations -Found New Housing	Outcome Goal	Year 3 of 3
Establishment of partnerships with providers of mental health supports and resources. Establishment of mental health workshops for clients and staff. Number of attendees at mental health workshops.	The grant prioritizes strengthening awareness of and support for the mental health needs of clients experiencing housing insecurity. Through this grant, WATCH CDC contracted the services of a mental health consultant, a Children's Charter bilingual licensed mental health counselor (LMHC), to accomplish the following: -Strengthened client intake protocol to incorporate two mental health related screening questions. -Identified local mental health providers who accept MassHealth as well as information on whether accepting new clients, providers intake process, services offered, and languages spoken. -Provided a staff mental health workshop refresher, Housing Insecurity & Anxiety: How to best respond to clients in distress. -Provided client mental health workshops, Managing Stress, in both Spanish and English about how to manage one's stress related to managing rent, housing situations, and their finances as well as to find community mental health resources. More than one-quarter (185) of all clients completing the housing intake forms/process indicated having stress, anxiety, or depression related to housing or financial difficulties. As a result,	Outcome Goal	Year 3 of 3

	WATCH CDC and Metro West CD staff provided all clients indicating mental health needs with information on mental health resources and supports. Moreover, staff referred 25 clients to local mental health providers based on the severity of mental health needs determined through screening questions and follow-up discussions. Follow-up with clients after they received resources suggests improved mental health with more than three-quarters (143) reporting reduced anxiety in managing housing challenges and 21 receiving mental health services.		

Percent of clients needing job support. Percent of clients needing financial support. Number of housing clients participating in Job and Financial Planning Clinic services. Total amount of funding and clients served to support economic independence. Types of economic supports provided and outcomes.	In addition to housing and non-housing / basic needs support, many clients served under this grant needed job search and financial planning assistance. -66% requested job support, including searching for jobs, gaining employment-related supports, creating resumes, applying for jobs, completing online applications, and practicing for job interviews. -19% requested financial planning assistance, including needing help with paying off dept, reducing expenses, making a budget, improving their credit score, making a rainy-day fund, and opening a checking or savings account. To address this need, WATCH CDCs full-time Job and Financial Planning Coordinator supports and mentors clients to greater financial self-sufficiency. The bilingual coordinator launched the Job and Financial Planning Clinic in the first year of the grant providing both one-on-one counseling sessions and group workshops. Job support activities and topic areas covered included job search, creating and updating resumes, completing online job applications, practicing for job interviews, and accessing job training, certification programs, and school opportunities. Financial planning topics included improving credit score, opening a checking or savings account, making a budget, making a rainy-day fund, paying off debt, and reducing expenses. During the second and third years of the grant, the coordinator partnered with Tech Goes Home to provide computer literacy classes. During the third year of the grant, 405 housing clients participated in Job and Financial Planning Clinic services, receiving one-on-one individual support from the coordinator. In addition, the clinic provided 42 educational workshops. 19 focused on job support and 23 on financial planning topics. The NWH Housing Security CHI grant enabled the distribution of nearly $17,000 to support the economic independence of housing clients through the following: -51 Back to Work (BTW) grants, of up to $500 each and totaling over $15,000, to 43 clients for removing barriers to work, including bus passes, tools, equipment, training programs, computers, and childcare. -Financial incentives, totaling $1,850, to 30 clients for active engagement in Job and Financial Planning Clinic services. Preliminary employment related outcomes for participation in the Job and Financial Planning Clinic include: -83 applied for a job -63 got a job -55 created or updated their resume -7attended job training Preliminary financial planning and money management related outcomes for participation in the Job and Financial Planning Clinic include: -13 made a budget -12 reduced their expenses -4 paid off debt -2 improved their credit score -1 opened a bank account	Outcome Goal	Year 3 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-Homelessness,

Target PopulationsRegions

- **Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston,
- **Environments Served:** Suburban,
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Status:** Refugee/Immigrant Status, **Partners:**

Additional Target Population

Partner Name and Description	Partner Website
Watch CDC	Not Specified
Metro West Collaborative Development	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 Jouel Gomez, Manager, Telecommunications

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Introduce new Interpreter technologies. Provide signage and instruction in multiple languages. Identify top utilizing departments of Interpreter Services.	Continued to use a combination of in-person, video, sign language and translations platforms for interpreter services. Feedback continues to be that the array of options and variety of device to use expands access and efficiency of service. The top five hospital departments utilizing interpreter services were Emergency, Medicine, Surgery, Urgent Care Walk-In and ICU. In response to the increase in numbers of requests a new vendor was brought on board this year. Deployment of VPOP (video) devices increased to 58 and increase from 40 in 2023 and 32 in 2021 and placed in high use clinical areas. Assessment of the number of devices needed is ongoing. Added interpreter request capability on Voalte - the highly used clinical communication devices. For the 24/7 phone line, three alternative vendors were added: Language line, Cyracom, and DT interpreting.	Process Goal	Year 3 of 3

	Signage, in multiple languages around the hospital that includes violence prevention messaging, respiratory illness guidance, and patient visitation protocols. Utilize the Patient and Family Guide during registration/admission to share information in multiple languages: Spanish, Vietnamese, Portuguese, Russian, Chinese, Haitian Creole, Luganda that offers assistance to patients who do not use English as a primary language or who are deaf or hard-of-hearing. At each entrance in various languages, information is provided regarding care of patients in the home who have the flu. The Patient Rights and Responsibilities posters, displayed throughout the hospital and off-site locations were updated. Materials are available in multiple languages for programs such as Domestic Abuse and Sexual Violence programs, financial services, and all COVID related information including vaccine information, flu, and RSV programs.		
Number of completed interpreter requests (face-to-face, telephonic, video and ASL).	Provided 26,960 completed Interpreter Service requests (face to-face, telephonic, video, ASL). A 12% increase over FY23. The top five languages by usage were: Spanish, Haitian-Creole, Russian, Portuguese, Chinese-Mandarin.	Outcome Goal	Year 3 of 3
Materials that are translated and made available in multiple 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. A System wide Interpreter Services policy was developed to ensure consistent and appropriate response to patient who need services. Documentation has been enhanced. Education among on these protocols is on-going. In addition, through MGB system-wide initiatives there has been an expansion of languages that are available in patient and employee portals.	Process Goal	Year 3 of 3
Forms of staff training.	Nursing Education continued to train all new staff in the areas of interpreter resources and health inequities. Continuous training provided for staff on Audio/Video IPAD technology and access of interpreter resources on Voalte in all patient care areas, inpatient and ambulatory, as well as off-site locations. Reference and resource materials are available in all areas. Set a regular cadence of communications hospital-wide on use and access to interpreter services and the importance of providing interpreter access for patient and community care.	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 HealthLanguage/Literacy,

Target PopulationsRegions

- **Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston,
- **Environments Served:** Suburban,
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Status:** Refugee/Immigrant Status, **Partners:**

Additional Target Population

Partner Name and Description	Partner Website
Cross Cultural Communications, Inc	https://embracingculture.com/

Language Line Solutions	www.languageline.com
Cyracom International	https://www.cyracom.com/

Mass General Brigham - Mental Health, Behavioral Health, and Substance Use

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 FY24, Mass General Brigham continued implementation of system-wide strategies that address needs prioritized by our hospitals Community Health Needs Assessments, focus on leading causes of death and health inequities, and build on the long history of impactful programs across our system. Our work in mental health, behavioral health and substance use disorder focuses on expanding the behavioral health workforce with a focus on provider diversity; and increasing access to behavioral health and substance use disorder services and treatment.

Program Hashtags Community Health Center Partnership, Health Professional/Staff Training, Physician/Provider Diversity, Prevention,

Program Contact Information Tavinder Phull, MPH, MBA, Vice President, Community Health Regulatory

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Expand the behavioral health workforce with a focus on provider diversity	912 behavioral health students across 8 college/universities have been supported	Process Goal	Year 3 of 3
Expand & support the behavioral health workforce with a focus on provider diversity	388 students now working in the behavioral health field in MA	Process Goal	Year 3 of 3
Expand & support the behavioral health workforce with a focus on provider diversity	53 clinicians recruited & retained in community health centers with loan repayments and salary supplements.	Process Goal	Year 3 of 3

EOHHS Focus Issues Mental Illness and Mental Health, Substance Use Disorders,

DoN Health Priorities N/A,

Health Issues Health Behaviors/Mental Health-Depression, Health Behaviors/Mental Health-Mental Health, Substance Addiction-Opioid Use, Substance Addiction-Substance Use,

Target PopulationsRegions

- **Served:** All Massachusetts,
- **Environments Served:** Not Specified
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Status:** Not Specified

Additional Target Population **Partners:**

Partner Name and Description	Partner Website
The Italian Home for Children	Not Specified
NAMI Mass	Not Specified
Mass Association from Mental Health (MAMH)	Not Specified

Mass League of Community Health Centers	Not Specified
Roxbury Presbyterian Social Impact Center	Not Specified
Golden Age Center	Not Specified
William James College	Not Specified
RIZE MA	Not Specified
Quincy College School of Nursing	Not Specified
Bridgewater State School of Social Work	Not Specified
Salem State School of Social Work	Not Specified
Bunker Hill Community College	Not Specified
U of Mass School of Nursing	Not Specified

Mass General Brigham Access to Care and Services

Program Type Access/Coverage Supports

Program is part of a grant or funding provided to an outside organization No

Program Description In FY24, Mass General Brigham continued implementation of system-wide strategies that address needs prioritized by our hospitals Community Health Needs Assessments, focused on leading causes of death and health inequities, and building on the long history of impactful programs across our system. Our work to improve access to care and services focuses on partnerships with community health centers, bringing care into the community, and supporting organizations and policies aimed at reducing access barriers.

Program Hashtags Not Specified

Program Contact Information Tavinder Phull, MPH, MBA, Vice President, Community Health Regulatory

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Increase access to care and services in Mass General Brigham CHNA prioritized communities. Provide clinical services focused on hypertension, immunizations and SUD through the Mass General Brigham Community Care Van Program in Boston, Chelsea, Revere, Lynn, and Salem.	The MGB Community Care Van Program provided 930 vaccines, 4100 blood pressure visits and 1200 diabetes visits in prioritized communities. 34% of encounters were with patients who identify as Black or African American, 30% of encounters were with patients who identify as Hispanic.	Process Goal	Year 3 of 3

Increase access to care and services in Mass General Brigham CHNA prioritized communities. Support policies to reduce barriers to accessing care and services.	Supported statewide advocacy organizations working to reduce barriers to accessing care and services, including providing funding for the Health Care for All Helpline. Additionally, advocated for state legislation around expanding MassHealth coverage to all children regardless of immigration status, mandating language access and inclusion services for state agencies, and behavioral health workforce investments. We also successfully advocated for state funding for universal school meals, the Affordable Homes Act (including establishment of the Massachusetts Healthy Homes Program), and a maternal health omnibus bill that creates a pathway to licensure for certified professional midwives and expands access to postpartum depression screenings.	Process Goal	Year 3 of 3
Increase access to care and services in Mass General Brigham CHNA prioritized communities. Provide support to community health centers.	Partnered with Massachusetts League of Community Health Centers to support health centers serving MGB CHNA-prioritized communities to increase access to primary care and behavioral health for underserved communities through multifaceted strategies to 1) expand culturally-responsive substance use disorder and recovery services; 2) address the statewide shortage of behavioral health clinicians in community settings; 3) promote community-driven research and evaluation to advance health equity; and 4) shape statewide policy to achieve racial justice.	Process Goal	Year 3 of 3
Increase access to care and services in Mass General Brigham CHNA prioritized communities. Execute affiliation agreements with select community health centers	Maintained longstanding partnerships with North Shore Community Health and Lynn Community Health Center to enhance the accessibility and quality of healthcare services for medically underserved residents in the North Shore region, with a focus on chronic disease management, substance use disorder, and social risk mitigation. Provided a total of $815,000 to North Shore Community Health, including $465,000 per the terms of our FY24 Affiliation Agreement and $350,000 to support the expansion and renovation of Peabody Family Health Center. Provided a total of $1,000,000 to Lynn Community Health Center, including $800,000 per the terms of our FY24 Affiliation Agreement and $200,000 to support medical respite care for patients of Lynn Recuperative Care Center.	Process Goal	Year 3 of 3

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

DoN Health Priorities N/A,

Health Issues All Health Issues

Target PopulationsRegions

- **Served:** All Massachusetts,
- **Environments Served:** All,
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Status:** Not Specified **Partners:**

Additional Target Population

Partner Name and Description	Partner Website
Hospitality Homes	Not Specified
Health Care for All	Not Specified
Health Law Advocates	Not Specified
Mass League of Community Health Centers	Not Specified

Health Care Without Walls	Not Specified
Lynn Community Health Center	Not Specified
Whittier Street Health Center	Not Specified
North Shore Community Health	Not Specified
The Pine Street Inn	Not Specified
Uphams Corner Health Center	Not Specified
New Commonwealth Fund	Not Specified

Mass General Brigham Newly Arrived Individuals

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 FY24, Mass General Brigham collaborated with the State, local municipalities, and many community-based organizations to address the urgent medical and social needs of the newly arrived migrants in Massachusetts. In addition to providing medical care, our work focused on providing support to community-based organizations working to support the needs of recently arrived migrants to the Commonwealth.

Program Hashtags Community Education, Health Screening, Prevention,

Program Contact Information Tavinder Phull, MPH, MBA, Vice President, Community Health Regulatory

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Connect newly arrived individuals to urgent medical and social services.	Established partnerships with community organizations to coordinate response to the arrival of new individuals to the Commonwealth including MGB Community Care Van clinics at select shelter sites.	Process Goal	Year 3 of 3
Support community organizations to meet the essential needs of newly arrived individuals.	Launched a partnership with JVS and MassHire to provide ESOL, work readiness, and employment opportunities, resulting in MGB hiring 24 newly arrived newly arrived individuals at SH and NWH.	Process Goal	Year 3 of 3

EOHHS Focus Issues Housing Stability/Homelessness,

DoN Health Priorities Built Environment, Employment, Social Environment,

Health Issues Chronic Disease-Hypertension, 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-Environmental Quality, 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 HealthPublic Safety, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of Health-Violence and Trauma,

Target PopulationsRegions

- **Served:** All Massachusetts,
- **Environments Served:** Not Specified
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Status:** Refugee/Immigrant Status, **Partners:**

Additional Target Population

Partner Name and Description	Partner Website
International Institute of New England	https://iine.org/
Family Aid	https://familyaidboston.org/
Immigrant Family Service Institute	https://www.ifsi-usa.org/
Centerboard	https://centerboard.org/
Health Law Advocates	https://www.healthlawadvocates.org/
Waltham Partnership for Youth	https://walthampartnershipforyouth.org/wraparound-waltham/

Mass General Brigham Nutrition 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 In FY24, Mass General Brigham continued implementation of system-wide strategies that address needs prioritized by our hospitals Community Health Needs Assessments, focus on leading causes of death and health inequities, and build on the long history of impactful programs across our system. Our work in Nutrition Equity focuses increasing 1) access to nutritious food, 2) community educational opportunities related to nutrition, and 3) SNAP and WIC enrollment and awareness.

Program Hashtags Community Education, Health Professional/Staff Training, Prevention,

Program Contact Information Anne Fox, Senior Program Manager, Community Health

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Increase SNAP and WIC enrollment. Provide education, resources and connections to SNAP and WIC Programs.	Through a new program, a WIC coordinator uses SDOH screening data to identify and refer individuals to the WIC program. In a partnership with Project Bread and Greater Boston Food Bank, MGB uses SDOH screening data to refer 1600 individuals for SNAP assistance outreach.	Process Goal	Year 3 of 3
Increase access to nutritious food. Provide support to expand food access.	Provided support to food pantries and other community food resources to increase food access, including $125K for nutrition equity community-focused subgrants administered in partnership with Greater Lynn Senior Services.	Process Goal	Year 3 of 3
Support community educational opportunities related to nutrition. Invest in innovative ways to teach community residents about nutrition.	Supported the development of teaching kitchens and learning hubs in MGB CHNA communities including Revere, Chelsea, and Lynn. Cooking classes are available in Spanish and focus on nutritious meals using readily available and culturally relevant ingredients. Collectively, the teaching kitchens had more than 1300 (non-unique) participants.	Process Goal	Year 3 of 3

Develop system-wide Community Health strategy for food access and nutrition equity. Establish workgroup, evaluate current work, existing gaps and best practice.	A Community Health Food Access and Nutrition Equity workgroup was established and included representatives from across the MGB system. The group shared challenges and opportunities, and proposed strategies for future work.	Process Goal	Year 3 of 3
Screen community members for food insecurity. Continue SDOH and food insecurity screening on the Mobile Health Van and other venues to provide resources and referrals to community members.	Full-time Community Health Workers on the MGB Community Care Vans screened 95% of eligible patients for SDOH needs and provided outreach and assistance. 40% of patients screened positive for food insecurity.	Process Goal	Year 3 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, Chronic Disease-Diabetes, Chronic Disease-Overweight and Obesity, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Nutrition,

Target PopulationsRegions

- **Served:** All Massachusetts,
- **Environments Served:** All,
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Status:** Not Specified **Partners:**

Additional Target Population

Partner Name and Description	Partner Website
Community Servings, Inc.	Not Specified
The Food Bank of Western MA	Not Specified
My Brother's Table	Not Specified
La Colaborativa	Not Specified
About Fresh	Not Specified
Salem Pantry Inc	Not Specified

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 can have profound adverse effects on women and their children.
Research shows that depressed and anxious parents often smile less, talk less and are less likely to touch and engage with their newborns throughout the first year of life. This can lead to conflict within the family, adversely impact the growth and development of a child and increase medical costs.

Program Hashtags Community Education, Health Screening, Prevention, Support Group,

Program Contact Information Buffy Sheff-Ross, Clinical Social Worker, LICSW

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Intervals of administering The Edinburgh Postnatal Depression Scale.	Collaboration with 3 OB practices using The Edinburgh Postnatal Depression Scale (EPDS) to screen pregnant and postpartum patients at the initial prenatal visit, between 24-30 weeks prenatally, 6 weeks postpartum, and 6 months postpartum. NWH is the first Partners hospital to screen at 6 months postpartum. Took on a process improvement project to look at completion rate of EPDS given at the initial prenatal visit and improved documentation around positive EPDS scores.	Process Goal	Year 3 of 3
Number of patient interactions with PMAD social worker. Expanded access to maternal mental health care to additional at-risk populations.	Continued the growth of the Perinatal Mood and Anxiety Disorder Initiative. 3,342 patients (a 57% increase over 2023) have been referred to the PMAD social worker since the program began in May 2019. An MSW student has been added to the service, allowing for an increase in billable hours from 132 in FY23 to 349 in 2024. Patient case complexity has increased, and add to struggles with mood changes during and after pregnancy. Examples include domestic violence with DCF involvement, unhoused individuals, child's health concerns and substance use, to name a few. There was also a great deal of bereavement support for women who experienced pregnancy loss. Research was underway in FY24 for the STEPS for PPD study, in collaboration with social workers at Salem Hospital, BWH and MGH.	Outcome Goal	Year 3 of 3
Number of group sessions held per week. Number of attendees per session. Reduction of anxiety and increased confidence in coping.	Continued group support sessions conducted twice per week for new moms conducted by a NWH nurse mid-wife. Open and general discussion as well as specific topic areas are related to both mom and baby care. - 12 new moms attend the event weekly, with an average of 8 sessions each. Monthly, content and clinical experts attend to discuss issues such as sleep, nutrition, exercise and family dynamics, to name a few in-person gatherings have also occurred, in an effort to prioritize community-building. A Group Alumni gathering also took this year with 20 families attending. The success of the new moms group has helped to launch a pilot in FY25 of a prenatal moms support group, hosted by the same NWH nurse midwife and focused on issues that Increase maternal preparedness for pregnancy and post-partum stages, increase joy and resilience during pregnancy, and increase patient satisfaction with OB experience at NWH.	Process Goal	Year 3 of 3

Number of community education and outreach programs held.	The Maternity Council, in partnership with the Brazelton Institute, launched its second cohort of the Newborn Behavior Observations (NBO) System TM Training in FY24, this time expanded to include 30 multi-disciplinary attendees, including 7 community partners. -All participants reported: some of the content "was new" and 50 % stated "most was new" -All reported that the training prepared them to observe and respond to stress in the newborn, with 65% reporting being very well prepared -Familiarity with Early Relation Health increased from 27% to 68% following the workshop The NBO Program was introduced at Pediatric Grand Rounds. The presentation titled, "Early Relational Health in the First 100 Days of Life" was conducted by Lise Johnson, MD, Director of the Brazelton Institute. Over 70 clinicians attended.	Process Goal	Year 3 of 3
Reasons for social work referrals.	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 were more complex this year and included domestic violence with DCF involvement, unhoused individuals, child's health concerns and substance use, fetal demise, elective termination, substance use, and unplanned pregnancy. Expanded relationships with community partners for collaboration of resources and support services.	Process Goal	Year 3 of 3
Number of Maternity Services Council members.	The Maternity Services Council is comprised of 32 hospital and community members and meets quarterly. Four new members joined this year. 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. The Council is led by Community Co-Chairs and a Hospital Champion.	Process Goal	Year 3 of 3

EOHHS Focus Issues Mental Illness and Mental Health,

DoN Health Priorities N/A,

Health Issues Health Behaviors/Mental Health-Depression, Maternal/Child Health-Parenting Skills, Social Determinants of Health-Access to Health Care,

Target PopulationsRegions

- **Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston,
- **Environments Served:** Suburban,
- **Gender:** Female,
- **Age Group:** Adults,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Status:** Domestic Violence History, **Partners:**

Additional Target Population

Partner Name and Description	Partner Website
Jewish Family & Children's Services	https://www.jfcsboston.org/
MCPAP	https://www.mcpapformoms.org/

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
Establishment of one or two strategic areas of focus identified per each Council.	Supported the work of 8 Councils: the Mental Health Council - a school outreach initiative focused on mental health in youth and adolescents through community education, school-based professional training and consultation and parent support programming community partnership; the Palliative Care Council - focus on awareness and education on advanced care illness and the expansion of therapeutic music programming for palliative care patients; the Maternity Services Council - focus to specifically address post-partum depression and mental health concerns in maternal patients and provide supports and education through a number of different modes. integrate the Newborn Observation Training curriculum as practice in the clinical and community setting. Expand pregnancy mother support by piloting a Pre-Natal program; the Domestic and Sexual Abuse Council - the development of a Coordinated Community Response Network to enhance community education, raise awareness and facilitate effective support systems for those affected by domestic and sexual violence; the Elder Council - focus on growing a fully-representative council membership and creating a robust platform for community education to include caregiving and healthcare technology; the	Process Goal	Year 3 of 3
	Work Force Development Council - providing employment to low-income youth in the surrounding community and providing opportunities and exposure for workforce entry through work base exposure in the student intern program and healthcare careers education among school-based educators; and the Substance Use Council - focused on reducing stigma through community and provider education and partnerships, and increasing awareness and access of Narcan with education and training for students, and education, training and distribution of Narcan to parents and school personnel; and the Heart Health and Wellness Council that promotes cardiac wellness and preventive healthcare through its multi-faceted engagement with community members, employees, and patients with education and evidenced-based initiatives. The signature program of this Council is the Firefighter Heart Health Initiative, and the Walk and Talk Health programming conducted in the community mainly among senior populations.		

Continued growth and involvement of all 8 Community Collaborative Councils.	Maintain 8 community-focused councils: Heart Health and Wellness Council, Domestic and Sexual Abuse Council, Elder Council, Maternity Services Council, Palliative Care Council, Youth Mental Health Council, Substance Use Council, Workforce Development Council. Each Council has approximately 28-30 members and meets 3 times per year. In FY 24, 29 community members joined The Collaborative and became a new member on one of the 8 Councils. The four objectives of the Councils are: Ambassadorship/advocacy, Community education and outreach, philanthropy, and programmatic impact.	Process Goal	Year 3 of 3
An established Collaborative Council leadership structure of a Community Chair and a Hospital Champion for each of the 8 councils and for the Collaborative as a whole.	Further developed the operational framework of the Community Collaborative. The multi-pronged approach includes the development of community-oriented clinical programs, community educational programming, and community engagement through council ambassadorship and advocacy. The Collaborative leadership and staff resources were expanded to add a senior project manager role who is responsible for executing on the strategic priority initiatives, developed charters, created metric and tracked outcomes. This role is also responsible for overall member engagement and several subcommittees for each Council as they relate to both education and programming. All financials and philanthropic commitments associated with Collaborative initiatives are also maintained. In FY24 , a Collaborative Oversight committee continued and led by NWH Hospital President with involvement from nurse and medical leadership, as well as community members. The Chief Medical Officer was also added as a member to the Committee. All Collaborative Leadership (Oversight Committee members, Community Co -Chairs and Hospital Champions) meet five times per year to set the direction for the Collaborative, track metrics, explore new initiatives, and to share best practices. All leaders provide input. These meetings fostered increased collaboration among the Councils.	Process Goal	Year 3 of 3
Number of community members on the Collaborative Councils.	The Collaborative has a total of 220 community members involved across all 8 councils. The community members include those who have expertise on the subject for their council, those who have "lived experience" and those who are passionately engaged on the focus area. The Councils are led by Chairs or Co-Chairs who are community members and Hospital Champions who are NWH clinical leaders in the focus area. Each Council meets three times per year. In FY 24, there was a focus on council member engagement for current and new members. The Collaborative Journey of Community Engagement and Impact was utilized to inform and education others about the Collaborative as well as to "onboard new members. Each Council created an onboarding strategy and identified members or leaders to serve as an on-boarding Laison. Council initiatives were reviewed at each Council meeting and created an opportunity for discussion and input.	Process Goal	Year 3 of 3

Number of Council community programs held.	Each Council conducts community programming to provide education on topic areas related to their Council's focus area. The platform for these programs is virtual which has enabled ease of access and convenience and has increased overall attendance. The format is varied with keynote speakers, panels, documentary viewings, and include experts and community members and patients. All programs incorporate time for discussion and engaging through questions and answers. A recording of the event and follow-up up resource materials are sent to every registrant after the program. In FY 24 a total of 15 Council program events were held.	Outcome Goal	Year 3 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 AddictionSubstance Use,

Target PopulationsRegions

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

Additional Target Population Status, **Partners:**

Partner Name and Description	Partner Website
REACH Beyond Domestic Violence	https://reachma.org/
The Second Step	https://thesecondstep.org/
2Lifecommunitites	Not Specified
Newton Fire Department	https://www.newtonma.gov/government/fire
Waltham Fire Department	https://www.city.waltham.ma.us/fire-department
Natick Fire Department	https://www.natickma.gov/183
Needham Senior Center	Not Specified
JCC - Newton	https://www.bostonjcc.org/
Waltham Senior Center	Not Specified
MCPAP	https://www.mass.gov/doc/massachusetts-child-psychiatry-access-project-mcpap-servicereport-fy21-and-fy22/download
JF & CS	https://www.jfcsboston.org/
SOAR Natick	https://www.soarnatick.org/
Newton Health and Human Services	https://www.newtonma.gov/government/health-human-services

MA District Attorney	https://www.mass.gov/directory-of-district-attorney-offices
Boston Bulldogs	https://www.bostonbulldogsrunning.com/
MassBay Community College	https://www.massbay.edu/
Waltham Partnership for Youth	https://walthampartnershipforyouth.org/
Spark Kindness	https://www.sparkkindness.org/
NWH School Districts: Natick, Needham, Newton, Wellesley, Waltham, Weston	Not Specified

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NWH Immigrant Health Support and Navigation

Program Type Total Population or Community-Wide Interventions

Program is part of a grant or funding provided to an outside organization No

Program Description Provide culturally centered health care access, support resources, linkages to community partners and organizations. Foster and create trusted environment to newcomers to the community setting - adults, children and family units. Navigate the healthcare system and basic needs for those just arriving in our communities.

Program Hashtags Community Education, Health Screening, 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
Number of individuals and households served. The languages used in the home of those seeking assistance at the Welcome Center. Types of supports offered.	NWH provided sustaining support to the Welcome Center located in the Waltham community. The Center is a bilingual welcoming space and referral hub dedicated to supporting newcomer immigrant families with children in the Waltham Public Schools district. WPY and Waltham Public Schools staff provide culturally sensitive support in Spanish, helping families access basic needs and services via 1-1 meetings and community events. In FY24, there were 149 Welcome Center visits for the school year. Newcomer immigrant students and families from all 11 of Waltham's schools utilized services at the Welcome Center. The languages of those seeking services were Spanish, English, Haitian-Creole, and Russian. Supports provided were accessing food and housing, healthcare, mental health services, school enrollment and processes and immigrant legal services. The Welcome Center hosted several workshops to support newcomer families and students in Waltham. All sessions were held in Spanish.	Outcome Goal	Year 3 of 3

Ways of providing a welcoming and responsive environment for new arrivals in the NWH. Interventions to assist newly migrant families and individuals navigating complex challenges.	Continued the NWH Migrant New Arrival Response Team throughout 2024. Discussed current challenges and opportunities in meetings with community-based organizations such as the Department of Public Health, Office of Refugee and Immigrant services, Charles River Community Health Center, shelter specific sites, food pantries, and others. Further developed staff educational resources with appropriate reference materials to care for new arrival individuals and families. These included a Trauma Informed Reference Guide and a Tool Kit for Cross-Cultural Communication. Expanded language access services through Interpreter Services. Continued with supplies of basic need with gift cards for essential items, car seats, and clothing. Clinical Leadership in Pediatrics established an Immigrant Health	Process Goal	Year 3 of 3
	Lecture for medical students that is held every 8 weeks to raise awareness for patient care to diverse populations. Topic areas include barriers, culturally competent care, system supports, and a patient case(s). Also includes review of current AAP guidelines for the evaluation and treatment of recent migrants from low resource settings.		

Collaboration through grants and partnerships with community organizations working with immigrant populations.	A total of $125,000 in grant funding was provided to Family Aid - Newton (@$100,000) and Waltham Welcome Center - Waltham (@$25,000) to assist these organizations to expand capacity in supporting refugees and immigrants through providing needed housing, access to resources, opportunities for success, and connection within our surrounding communities. Results and impact of the funding was as follows: 1. Waltham Partnership For Youth/Welcome Center: WPY's Wraparound program staff, including the Welcome Center Coordinator, also conduct Needs Assessments with a cohort of newly immigrated middle and high school students. The Needs Assessment process is an opportunity to build relationships with individual students, highlight students' strengths, and identify areas where they would benefit from additional community resources/services. Between April-September 2024, we conducted 74 Needs Assessments with newcomer middle and high school students. Below is an overview of the services that we provided between April-September 2024: -69 cases of direct support with accessing resources to address food insecurity -53 referrals to partner organizations to address basic needs, including housing, food insecurity, mental health, family counseling, employment/jobs, and more -13 students received donated clothing -11 cases of applying for affordable wifi -10 cases of direct support with accessing their home country's Consulate - 1 case each of submitting a rental assistance application, enrolling. We have also provided 13 students with Flex Funds, which are available to help students and families through life's inevitable emergency situations so that students can continue along their personal pathway to success. Between April-September 2024, we distributed $3,660 in Flex Funds, going towards everything from emergency housing assistance, to food, and transportation. It should be noted that 10 of the 13 students needed support with accessing food. As such, we distributed $1,450 in grocery store gift cards to 10 students and their families. 2. FamilyAid/Family Navigation Center - Built state-of-the-art training and educational spaces, a teaching kitchen, study and living lounges, and indoor and outdoor play areas for children in our care that are not part of government shelter grants and loans but are essential to our families' ability to thrive long-term. The Director of 2Gen Services and team of six Navigators have been formalizing partnerships with community service providers to support FNC families with adult learning, employment and training resources, food, transportation, childcare, early childhood enrichment, after-school activities, and more. 20 committed community partners and are in conversation with 27 other organizations.	Process Goal	Year 3 of 3
Number of clients taking part in the program for ESOL and job readiness. Number of clients employed.	Created the Shelter To Employment program, a partnership with JVS Boston, MassHire MetroWest, NWH and MGB, and Middlesex Human Services Agency, Inc (Extended Stay site in Waltham) to provide contextualized English for Second Language classes to newly arrived immigrants living in shelters and place these job	Outcome Goal	Year 3 of 3

	seekers in high quality employment at Newton Wellesley Hospital, Salem Hospital and community employers. Provided career coaching, ESL+OL, and employment opportunities. 42 clients served: with a total of 12 employment placements. The six placements at NWH were in Support Services (food services, EVS, transport, and materials management). 6 positions were full time and all offered insurance. The average wage was $19.61.		

EOHHS Focus Issues N/A,

DoN Health Priorities N/A,

Health Issues Chronic Disease-Diabetes, Health Behaviors/Mental Health-Mental Health, Maternal/Child Health-Reproductive and Maternal Health, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of HealthAccess to Transportation, 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-Racism and Discrimination, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of HealthViolence and Trauma,

Target PopulationsRegions

- **Served:** Dedham, Framingham, Newton, Waltham,
- **Environments Served:** Suburban,
- **Gender:** All,
- **Age Group:** Adults, Children,
- **Race/Ethnicity:** All,
- **Language:** English, Haitian Creole, Portuguese, Spanish,
- **Status:** Domestic Violence History, Refugee/Immigrant Status,

Additional Target Population

Partners:

Partner Name and Description	Partner Website
Waltham Partnership for Youth Welcome Center	Not Specified
Waltham Public Schools	Not Specified
Family Aid	Not Specified
Jewish Vocational Services	https://www.jvs-boston.org/
MassHire	https://masshiremsw.com/

NWH 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 Greater Boston Food Bank's report estimates that 32 percent or 1.8 million adults in the state experienced food insecurity in 2021. Food insecurity rates were highest among Latinx adults, Black adults, people who identify as LGBTQ+ and adults with children. The connection between food security and nutrition-related chronic diseases is the reason Mass General Brigham system institutions have created 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
Formed partnerships with food access community organizations.	Further developed the Nutrition Security and Equity Community Network. Included are organizations providing food access (schools, senior services, public health, food pantries, health services, community farms, faith, and community organizations) in the NWH geographic area of Waltham, Wellesley, Weston, Natick, Needham, and Newton. The Network also includes NWH leadership and clinicians. Meet three times per year. Topics discussed were methods of service delivery and distribution, increase in client needs and more diverse client populations, non-food supports needs, increase of immigrant and unhoused clients, ability to provide cultural relevant foods selection, access to support programs, and increased level of anxiety related to accessing support programs in the community. Broader regional and federal efforts on hunger, nutrition and health were shared for participation. The Work Group has grown to include additional members and types of food delivery partners. Members have expressed the value in convening the group and collaborating on topics, challenges, opportunities and sharing of best practices related to nutrition security and equity. A recent comment from a member was: "valuable collaborative meeting this morning. I found the topics covered and exchanges very worthwhile." Food resource options are included in the NWH Community Resource Book that is distributed to NWH clinical teams. Continued representation on the Newton Food Pantry Advisory Board. On-going partnership of NWH and Healthy Waltham and other food delivery sources.	Process Goal	Year 3 of 3
Number of outreach events held. Number of attendees at programs. Identified at-risk populations.	Conducted three outreach events that included blood pressure checks by a NWH nurse team (77 participants). Participated in the Empty Bowls program to raise awareness about food insecurity on college campus. Bring the community together and promote available resources and support to address the statistic that over 30% of college students on campus are food insecure. Held a community outreach/education event for the 2nd year at the Waltham Boys and Girls Club for middle school campers. (40 campers). Participation from NWH pediatrics, nutrition and food, and community health. Instruction and hands-on guidance were given for the students to make three nutritious recipes. Education of healthy food choices and options were provided as well with a lens for cultural awareness given the diversity of youth campers. The campers were then responsible for serving and speaking to the elementary age campers (60 campers) about what they had learned. Recipe cards in multiple languages were provide to the student after the program and to bring home to their households.	Process Goal	Year 3 of 3
Provide NWH funding to local food provider organizations to grow capacity, extend client reach and access to healthy foods.	As a result of the challenges for food access among families in the Waltham community, NWH increased grant funding to the Waltham Boys and Girls Club for the Summer Eats Program to $15,000. Summer Eats is located at 14 sites throughout Waltham to ensure students have access to free healthy food during the summer months. This past year WBGC served 55,340 healthy meals and snacks to approximately 1,200 children and teens throughout Waltham and a take-home grocery bag program, which distributed 100 bags of nutritious grocery items each month September 2022 - June 2023.	Process Goal	Year 3 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 PopulationsRegions

- **Served:** Natick, Newton, Waltham, Wellesley, Weston,
- **Environments Served:** Suburban,
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Status:** Refugee/Immigrant Status, **Partners:**

Additional Target Population

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

Preventive Health/Health Engagement

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, Prevention,

Program Contact Information Jane Barr, Wellness Coordinator, Cardiovascular Health Center

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Number of senior-specific focused programs held.	Held multiple virtual and in person senior educational and socialization events with focused on exercise, staying healthy, nutrition, heart health, and chronic conditions. 500 seniors engaged in the events.	Outcome Goal	Year 3 of 3

Number of Cardiovascular Council members.	The Heart Health and Wellness Council, comprised of 29 community and hospital members (one new member welcomed in FY24), met three times in FY24 year. The Heart Health & Wellness Council reaches out to the diverse populations of Newton-Wellesley Hospital to promote preventive health. Through community-based education and hands-on programming, the Council encouraged fitness, nutrition, and stress management to reduce the risk of cardiovascular and other chronic diseases. In addition, the Council champions cutting-edge technologies within the Elfers Cardiovascular Center for the diagnosis and treatment of heart disease.	Process Goal	Year 3 of 3
Increase awareness within NWH medical community and South Asian patient population about risk for CV disease Comprehensive and advanced screening for risk factors and CV disease at BMI < 23 Provide culturally appropriate, personalized lifestyle advice and health coaching with special focus on diet and exercise.	Over 100 visits were conducted by staff that included cardiology clinicians, exercise instructors, and dieticians, Provided interactive education at a Test Kitchen located in the community. The Wellness/Fitness Coach conducted 33 phone intakes and scheduled 44 in person fitness sessions. The sessions consist of one 30 minute fitness eval and one 30 minute personalized exercise program session. A platform called Medbridge to provide detail videos of exercise program and ability for patients to track progress was also utilized.	Outcome Goal	Year 3 of 3
Number of Cardiovascular diseaserelate prevention and outreach programs held.	Participated in community outreach events for schools, senior centers, and civic organizations. Expanded focus on AED and CPR instruction and demonstration to high schools in the NWH communities to include the purchase of 16 Trainers for high schools.	Outcome Goal	Year 3 of 3
Number of communities where Heat Heath initiative is taking place. Number of sessions held. Number of participants.	The Heart Health Initiative has been implemented in to all six of the NWH community firehouses, and the Recharge program has been fully implemented, as well. More than 300 firefighters participated in FY24. All three sessions were conducted on site in FY24. Session one: Cardiovascular Risk Evaluation American Heart Association Cardiovascular Risk Assessment Blood Pressure Screening Functional Movement Screening Stress, Sleep & Relaxation discussion and techniques Session two: Nutrition Rate Your Diet Assessment Heart healthy nutrition education Recipe adaptation for heart health Cooking demonstration and tasting Session Three: Exercise Godin Leisure-Time Exercise Questionnaire Exercise program based on Functional Movement Assessment with modifications for different abilities.	Outcome Goal	Year 3 of 3
Number of community agency partners for Walk and Talk Health. Number of participants walkers.	During FY 24, all six of NWH communities took part in Walk and Talk Health (Waltham, Newton, Needham, Natick, Weston). The session took place in community setting locations. A total of 900 individuals participated.	Outcome Goal	Year 3 of 3

Number of disease prevention and education programs held.	In FY24, NWH conducted screenings for the community related to illness to include mammograms (27 conducted), lung cancer screening day (3 patients screened), and expanded the colon cancer screening outreach project through American Cancer Society ECHO initiative. Educational forums were held for all members of the community on breast and lung cancer (101 registrants). Post- sessions, resource materials were sent to program attendees for further detail on follow up care. NWH also actively engaged to promote and educate on cancer care education and screening awareness at a number of community-wide onsite events. Interacted with over 2000 community members. Conducted cancer survivorship events focused on support, education, and well-being. Partnered with the American Lung Cancer Screening Initiative (ALCSI) and a local college to advocate and raise awareness for reducing barriers for lung cancer screenings and a focus on advocacy.	Outcome Goal	Year 3 of 3
Cardiovascular Health: Conduct the Small Steps for Better Health Program and offer it to a variety of at-risk populations. Curriculum is comprised of educating on food selection, how stress is handled, and the importance of exercise Content and discussion emphasize the importance of making small changes to have a large, positive effect on health.	The Small Steps Program was held at 6 community sites - Senior centers, libraries and living communities. In FY 24 the focused population was seniors and over 200 individuals participated. Discussion covered highlights of a heart healthy diet, took a look at key ingredients that nourish the heart, reviewed the latest physical activity recommendations and looked at how resiliency techniques can help manage stress	Outcome Goal	Year 3 of 3
Number of events NWH participated in.	NWH had various levels of staff participate in education and wellness programs held by community organizations. Topics ranged from sun and heat safety, mental health, wellness, stress management, youth mental health, substance use, senior wellness, and medical innovation (robotics) others.	Process Goal	Year 3 of 3
Number of PAVING Program sessions held and number of participants.	Based on the principles of lifestyle medicine, PAVING the Path to Wellness is a 12-week program which provides education on the importance of physical activity, healthy eating, sleep, stress management, and the power or personal connections for women with a diagnosis of breast cancer. Participants in this program take each step together and share personal strategies and solutions for positive lifestyle changes, both during and after treatment for breast cancer. The PAVING program empowers participants to adopt and sustain healthy habits for a lifetime. Participants benefit from the supportive, collaborative environment. In FY24, a 6-week PAVING program focused on the needs of those with breast cancer was held in collaboration with another healthcare institution. Multiple groups were held through-out the year with a total of 75 participants.	Outcome Goal	Year 3 of 3
Number of staff representing NWH on community boards, committees, etc.	Over 18 NWH clinicians and staff served on organized local community boards and offered their specialized perspectives on strategic initiatives. These included health departments, youth organizations, business chambers, substance use coalitions, crisis response teams, social service, safety agencies, and nonprofit agencies.	Process Goal	Year 3 of 3

Number of flu vaccine provided. Number of flu clinics held.	In FY24, NWH held four community flu clinics all within the Waltham community to include the Healthy Waltham site for food distribution. NWH administered a total of 104 flu vaccines in the community. Promotion of the flu clinics were communicated in Spanish and a NWH provided an on-site Spanish interpreter.	Outcome Goal	Year 3 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,

Target PopulationsRegions

- **Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston,
- **Environments Served:** Suburban,
- **Gender:** All,
- **Age Group:** Elderly,
- **Race/Ethnicity:** All,
- **Language:** English,
- **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Natick Department of Public Health	Not Specified
Natick Senior Center	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
Healthy Waltham	Not Specified

Research

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 involvement in research as an investment in our patients and our community as a whole. Our engagement in innovative research programs provides our patients access to cutting-edge treatments through participation in clinical trials and improves clinical care through the development and implementation of evidence-based treatment strategies.

Program Hashtags Research,

Program Contact Information Maureen Dwyer, Director, Office of Clinical Research

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Leveraging technology options in a busy clinical setting to promote advance care planning.	An on-going study conducted to examine the potential of a video-supported intervention initiated during the emergency department visit to promote advance care planning.	Process Goal	Year 3 of 3
Number of participants enrolled in the study.	This on-going study seeks to understand if new drugs help patients in the hospital with COVID-19 get better faster. Getting better faster includes getting off oxygen and going home from the hospital. This study will enroll up to 2000 people at up to 100 sites.	Process Goal	Year 3 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-Physical Activity, Infectious Disease-COVID-19,

Target PopulationsRegions

- **Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston,
- **Environments Served:** Suburban,
- **Gender:** All,
- **Age Group:** All,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Status:** Not Specified

Additional Target Population **Partners:**

Partner Name and Description	Partner Website
Not Specified	Not Specified

Senior Wellness

Program Type Total Population or Community-Wide Interventions

Program is part of a grant or funding provided to an outside organization No

Program Description Addressing the goals of our community elders is a priority in developing Senior Wellness initiatives. Services and programs are created to value increased independence, safety, and happiness throughout life. They examine a variety of elements of physical and emotional well-being.

Program Hashtags Community Education, 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

Number of Elder Council members.	The Elder Care Council is comprised of 28 hospital and community members, welcoming 8 new members in FY24. The Elder Council is led by a Community Chair from one of our senior living communities. and a Hospital Champion who has expertise in the areas of inpatient and outpatient services, population health, and the care continuum. The Council meets three 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, addressing risks related to falls, delirium, and needs related to the care continuum.	Process Goal	Year 3 of 3
Range of community partnerships	Collaborated with local senior centers, YMCA's, housing complexes, and others on health education and senior wellness activities. Program topics included nutrition, mental health, advanced care planning, heart health, chronic disease, health navigation and technology, volunteer opportunities, healthcare access and coverage, and a variety of other subjects.	Process Goal	Year 3 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 PopulationsRegions

- **Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston,
- **Environments Served:** Suburban,
- **Gender:** All,
- **Age Group:** Adults, Elderly,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Status:** Not Specified **Partners:**

Additional Target Population

Partner Name and Description	Partner Website
Natick Senior Center	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

Substance Use Outreach, Treatment and Education

Program Type Total Population or Community-Wide Interventions

Program is part of a grant or funding provided to an outside organization	No
Program Description	The substance use program at NWH is designed to provide multidisciplinary addiction consultation and coordinate a treatment transition for long term recovery for patients; educate clinicians on caring for substance use disorders; and collaborate with the community on substance use disorder prevention and treatment.
Program Hashtags	Community Education, Health Professional/Staff Training, Prevention, 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
Number of awareness campaigns held.	For the sixth 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. The annual remembrance event held in front of NWH was attended by staff, hospital administrative and clinical leadership, patients, families, and community members. Speakers at the 2024 ceremony included Marion Ryan, Middlesex County District Attorney, members of SOAR Natick a support group for parents with family suffering from opioid addiction, and an impact testimonial from an individual in recovery. The Purple Flags were on display during September and October 2024 on the front lawn of NWH. In addition to the annual remembrance event, additional awareness events and resources were shared to focus on the need for reducing stigma associated with substance use. An on-going awareness campaign was conducted throughout Recovery Month for the community, employees, and visitors. Social media was leveraged to bring attention to substance use disorders and addiction.	Process Goal	Year 3 of 3
Identification of hospital-wide efforts. Developed and conducted training and education for providers and others to understand resources and to raise awareness of treatment options and protocols.	In FY 24, 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 postsurgical opioid prescribing guidelines, and one-on-one PCP outreach to support chronic pain and substance use patients with physician-led support.	Process Goal	Year 3 of 3

Number of education sessions conducted. Types of education sessions held.	Expert Substance Use Service clinicians provided training in pain management and medical management of addiction, with a special focus on increasing the visibility of NWH SUS and educating primary care physicians in treatment options. To support this effort, the SUS team hosted a Grand Rounds lecture with Dr. Joji Suzuki, Director of the Division of Addiction Psychiatry and Director of Addictions Education in the Department of Psychiatry, Brigham and Women's Hospital. Discussed were areas of clinical and research interests in the assessment and management of substance use disorders and related conditions in general medical settings, motivational interviewing, office-based opioid treatment, implementation of collaborative models of care, and medical education. A second grand rounds was held with Dr. Alex Walley, Professor of Medicine and an addiction expert at Boston Medical Center and Chobanian and Avedisian School of Medicine and Massachusetts Department of Public Health's Bureau of Substance Addiction Services and the Overdose Prevention Program (BSAS) Medical director Dr. Walley is focused on the medical complications of substance use, specifically HIV and overdose. Dr Walley has conducted multiple studies related to the opioid crisis and the integration of addiction specialty care and general medical care. The Substance Use Clinical Team also organized a 3/4-day PCP Interdisciplinary Symposium titled, "Pain Manger and Substance Use Disorder Pearls for the General Practitioner". There were 40 PCP attendees. CEU's were provided.	Outcome Goal	Year 3 of 3
Number of Narcan and Epipens distributed to community.	Provided 150 doses of Narcan and Epipens to local fire departments, schools, and colleges.	Process Goal	Year 3 of 3
Number of Naloxone kits distributed in the Emergency Department.	In FY24, NWH dispensed approx. 60 naloxone kits to patients in the Emergency Department with diagnosis of opioid overdose.	Outcome Goal	Year 3 of 3
Number of Narcan doses distributed to community.	Access and use of Narcan is an effective option of treating drug overdose. The use of this resource in the community is a need for various agencies. NWH is able to provide Narcan and training to our community partners to support their efforts of dealing with the opioid crisis. In FY24, NWH provided 140 doses of Narcan to local community partners police and fire, public health, schools and shelters. Provided training to community partners, as necessary. For the second year, conducted Narcan training for the 25 summer youth interns. Assoc. Director of the Substance Use Clinic provided hands-on Narcan training along with the distribution.	Outcome Goal	Year 3 of 3
Number of patients seen in Substance Use Service. Percentage source of referrals.	SUS front-line clinicians (MD's, PA, Recovery Coach and Social Worker) completed 2500 patient visits. Highest Referral Reasons were: 72% alcohol and 9% opioid. Most Frequent Referral Sources: Emergency Department (287 pts) and Primary Care clinicians (160 pts)	Outcome Goal	Year 3 of 3

Number of sessions held and participating activities.	Conducted and participated in community wide lectures and resource nights on alcohol use and opioid use, the intersection of substance uses and mental health, and stigma. Internal and external experts took part in the sessions. A variety of mediums were used such as film documentaries, Q&A panels, personal story sharing, and research. Resources, treatment, and awareness options were highlighted as part of every event's content and follow up information was provided after each program. Events were conducted virtually and in-person. 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 3 of 3
Number of Substance Use Council members.	The Substance Use Council, comprised of 29 community and hospital members, represent both clinical and societal perspectives. The Council meets three times per year and focuses on key initiatives that further ways to provide critical services at the time of greatest impact. The FY24 priority initiatives included building a pilot of a NARCAN training and distribution program for the local school communities in the NWH catchment area, which will launch in FY25. Additionally, the SUS Council hosted a popular webinar in partnership with the Palliative Care Council by Dr. Beth Darnall, scientist, pain psychologist, author, and Associate Professor of Anesthesiology, Perioperative and Pain Medicine at the Stanford University School of Medicine where she directs the Stanford Pain Relief Innovations Lab, titled A Mind-Body Approach to Pain: Practical Management Strategies for Relieving Pain.	Process Goal	Year 3 of 3
Number of support group sessions held.	In FY24, the SUS Recovery Coach conducted three weekly group support sessions for clinic patients and the community (virtual and in-person) throughout the year. The sessions took place both in-person and virtually, with upwards of 35 joining per week. Group participants are between the ages of 20-75 years old. A SUS clinician specializing in individual, dialectical and cognitive behavioral therapy also launched a new monthly family and friends support group in FY24. Efforts in future years will focus on recruitment from both the clinic and the broader community, with a focus on specialized populations (spouses, parents, siblings, friends, etc.)	Outcome Goal	Year 3 of 3
Placement of MedSafe receptacle in the hospital. Outreach activities for safe medication disposal.	Maintained a MedSafe receptacle for the safe disposal of medications. Promote use among staff, the community and physician practices of this option. Took part in Drug Take Back Days activities internally at the hospital and in the community. Created promotional materials, had a resource table staffed with clinicians, and provided a location for medication drop-off.	Process Goal	Year 3 of 3
Number of representations on community work groups, task forces, collaboratives.	In FY24, 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 Substance Use Task Force, Boston Bulldogs, Natick 180 Coalition (in a leadership role), in addition to others. The hospital continues to partner with the Middlesex District Attorney's office for the Charles River Regional Opioid Task Force. Members of the NWH SUS clinical team and community health regularly participate and present at the above meetings.	Process Goal	Year 3 of 3

EOHHS Focus Issues Substance Use Disorders,

DoN Health Priorities N/A,

Health Issues Substance Addiction-Substance Use,

Target PopulationsRegions

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

Additional Target Population Status, **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

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

Program Type Total Population or Community-Wide Interventions

Program is part of a grant or funding provided to an outside organization Yes

Program Description The DV/SA Program provides free, voluntary, and confidential services to patients and employees who are experiencing domestic violence, family violence and sexual assault.

Program Hashtags Community Education, Health Professional/Staff Training, Prevention,

Program Contact Information Rehana Rahman Manager, DSV Program

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Partnership impacts on at-risk DSV populations.	Program staff continue to partner with MenHealing, a national non-profit organization dedicated to providing help for male survivors of sexual assault, sexual abuse, and sexual trauma across the lifespan. - Program staff co-facilitated a Level2 Advanced Weekend of Recovery (WOR) in-person Retreat to support MenHealing's mission to expand its services to historically marginalized communities. - Program staff continued to support the advancement of several projects and supporting efforts to adopt culturally appropriate practices in an effort to expand outreach and programming to marginalized communities and to increase participation among men of color who are survivors of sexual assault. With a $2,500 grant from the NWH Community Benefits Program, MenHealing the "Just healing" MensHealing podcast Series continued with several episodes airing. - NWH is supporting Saheli Boston (DV Organization that specializes in serving South Asian and Arab women and families) in its mission to become a dual domestic violence and sexual assault program. - With funding support from the NWH Community Benefits Program, DSV program staff co-facilitated three support groups in partnership with Saheli. - In the Fall a 6-week skill building support group with children ages 7-12 who have witnessed Domestic Abuse in their home was held. o Participants engaged in social skill building and emotion regulation through engaging in group discussion, mindfulness exercises and play therapy activities. In 2024, the NW DV/SA Program continued its third year partnership with BARCC to provide ongoing trauma-informed clinical and structural guidance to better serve survivors of sexual violence and abuse.	Process Goal	Year 3 of 3

Number of clients served by REACH Latinas Know Your Rights (LKYR) Program.	In FY 2024, NWH continued its collaboration with REACH Beyond Domestic Violence to better serve the needs of Spanish speaking survivors through a $50,000 grant. In addition to run the LKYR program. Since the grant was first initiated in FY 2019, it has allowed the partnership to directly serve over 400 Latina survivors in Waltham, ensuring that dozens of families received emergency rental assistance, support with relocation, utilities, and access with other basic needs such as food. In FY24, NWH also launched a Coordinated Community Response (CCR): MetroWest Domestic and Sexual Violence Collaborative, a partnership with Journey to Safety, Newton Wellesley Hospital Domestic Violence/Sexual Assault Program, Reach Beyond Domestic Violence, and The Second Step, with goals: -To foster collaboration and connection among providers - To remove barriers to access to services and enhance effectiveness of services for survivors -To promote sustainability in the field of domestic and sexual violence Funding from the NWH Community Collaborative has supported the hiring of an expert resource to identify needs and strategic planning initiatives for the program, and also identify key stakeholders, hosting focus groups and making recommendations for the future of the project.	Process Goal	Year 3 of 3
Number of clients served.	In FY24, the program served over 109 distinct survivors of violence and abuse and provided 108 case consultations to the hospital and community.	Outcome Goal	Year 3 of 3
Number of council members.	The Domestic and Sexual Abuse Council, comprised of 17 members, with 3 new members joining this year. The Council meets three times per year. The Council has been instrumental in disseminating emergency resources to victims of abuse, developing support programming, fostering networks, and reacting to community and partner needs. This year, the Council hosted educational activities for the community including the well-received How to Talk to Your Kids about Relationships - and Why You Can't Wait with Jess Teperow, Founder and CEO of JT Consulting and expert in gender-based violence	Process Goal	Year 3 of 3
Number of hours for planning, counseling and advocacy related work/services. Topic areas of trainings held.	In FY 2024, provided 14 DSV specific trainings to the hospital and the community and hosted 4 facilitated trainings on antiracism and anti-discrimination for social workers across the Greater Boston hospitals. In addition, thousands of hours of additional time were devoted to community education, technical assistance training, policy development, and collaboration with community organizations, such as: DV Training for MGB Home Hospital Lunch & Learn: DV101 for Inpatient SW - Focused on overview of DSV frameworks -Future training on documentation, screening and case presentation DVSA Training for Chief Medical Officer and Chief of Emergency Medicine NWH DV/SA I Confidential do not copy or distribute DVSA Training for Nursing Residency Program COBTH DV Council Training for NeighborHealth Gender-Based Violence Coalition	Process Goal	Year 3 of 3

Number of sites served. Number of new sites established. Extent of regions impacted. Additional resources provided through community partnerships.	The National Telenursing Center (NTC) was established in 2012 with a Department of Justice (DOJ) grant. NWH partnered with MA DPH SANE Program, Boston Area Rape Crisis Center, US Navy, National Indigenous Women's Resource Center, amongst others, to begin utilizing telemedicine to export specialized forensic nursing expertise to areas of the country disproportionately impacted by sexual assault. NWH added 4 more Tele SANE positions in FY 2023. Initial pilot sites included: - Multiple military sites, including 29 Palms, CA - Indian Health Services facility in Polacca, AZ- Rural critical care access hospitals, CO & CA NTC staff are on a Technical Assistance (TA) Team with the International Association of Forensic Nurses (IAFN) providing TA to 4 demonstration sites which are launching TeleSANE services with DOJ/Office for Victims of Crime (OVC) grant funding. The 4 sites include: - Avera Health in South Dakota (also serving Nebraska and North Dakota) - University of Arkansas Medical Center - Texas A&M University - Tundra Women's Coalition in Alaska Currently, NTC staff/MA DPH SANE are supporting Rhode Island in their development of a regionally based SANE Program, based on the MA model. Initial sites include Rhode Island Hospital, Miriam Hospital, Newport Hospital and Hasbro Children's Hospital. NTC staff/MA SANE are now also offering TeleSANE services to 10 MA hospitals thanks to a DOJ/OVC Technical Assistance (TA) grant: - Martha's Vineyard Hospital,- Nantucket Cottage Hospital - North Shore Medical Center - Baystate Franklin Medical Center - Good Samaritan Medical Center - MetroWest Medical Center - Athol Hospital	Process Goal	Year 3 of 3
	- Sturdy Memorial Hospital - Beverly Hospital - Saint Anne's Hospital - Indian Health Services facilitate, Polacca, AZ		
Types of education/resources provided. Impact of education and awareness activities.	Program staff took part in multiple forums and offered expertise in the area of DSV. One highlight: DVSA Program partnered with NWH's Department of Spiritual Care (DSC) to provide 50+ bags of chocolate with a summer greeting to different people and programs throughout the hospital. Bags were provided to the Senior Leadership Team, the Emergency Department, nursing leadership, inpatient units, etc Promoted and participated in activities related to Domestic and Sexual Violence related Awareness Months. Including the Rainbow Wave, DVSA Flyers in all hospital bathrooms, State House Advocacy and 5 tabling and one awareness raising event.	Process Goal	Year 3 of 3

Variety of programs offered. Number of community collaborations. Extent of multi-lingual programming offered.	The program continues working to build options for support and empowerment groups this year. Program staff offered 12 support groups in collaboration with our community partners. Those support groups included the following among others: Resilience Toolkit Group: A six-week support group for survivors of violence, abuse and trauma, intended to provide survivors with the tools for self regulation, rebuilding sense of self and widening their emotional tool belt. Child Witness to DV group in partnership with REACH: Three groups, different age ranges, 12-week program Topics include: feelings awareness, identities and belonging, coping skills, trauma responses, conflict resolution and more. Post-separation Abuse Workshop: Post-separation Abuse workshop in English for survivors who are interested in learning and/or challenged with topics such as: -Neglectful or Abusive Parenting -Coercive Control -Legal Abuse -Financial Abuse -Divorce: basics about divorce, pros and cons of filing, process -Separate Support: pros and cons compared to divorce, process - Custody: legal vs. physical, process, GAL, DCF, joint custody issues -Child Support: basics, process, paternity, DOR -Enforcing Agreements & Court Orders: Motions for Contempt -Restraining orders/Harassment orders	Process Goal	Year 3 of 3

EOHHS Focus Issues N/A,

DoN Health Priorities Violence,

Health Issues Health Behaviors/Mental Health-Mental Health, Injury-Other, Social Determinants of HealthDomestic Violence, Social Determinants of Health-Violence and Trauma, Substance Addiction-
Alcohol Use,

Target PopulationsRegions

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

Additional Target Population 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 Community Education, 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
School system partnership and collaborations.	Expanded Newton-Wellesley staff representatives serving on the Waltham High School Health Assisting Program Advisory Committee Meeting and the Waltham High School - School to Career Work Team. to include nursing clinical leaders. For the new Waltham High School Health Assisting classrooms in the new high school, NWH provided a significant volume of hospital and clinical supplies for use in the program. In addition NWH provided all the first aid materials for the 1st year exploratory students. when additional supplies, resources, and additional connections to the hospital setting. Developed of a structured clinical and co-op placement in nursing for Health Assisting students. Clinical rotational assignments on the nursing units started in January 2024. # of students: 8 Units where placed: medical/surgical Training provided: CNA and BLS at WHS Number of hours per week/schedule: approx. 20hr/week per student	Process Goal	Year 3 of 3
	Year of students: seniors class of 2024 Feedback from students: Students are very happy at NWH. It is an adjustment for them working in a fast paced environment and learning additional skills on the job. They are also learning real-life skills and learning what it means to be a good employee and coworker. They are learning how to manage all sorts of patients and illnesses. They are gaining experience in ways they could never have in the classroom. Feedback from WHS Health Assisting Advisor: Working with NWH has been great. The nurse educators and directors are truly invested in our students and giving them the best experience possible. Communication is a priority for them which really helps me to be involved in the students co-op experience from afar. I feel safe having the students placed at NWH and believe this is an incredible experience for all of us.		

Extent of outreach.	Leveraged community networks to promote opportunities for employment in healthcare. Promoted training programs through multiple community agencies and within the Mass General Brigham System. Highlighted opportunities to become employed in high vacancy areas such as lab tech, pharmacy tech, medical assistant, patient care assistant, surgical tech, and central sterile. Provided information in multiple languages to access populations of all backgrounds. Attended multiple events held in the community, with the Newton Dept of Health and Human Services, and healthcare career days and collaborated with community partners to promote healthcare placements of at all levels and for both adults and youth.	Process Goal	Year 3 of 3
Number of collaborative affiliations. Number of adult and youth vocational volunteer participants. Total hours of adult and youth vocational volunteers.	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. In FY24, there were 21 student vocational program partnerships with 24 participating students who contributed 956 hours of service. In FY24, 7 adult vocational program partnerships with 7 individuals took part and contributed 622 hours of volunteer service. All placements offered opportunities for the development of workplace skills, interaction with a healthcare team, exposure to and growth in understanding the healthcare environment, work expectations and overall job responsibilities.	Outcome Goal	Year 3 of 3
Number of placements. Forms of community engagement.	Provided placements for three of Newton interns at NWH. The students were placed in multiple areas of the hospital to include transport, patient ambassador, and outpatient clinics. The students also attended weekly career exploration sessions held throughout the summer. Session presenters were a variety of hospital staff in all levels of healthcare. Provided a summer paid internship placement in Child and Adolescent Psych for the purpose of exposure in the field of mental health. Student focused on the development of resources, and content for further educating youth about the field. Participated in Family Access/Newton Health and Human Services Youth Network with a variety community partners with the goal of fostering growth and empowerment among youth as well as career exposure and opportunities for advancement.	Process Goal	Year 3 of 3
Number of sessions held. Number of participants.	Conducted 7 weekly career exploration sessions during the summer for community youth. Attendees included the NWH/Waltham Partnership for Youth interns, the City of Newton interns, and the NWH high school and college volunteers. Reaching 160 youth. Involved 20 NWH staff participating in the weekly programs. Focused on both clinical and non-clinical roles, career paths/journeys, addiction medicine, dermatology, pediatric medicine, mental health, medical innovations and technology advancements in healthcare. Included case studies, panel discussion, Q&A, and use of equipment.	Outcome Goal	Year 3 of 3

Number of student interns. Number and types of student placements. Number of career exploration/medical innovation sessions.	In FY23, hired 23 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. Placements included a wide array of clinical and non-clinical departments that included Radiology, Women's Imaging, MRI, Gastroenterology, Surgical Practice, Nursing, Environmental Services, Transport, Volunteer Services, Public Safety, Patient Experience, Joint Center, Cardiology, Clinical Education, Primary Care, Sterile Supply, and Ambulatory Services. 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 20 NWH staff participated in the career exploration/medical innovation sessions. Several students were also able to shadow and speak with staff in areas of their interest. Of the NWH intern cohort, 38% were of Hispanic or Latino backgrounds. 18 distinct ethnicities were represented. Transportation was provided to students to reduce barriers for participating in the program. At the conclusion of the program, 79% of the interns are considering a career in healthcare. For goals achieved, the students felt they learned about work environments, how to manage their time better. how to get along with others, manage projects, adapt to change, and communicated effectively. A Peer Leader Intern was also hired by NWH. The position was held by an alumni intern. This intern took on a leadership role to be a resource and liaison for the whole program, conducted intern sessions, and consistent communication. The Peer Leader also attended hospital wide meetings and took part in community health outreach efforts. At the completion of the internship students shared "Word of Wisdom" that will be shared with the next cohort of interns during the summer of 2024. Some words stated were: "Give 100% effort"; "Don't hold back on asking for advice."; "Ask questions"; "Know that even the smallest actions mean something"; and "Be open to learning as much as possible." The 23 NWH intern placements is 28% of the entire WPY intern program of 81 students.	Outcome Goal	Year 3 of 3
Number of students enrolled. Number of students trained. Number of program graduates. Number of graduates employed.	In FY 24, in partnership with Jewish Vocational Services, continued the Central Sterile Processing (CSP) Training and Certification program to address the vast opportunities existing in the field. Jewish Vocational Services identified individuals to participate and attend the training and the students were assigned to NWH for their clinical rotation. Results of the program for FY24 were: -100% completion rate for those in training -83% job placement rate -100% pass rate on the CRCST exam on the first attempt -100% retention rate at both 30 and 90 days	Outcome Goal	Year 3 of 3
Number of students trained. Number of program graduates. Number of	Lasell University and Newton-Wellesley Hospital continued on a collaboration to diversify the health care profession, create a	Outcome Goal	Year 3 of 3

graduates employed.	pathway to professional-level jobs in the medical field, and help address the national shortage of skilled surgical technologists. The innovative initiative, now in its second year, is an extension of Lasell's Health Sciences degree program and combines classroom and lab-based learning with hands-on clinical experience at NWH that includes rotations in the main Operating Rooms, GI unit, Sterile Processing, Outpatient Surgery Center, Cardiovascular Center, and Labor and Delivery. It is also designed to support career advancement for a diverse student population, providing flexible scheduling, support for tuition and fees, and a clear path to a Bachelor of Science degree. Students enrolled in the Surgical Technology Program complete laboratory-based coursework in the Lasell University state-of the-art Science and Technology Center and complete 400 hours of supervised clinical work at NWH, including sessions in the Shipley Medical Simulation Center where students will practice and hone their skills. As part of the program curriculum, students prepare for the certification exam offered by the National Board of Surgical Technology and Surgical Assisting. In FY24, the Advisory Team focused on transitioning the program to a two-year associate degree status. As part of that process concentrated on changes to the overall curriculum. Curriculum includes professional development, physiology, instrument device instruction, data management, and the sterilization process.		
Number of Workforce Development Council members. Initiatives of the WFD Council.	The Work Force Development Council comprised of 27 community and hospital members. with 3 new members joining this year. An additional new member was added as a youth representative from the community of Waltham. The Council meets three 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. A high focus area has been to focus on high vacancy areas within healthcare and opportunities for training and education into those fields. The Council is also strategically focused on bringing educators and guidance counselors together to be learn about health care career options in order to better inform the students they engage with. The Council continues to promote health care options that require a two-year degree or less, certification programs and direct entry options. 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. Council meetings include a speaker related to current trends and new programs offered in the community.	Process Goal	Year 3 of 3

Total number of Waltham Partnership for Youth Interns (City-wide). Successful employment of WPY Career Exploration and Training Coordinator.	Continued sponsorship for the Career Exploration and Training Coordinator at the Waltham Partnership for Youth. The Career Exploration & Training (CET) program connects students to life-altering career development opportunities through meaningful paid internship experiences and professional development, including the Summer Internship Program, Teaching for Social Justice Program, and Teen Mental Health Alliance Internship Program. For the internship program, the position is responsible for the placement, training, and development of 100 summer interns in the City of Waltham. In reaction to the need to expose students to the field of mental health as well as the need to grow the workforce in this area, NWH's sponsorship continues to include the Career Exploration and Training Mental Health & Healthcare Professionals of Tomorrow Coordinator.	Process Goal	Year 3 of 3

EOHHS Focus Issues N/A,

DoN Health Priorities Employment,

Health Issues Social Determinants of Health-Income and Poverty,

Target PopulationsRegions

- **Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston,
- **Environments Served:** Suburban,
- **Gender:** All,
- **Age Group:** Teenagers,
- **Race/Ethnicity:** All,
- **Language:** All,
- **Status:** Refugee/Immigrant Status, **Partners:**

Additional Target Population

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	lasell.edu
Jewish Vocational Services	https://www.jvs-boston.org/

Expenditures

Total CB Program Expenditure $6,438,594.00

CB Expenditures by Program Type	Total Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
Direct Clinical Services	Not Specified	Not Specified
Community-Clinical Linkages	$2,500.00	$2,500.00
Total Population or CommunityWide Interventions	$4,551,967.00	$1,287,142.00
Access/Coverage Supports	$1,884,127.00	$623,476.00
Infrastructure to Support CB Collaborations Across Institutions	Not Specified	Not Specified

CB Expenditures by Health Need	Total Amount
Chronic Disease with a Focus on Cancer, Heart Disease, and Diabetes	$731,948.00
Mental Health/Mental Illness	$1,521,386.00
Housing/Homelessness	$54,760.00
Substance Use	$710,130.00
Additional Health Needs Identified by the Community	$3,420,370.00

Other Leveraged Resources	$2,186,544.00

Net Charity Care Expenditures	Total Amount
HSN Assessment	$6,761,583.00
HSN Denied Claims	$80,856.00
Free/Discount Care	$762,296.00
Total Net Charity Care	$7,604,735.00

Total CB Expenditures:	$16,229,873.00

Additional Information	Total Amount
Net Patient Service Revenue:	$718,117,953.00
CB Expenditure as Percentage of Net Patient Services Revenue:	2.26%