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
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Contact Address: (Optional, if different from above)	2014 Washington Street
City, State, Zip: (Optional, if different from above)	Newton, Massachusetts 02462

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

Mission and Key Planning/Assessment Documents

Community Benefits Mission Statement:

For Newton-Wellesley Hospital to address the unmet needs, improve the health of at-risk populations, increase prevention efforts, and impact healthcare disparities in the communities it serves. Efforts and support to prevent socio-medical challenges and to help community residents stay healthy include raising awareness of health issues, advocating for change to improve health, presenting prevention programs, and partnering with the community to develop additional resources to address unmet needs of the community. Further explained:
- To increase access to care in an equitable and efficient fashion to all.
- To identify and address specific health care needs which are unique to the hospitalâ€™s community.
- To improve the health of the community and reduce health care costs through programs of preventative medicine and health promotion.

Target Populations:

Name of Target Population	Basis for Selection
Child & Adolescent (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
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
Immigrant	Community Needs Assessment data; Department of Public Health data, Public School system data
Residents experiencing housing and food insecurity	Covid-19 state data; Greater Boston Food Bank Food Access Report; local food pantry data; local and regional housing authority data; US Census; local community assessments
People of color	Community Needs Assessment data; Department of Public Health data
Chronic Disease Populations	Census data; MA Department of Public health data; MA Disease Registryâ€™s.

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

Community Health Needs Assessment:

Date Last Assessment Completed:

9/30/2022

Data Sources:

Community Focus Groups, Interviews,

CHNA Document: NWH CHNA REPORT 2022.PDF

Implementation Strategy:

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

Key Accomplishments of Reporting Year:

- Among community dwelling elders, fall-related injuries are the most common type of injury. In FY21, 24 elders participated in the Matter of Balance program, bringing the total number of participants since the program inception in 1997 to 1,900. In addition, Strength and balance classes were held virtually twice per week with 25 seniors attending per class.
- The NWH Wellness Center held exercise and wellness programming free of charge to the community over a virtual platform. All programs are specifically geared to the senior community. Five classes are offered per week. Approximately 125 class participants per week.
- Tai Chi has also been identified to improve balance and well-being among elders. Three classes of Tai Chi were held virtually per week with 25 seniors taking part. Feedback from the sessions is an improved confidence with balance ability, enhanced socialization, and an overall feeling of wellness.
- Conducted four Senior Community Living Forums with Assisted Living Facilities and Independent Living Facilities.
- In FY22, the Domestic Violence/Sexual Assault Program at NWH provided free, voluntary, and confidential services to over 378 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). A grant to Menâ€™s Healing for programâ€™s dedicated to men of color who are survivors of sexual assault; and grant to Saheli for domestic and sexual violence for South Asian and Arab women.
- DSV program staff facilitated an expressive arts workshop series, facilitated psychoeducational and coping skill - Building support groups, and facilitated two Trauma-Sensitive Yoga Groups. Provided 223 consultations to community providers and NWH staff and providers.
- Facilitated the SANE Tele-nursing Center at NWH served eight pilot sites across the nation on a 24/7 basis, providing real-time consultation to clinicians serving survivors of acute sexual assault at military installations, on Native American reservations, and in rural parts of the country. Provided technical assistance and education to ten Massachusetts hospitals using TeleSANE services.
- Provided 4 in-person CPR and First Aid trainings allowing 45 Advocates and staff from partnering DV/SA agencies to be re-certified at no expense to the organizations. Conducted a community-wide educational program with follow-up resources and support after the event.
- In FY22, facilitated 2424 rides through the Modivcare/Lyft platform for ease of access to and from hospital care.
- Provided assistance to 136 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
- in collaboration Population Health, quarterly Senior Living Forums were conducted with local ALFâ€™s/ILF'. 4 Forums held with 25 attendees at each.
- Expanded the presence of NWH Community Health Workers in the communities of Waltham, Newton, Needham, Natick, Weston, and Walpole. This was in response to a recognized need to provide support to patients in the areas related to SDOH.
- In FY22, NWH administered 64 flu vaccines at a variety the Waltham mobile food market. Provided interpretation during each clinic.
- In FY 22, 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 FY22, held 7 virtual educational programs in the Senior Webinar Series. Topics focused on exercise and wellness, heart health, nutrition, chronic disease, and advanced care planning. 750 seniors attended.
- In FY22, held two mental health summits (virtual and hybrid) with 50 attendees at each summit. Attendees included principals, school nurses, social work, guidance staff, therapeutic staff, and youth development staff from high schools, middle schools, private schools, and youth-based organizations from the NWH primary service area.
- In FY22, 4500 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 1,500 participants through educational outreach, clinical consultation, small group programming, and professional development talks. Provided 34 professional development talks and programs to the community partners.
- Continued the Building Resilience Series offered community wide. Conducted the group workshops (Building Resilient Kids and Building Resilient Teens) with 150 participants.
- Expanded the Resilience Project team with the addition of a school liaison clinician to further support local public schools. The Resilience Project had a presence in 18 middle and high schools in the NWH communities.
- In FY22, NWH distributed 231 doses of Narcan to community agencies/partners. NWH dispensed 62 naloxone kits to patients in the NWH Emergency Department with diagnosis of opioid overdose.
- Substance Use Service clinicians completed 2700 patient visits (9.5% increase over FY21). 70% for alcohol use and 20% for opioid use). Referrals were 55% from the Emergency Department and 34% from primary care.
- SUS Recovery Coach conducted twice weekly group support sessions (one virtual, one in-person). 88 groups have been held in FY22. There is, on average, 6-15 people per group who are between the ages of 20-75 years old.
- Collaborated with SOAR Natick on efforts to reduce stigma and promote engagement and discission on the issue of addiction. Displayed the Opioid Art Project and the Purple Flag Project at NWH with an additional presence during the Boston Marathon. Middlesex District Attorney Marian Ryan participated in the event at NWH.
- The hospital continued its partnership with the Middlesex District Attorneyâ€™s Office in the Charles River Regional Opioid Task Force, taking part in monthly education and discussion sessions.
- Hired 16 Waltham High School students through the Waltham Partnership for Youth Summer Internship program (the largest number of students of any participating organization). Expanded to new placements including the Simulation Center, Central Sterile Supply and Patient Experience. 6 Medical Innovation and Career Exploration Sessions were held for the interns with 25 staff taking part.
- Continued to grow back the volunteer vocational program post-covid. In FY22, there were 5 affiliated organizations with 15 volunteers who contributed 816 hours of service. Participants interacted in a work- based learning environment and develop social skills and built on employment skills.
- Held a Healthcare Exploration Career Series held over four nights. There were 200 attendees for the series and 16 staff participants. 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.
- Newton-Wellesley Hospital and Lasell University collaborated and designed a program to diversify the health care profession, create a pathway to professional-level jobs in the medical field, and help address the national shortage of skilled surgical technologists.
- To address maternal mental health, grew the Post-Partum Mood and Anxiety Disorder Program with 1460 patients referred since the program began in May 2019. 33-61 new patients were seen monthly and communication with 30 plus patients a week was maintained.

- NWH Nurse Mid-wife held the Post-Partum Mothers Support group two days per week with 11-15 new moms attending each session.
- Established the NWH/Community Nutrition Security and Equity Work Group.
- Established the Food as Medicine Initiative. Created a Food as Medicine multidisciplinary hospital team. Conducted a FAM community education program with 515 registrants.
- Provided $10,000 grant funding to the Waltham Boys and Girls Club for the Summer Eats Program. Sponsored healthy meal options at the Newton Food Pantry (NFP) during National Nutrition Month with recipe cards translated in 3 languages.
- In FY22, NWH conducted screenings for the community related to illness to include mammograms, lung cancer screening day, and embarked on a colon cancer screening outreach project.
- Educational forums were held for all members of the community on breast cancer, prostate cancer, and lung cancer with a total of 350 attendees.
- Developed 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 at the Newton and Waltham Firehouses.
- 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 key contributor in the planning for the October 2022 Boston Marathon.
- Provided 17,413 completed Interpreter Service requests, including face-to-face, telephonic, video, ASL. A 34% increase over FY21.
- Continued to evolve and engage the NWH Community Collaborative with 8 Councils (Cardiovascular Health, Elder Care, Maternity Services, Palliative Care, Resilience (youth mental health), Work Force Development, Domestic and Sexual Abuse, Substance Use), comprised of a total of 160 community and staff members. Each Council has leadership from the community and the Hospital. The Collaborative strives to address unmet needs of the community for their focus area through the development of programs/service/initiatives as well as community-wide education and awareness.
- Continued to support Wraparound Waltham an initiative developed to address ethnic and cultural disparities in dropout rates for students in Waltham.
- Of the 126 Wraparound students, 96% progressed academically.
- During the 2021-2022 School Year (SY2021-2022), 158 Newcomer Waltham High School (WHS) students participated in Wraparound programming.
- Wraparound held 5 Welcome Class sessions. 133 newcomer students participated in the Welcome Class during SY2021-2022.
- 98% of Wraparound students met individually with the Academic Case Manager at least once; 30 WPS students participated in Doc Wayne programming; 34 Wraparound students participated in Childrenâ€™s Charter programming; and 48 Wraparound students and their families received direct services from The Right to Immigration Institute.
- During the first year of NWH grant to WATCH CDC and MetroWest CD combined to serve 692 client households, representing at least 1,766 individuals, residing in the hospital's priority communities. More than three-quarters (78%) of the clients served through this grant were people of color; the majority of which identified as Latinx.
- WATCH CDC and Metro West CD provided housing-related case management, including more than 800 housing related documented actions, to 440 clients.
- During the first year of the grant, WATCH CDC and Metro West CD provided non-housing related case management, including more than 575 actions, to 254 clients.
- Job and Financial Planning Clinic services were provided to 159 housing clients. In addition, the clinic provided 46 workshops â€“ 25 focused on job support and 21 on financial planning topics â€“ offered in both Spanish and English.
- During the first year of the grant, WATCH CDC contracted the services of a mental health consultant, a Children's Charter bilingual licensed mental health counselor (LMHC) for client workshops held in Spanish as well as staff training.
- Completed a Community Health Needs Assessment and Strategic Implementation Plan. Expanded the Community Benefits Committee with additional community members to enhance the engagement process. Conducted focus groups in multiple languages at community locations. Collected secondary data. Established four priority areas with accompanying Goals and Initiatives. Presented to NWH leadership, the Board, and to the community.

Plans for Next Reporting Year:

In addition to the hospitalâ€™s ongoing program and those in partnership with other organizations, the hospital will be carrying 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. NWHâ€™s efforts in all priority areas emphasize improvement in health status and working collaboratively within and across its communities. This work will be conducted 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 Newton-Wellesley Hospital community health needs assessment in 2022 also allows all the CHNAâ€™s across the Mass General Brigham healthcare system to have been completed in the same cycle. This will enable collaboration across system communities and the potential for a comprehensive response and programming, and ultimately impact for similarly identified needs.

Evaluation of outcomes related to the two DON/CHIâ€™s will continue throughout 2022 with plans to communicate findings to broader audiences. The two programs are: Wraparound Waltham under Waltham Partnership for Youth ($1.5 million grant), and the Housing Initiative under WATCH Community Development Corporation (WATCH CDC) and MetroWest Collaborative Development (Metro West CD) ($1.9 million grant). Both initiatives focus 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 expound upon and further develop all the NWH Community Benefit Program Areas.

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

Community Benefits Programs

Certified Application Couselors	
Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	No
Program Description	Hospital Certified Application Counselors (CACs) provide information about the full range of insurance programs offered by EOHHS and the Health Connector. Our CACs help individuals complete an application or renewal; work with the individual to provide required documentation; submit applications and renewals for the Insurance Programs; interact with EOHHS and the Health Connector on the status of such applications and renewals; and help

	facilitate enrollment of applicants or beneficiaries in Insurance Programs.
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 served patients who needed assistance with their coverage.	Process Goal	Year 1 of 3

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

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

Mass General Brigham â€" 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 FY22, Mass General Brigham began 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 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	Community Education, Community Health Center Partnership, 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
Increase access to care and services in Mass General Brigham CHNA prioritized communities.	Partnered with the Mass League of Community and provided support to Community Health Centers serving Mass General Brigham CHNA prioritized communities.	Process Goal	Year 1 of 3
Increase access to care and services in Mass General Brigham CHNA prioritized communities.	Launched Mass General Brigham Community Care Van Program in Boston, Chelsea, Revere, Lynn, and Salem.	Process Goal	Year 1 of 3
Increase access to care and services in Mass General Brigham CHNA prioritized communities.	Supported statewide advocacy organizations working to reduce barriers to accessing care and services.	Process Goal	Year 1 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 Populations	• **Regions Served:** All Massachusetts, • **Environments Served:** All, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
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
Codman Square Health Center	Not Specified
DotHouse Health	Not Specified
Whittier Street Health Center	Not Specified
Dimock Center	Not Specified
North Shore Community Health	Not Specified
County of Duke's County	Not Specified
The Pine Street Inn	Not Specified
Uphams Corner Health Center	Not Specified
New Commonwealth Fund	Not Specified
Louis D. Brown Peace Institute	Not Specified

Mass General Brigham â€" 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 FY22, Mass General Brigham began 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	Established partnerships with educational institutions in increase the BH workforce pipeline.	Process Goal	Year 1 of 3
Expand the behavioral health workforce with a focus on provider diversity	Established partnerships with community health centers to expand and retain diverse BH workforce.	Process Goal	Year 1 of 3
Increase access to behavioral health and substance use disorder services and treatment.	Partnered with community-based organizations and providers to expand access to services.	Process Goal	Year 1 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 Populations	• **Regions Served:** All Massachusetts, • **Environments Served:** All, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
The Italian Home for Children	Not Specified
NAMI Mass	Not Specified
Mass Association for 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	Not Specified

Work	
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 â€“ 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 FY22, Mass General Brigham began 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.
Program Hashtags	Community Education, Health Screening, 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.	Established a Nutrition Equity Working Group that meets monthly to discuss and implement strategies for improvement.	Process Goal	Year 1 of 3
Increase access to nutritious food.	Provided support to food pantries and other community food resources in increase food access.	Process Goal	Year 1 of 3
Support community educational opportunities related to nutrition.	Supported the development of teaching kitchens and learning hubs in MGB priority communities.	Process Goal	Year 1 of 3

EOHHS Focus Issues	N/A,
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 Populations	• **Regions Served:** All Massachusetts, • **Environments Served:** All, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
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

Patient Care Associate (CNA) Training Program/ DTA Works-Health Care Administrative Support Training Program, Environmental Service Worker Training Program

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	To serve low-income community residents more effectively, as well as meet the demand for critical hard-to fill roles in healthcare during the COVID-19 crisis, we continued collaborating with community-based organizations and state agencies to create and conduct pipeline training programs for Mass General Brigham. This partnership model allowed us to increase the number of individuals we recruit and serve, as well as to create stronger talent pipelines thanks to the deep community connections of our CBO partners. To follow safety protocols, all training sessions were switched to the remote/blended format. Patient Care Associate (PCA) Training Program is a 7-week free, training/employment program for community residents to train as a Patient Care Associate in acute care and receive placement assistance in permanent PCA positions at Brigham and Womenâ€™s Hospital. The program was developed by Mass General Brigham Workforce Development in collaboration with HEART Consortium/Center for Community Health Education and Research and Service (CCHERS), Laboure College, as well as Brigham Health Talent Acquisition and Workforce Development. The syllabus is comprised of online clinical instruction, in-person skills practice sessions, as well as clinical training at Brigham and Womenâ€™s Hospital. The

	job readiness component is facilitated by Mothers for Justice and Equality and includes such topics as trauma informed job readiness, financial literacy, transitioning to hierarchical hospital employment, managing home-work balance. HEART/CCHEERS instituted a robust outreach and recruitment program to identify individuals who live in the target area (residents of public and publicly assisted housing living along the Southwest Corridor from Chinatown through the South End and Roxbury into Mission Hill and out to Jamaica Plain and Roslindale). HEART worked in collaboration with MGB and Brigham Health Workforce Development, Human Resources and Nursing teams to screen and assess potential applicants for PCA training, and participate throughout the decision-making process for enrollment, recognizing that MGB/Brigham Health has ultimate decision-making responsibility for each training enrollee in accordance with its policies and procedures, and as the potential employer for training candidates. DTA Works â€" Health Care Administrative Support Program was offered in partnership with the Massachusetts Department of Transitional Assistance and Project Hope. It prepares recipients of Transitional Aid to Families with Dependent Children (TAFDC) for successful entry or re-entry into the workforce through mentorship, a 6-week virtual job readiness training, and up to 6 months paid by the State internships within MGB. Successful program graduates are provided post-internship job placement assistance services and on-the-job support. Health Care Environmental Service Worker Training Program is a 4-week intensive online training designed by BEST Hospitality Training in partnership with MGB Workforce Development and MGB Talent Sourcing Team to meet the growing need for environmental service aides during the COVID-19 crisis. Conducted by Best Hospitality Training, this program focuses on topics such as healthcare workplace environment/environmental service aide position and terminology, chemical safety, illness prevention, ergonomics, HIPAA, communication skills, customer service, conflict resolution, professionalism, interview skills and resume writing, and computer skills. Upon completion, program participants are assisted with placement in environmental service aide roles at MGB and other Boston area healthcare organizations. While we do not run PCWD program internally any longer, we continue working with the PCWD alumni to provide them with on the job assistance and academic/professional development coaching services. Foreign-Trained Health Care Professionals Program The Foreign-Trained Health Care Professionals Program is a new initiative created to assist underemployed foreign-trained incumbents within Mass General Brigham, as well as external low-income internationally educated health care professionals interested in employment within MGB. We provide one-on-one career counseling, job search assistance, as well as assistance with foreign degree evaluation and US credentialing process.
Program Hashtags	Mentorship/Career Training/Internship,
Program Contact Information	MJ Ryan, Sr Director of Workforce Development and Economic Opportunity; Elena Kuyun, Workforce Development Manager,

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide low-income community residents with training, career coaching/case management, internships and job placement services which offer family- sustaining wages, generous benefits, and opportunities for advancement within Mass General Brigham while meeting managers needs for highly skilled employees.	We ran a cohort of 10 students between March 28 and May 13, 2022, and 8 were hired into permanent roles within BWH. We also placed all 9 graduates from the 9-week Patient Care Technician Pilot with Jewish Vocational Service into Patient Care Technician positions with MGH and BWH hospitals. DTA Works â€" Health Care Administrative Support Program 10 students started the DTA Works training on September 12, 2022 and will be placed into their internships with MGH and BWH Departments in January of 2023. Health Care Environmental Service Worker Training Program trained 7 participants between October 2021 and March 2022 and 2 graduates were placed into permanent roles within MGB. The training numbers for this program started to decline as hospitality industry was actively recruiting the BEST program graduates again. We do not expect to run another cohort with the BEST Corp in the foreseeable future. Foreign-Trained Health Care Professionals Program served 16 individuals (career counseling, resume critique, job interview preparation, job search assistance, foreign degree evaluation). Five of them were placed into permanent positions.	Process Goal	Year 3 of 3
	Goal Description Goal Status Provide low-income community residents with training, career coaching/case management, internships and job placement services which offer family- sustaining wages, generous benefits, and opportunities for advancement within Mass General Brigham while meeting managersâ€™ needs for highly skilled employees. We ran a cohort of 10 students between March 28 and May 13, 2022, and 8 were hired into permanent roles within BWH. We also placed all 9 graduates from the 9-week Patient Care Technician Pilot with Jewish Vocational Service into Patient Care Technician positions with MGH and BWH hospitals. DTA Works â€" Health Care Administrative Support Program 10 students started the DTA Works training on September 12, 2022 and will be placed into their internships with MGH and BWH Departments in January of 2023. Health Care Environmental Service Worker Training Program trained 7 participants between October 2021 and March 2022		

Provide low-income community residents with training, career coaching/case management, internships and job placement services which offer family- sustaining wages, generous benefits, and opportunities for advancement within Mass General Brigham while meeting managersâ€™ needs for highly skilled employees. Connect program graduates to Partners HealthCare and affiliate-based Workforce Development programs and resources.	and 2 graduates were placed into permanent roles within MGB. The training numbers for this program started to decline as hospitality industry was actively recruiting the BEST program graduates again. We do not expect to run another cohort with the BEST Corp in the foreseeable future. Foreign-Trained Health Care Professionals Program served 16 individuals (career counseling, resume critique, job interview preparation, job search assistance, foreign degree evaluation). Five of them were placed into permanent positions. Connect program graduates to Partners HealthCare and affiliate-based Workforce Development programs and resources. Graduates are eligible to participate, after meeting employer-specific criteria, in onsite career development classes and initiatives from educational opportunities to advanced clinical training, career and academic coaching, and leadership development. Onsite classes offered within various MGB member institutions include English for Speakers of Other Languages (ESOL); Adult Basic Education (ABE); pre-college; computer skills; management & leadership training as well as specific clinical & non-clinical advanced training opportunities. After six months of employment, graduates seeking career advancement opportunities are referred to the Mass General Brigham Career Coach who works with them one-on-one to set personal and professional goals and guide them as they work towards them. Community program graduates are also offered resources to advance in their career through Mass General Brigham Advancing Careers Through Education Program, which includes assessment, academic, and college readiness support. During the period from FY10 through FY22, 82 PCWD graduates enrolled in the Partners HealthCare Online College Preparation Program (OCPP) and other online programs, designed to help individuals navigate the online learning environment. Online educational options help to increase access to higher education for working adults. From FY14 to June of FY22, 27 PCWD graduates participated in College for America (CfA), and are currently enrolled in online, competency-based, AA degree, BA degree and Certificate programs.	Process Goal	Year 3 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	N/A,
Health Issues	Social Determinants of Health-Education/Learning, Social Determinants of Health-Homelessness,
Target Populations	• **Regions Served:** All Massachusetts, • **Environments Served:** All, • **Gender:** All, • **Age Group:** Adults, • **Race/Ethnicity:** Not Specified • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Project Hope	www.prohope.org
MA Department of Transitional Assistance	https://www.mass.gov/orgs/department-of-transitional-assistance
BEST Hospitality Training	https://besthtc.org/evsinfo/
Center for Community Health	https://www.cchers.org/
Education Research and Service/HEART	Not Specified
African Bridge Network	https://africanbn.org

Access to Care

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	To assist with access to care issues, NWH develops transportation resource outlets to facilitate client access to needed healthcare. NWH also works with and supports various community agencies with transportation options. Community Health Workers facilitate healthcare access and support services through direct referrals and community connections. NWH provides resources for timely school immunizations for Waltham youth.
Program Hashtags	Community Education, Prevention,
Program Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide transport options to facilitate transition to and from hospital care.	In FY2022, facilitated 2424 rides through the Modivcare/Lyft platform for ease of access to and from hospital care. Among areas using this service are the Emergency Department, Cancer Center, and Integrated Care Management Program.	Outcome Goal	Year 1 of 3
Provide Community Health Workers to support patients and create resources and linkages with the community.	In FY 2022, expanded communities served by NWH Community Health Workers to now include: 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, the most frequent of which are: Nutrition Security, Financial Hardship (Utility Bills/Medications), Housing, Transportation, Care for Elder/Disabled, and Childcare. CHW's are educated and have successfully formed partnerships with local community service organizations. A bi-weekly Resource Guide has been created to enhance access to resources in the community related to SDOH categories such as food and housing. The Guide includes 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 1 of 3
Make appointments for those in need of accessing clinical services for either primary or specialty care.	In FY22, the hospital's Care Finder program facilitated scheduling appointments for patients in need of a physician or hospital service. Total year end call volume was 10,705 calls (a 19% increase over FY21).	Process Goal	Year 1 of 3

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

Partners:

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

Child and Adolescent Mental Health Services at Newton-Wellesley Hospital

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	The National Institute of Mental Health reports that 1 in 5 children or adolescents experience a mental health problem before the age of 18, yet only 1 in 5 of these children or adolescents receives the treatment they need. The hospital is focused on addressing the mental health needs of the families in our community through collaboration with area high schools and middle schools with emphasis on managing mental health problems and prevention initiatives.
Program Hashtags	Community Education, Health Professional/Staff Training, Prevention, Support Group,
Program Contact Information	Liz Booma, MD, Chief, Child & Adolescent Psychiatry, 2014 Washington St., Newton; 617-243-6490

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
The Resilience Project is an innovative school and community based initiative designed to promote the mental health and well-being of adolescents. It provides support to students, parents, educators, counselors and communities with school personnel, customized educational programming and improved access to treatment services.	The goals of the Resilience Project are to expand clinical access to mental health services, foster school partnerships, and develop and conduct parent and community programs. All three goals have seen growth during FY22 through increased patient volume, enhanced school collaborations, and expansion of offerings and participants attending community and parent programs. There was engagement with more than 1,500 participants through educational outreach, clinical consultation, small group programming, and professional development talks.	Process Goal	Year 1 of 3
Create a regular platform for parent and community education and awareness on the topic of mental	In FY22, 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 Series had topics related to mental health, parenting, and educatorsÃ¢â‚¬â„¢ professional development. Topics presented included supporting kids and teens through school-related anxiety and avoidance, managing screen time, supporting	Outcome Goal	Year 1 of 3

health.	studentsÃ¢â‚¬â„¢ behavioral and emotional regulation at school, understanding disordered eating, pediatric mental health in the time of Covid-19, the impact of mentorship on youth, and supporting students with mental health and unique learning needs with the transition to college.		
Address parenting education and the development of skill-building tools for mental health and resilience.	In FY 22, held 7 small-group parent workshops to nearly 150 participants The Raising Resilient Teens continued with three cycles per year. The Raising Resilient Kids program was created and is held three times per year. 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. The group also offers an Alumni Drop-In Group for parents and caregivers who have completed the workshop but would like an ongoing connection with other parents and support from the workshop facilitators.	Process Goal	Year 1 of 3
Create school-specific mental health programming to include a clinical consultation service and training.	In FY22, provided more than 34 psychoeducational and professional development presentations to the community, including schools, parents, and medical professionals. Provided 5 professional development talks to pediatricians and medical students.	Outcome Goal	Year 1 of 3
Provide professional educational and opportunity for collaboration with middle and high schools and others working with and engaged with youth on the issue of mental health.	Hosted the 6th and 7th Annual Educational Summit, a professional development program, for local educators. Themes for the 2021 and 2022 Educational Summits were Bouncing Forward: Applying Positive Psychology to Support Student and Educator Resilience and The Long Game: The Impact of Resilience and Relationships on Student and Educator Development, respectively. The Summit was held in hybrid mode. The 7th Summit was held in August prior to the start of the school year. Both Summits had approximately 50 attendees.	Outcome Goal	Year 1 of 3
Support local initiatives focusing on mental health.	In FY22, NWH clinical staff was represented on numerous local committees, and task forces across communities that focus on mental health in adolescents.	Process Goal	Year 1 of 3
The Resilience Project Council (youth mental health), within the Newton-Wellesley Community Collaborative, is an innovative school-and community-based initiative designed to promote the mental health and well-being of adolescents.	The Resilience Council, comprised of 22 community and hospital members, met three times in FY22 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 1 of 3
Provide mental health care services to patents in the Child and Adolescent Clinic and in the Emergency Department.	In FY22, 4500 children were seen for visits in the Child and Adolescent Clinic and 800 consults were provided. In reaction to the overwhelming need for pediatric mental health need in the community and being experienced in the Emergency Department, the division launched two new support initiatives: PATHS for Kids and a Child Psychiatry Short-Stay Service (ChiPS). Through these programs more children and teenagers in our community are finding their way to Newton-Wellesley for psychiatric care. With growth of 15 percent more volume projected for 2022-23.	Outcome Goal	Year 1 of 3
Conduct the PACT (Parenting At Challenging Times) Program with individual consultations and follow-up parent guidance visits to patients receiving cancer treatment or care at the Mass-General Cancer Center at Newton-Wellesley Hospital who are parents to children age 24 and under.	PACT services are provided by child and adolescent psychiatrists, psychologists, and clinical social workers with expertise in child development, family communication, and coping. PACT clinicians provide guidance to patients on topics such as: - Supporting comfortable, honest, and child-centered communication, including about the patientÃ¢â‚¬â„¢s diagnosis and treatment - Addressing common parenting concerns and questions - Promoting resilience of the whole family, such as protecting family time, minimizing disruption to a childÃ¢â‚¬â„¢s routine, and shoring up additional family supports - Implementing practical strategies to manage common challenges including hair loss, hospital visits, and communication with children's schools In FY22, PACT provided 108 free individual consultations for 69 patients. PACT continued its new team approach with 4 clinicians including a new director to continue to meet the growing need for support and guidance for parents with cancer. PACT clinicians have participated in the 2022 Cancer Center Survivorship Webinar series in June 2022, updated the PACT brochure and website, and created a new PACT virtual open support group for parents who are Cancer Center patients, scheduled to begin in late fall 2022.	Outcome Goal	Year 1 of 3
Provide specific outreach to the schools in the NWH communities.	In FY22, the School Outreach program allows for engagement with over 18000 students in the 18 local middle and high schools in the NWH communities. Engaged with over 1900 students through school programs. Expanded the Resilience Project team with the addition of a school liaison clinician to further support local public schools. The Resilience Project's School Outreach Program provided seven direct to-student's programs, reaching over 2,200 students.	Outcome Goal	Year 1 of 3

EOHHS Focus Issues	Mental Illness and Mental Health,

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

Partners:

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

Community Emergency Preparedness

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	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
Convene community partners for emergency management planning. Serve in leadership capacity for local emergency management and disaster planning.	Convened and participated in numerous local, state and regional planning meetings, committees, and initiatives for emergency management planning. Including the Newton Stakeholder event related to Cyberseurity. Collaborated with EMS, Fire, Police, City Services, Health and Human Services, and others on emergency preparedness.	Process Goal	Year 1 of 3
Conduct community-wide emergency management exercises and drills.	Held a tabletop exercise focused on preparing NWH to manage an influx of patients to the ED from an MCI	Outcome Goal	Year 1 of 3
Collaborate, coordinate, and communicate with community partners related to emergency planning efforts around the Boston 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.	Process Goal	Year 1 of 3
Collaborate, coordinate, and communicate with community partners related to emergency planning efforts.	Related to Covid-19, continued to serve as a key contributor and convener of community partners to ensure consistent communication with local departments of health, first responders, and others. As a hospital served as a content expert to multiple agencies and in many forums.	Process Goal	Year 1 of 3
Participate in HazMat Incident Planning.	NWH collaborates with Newton Fire to plan for and respond to hazardous materials incidents in the region.	Outcome Goal	Year 1 of 3

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

Partners:

Partner Name and Description	Partner Website
Natick Public Health Departments	Not Specified
Needham Public Health Department	Not Specified
Newton Public Health Department	Not Specified
Waltham Public Health Department	Not Specified

Wellesley Public Health Department	Not Specified
Weston Public Health Department	Not Specified
Natick Police Department	Not Specified
Needham Police Department	Not Specified
Newton Police Department	Not Specified
Waltham Police Department	Not Specified
Wellesley Police Department	Not Specified
Weston Police Department	Not Specified
Natick Fire Department	Not Specified
Needham Fire Department	Not Specified
Newton Fire Department	Not Specified
Waltham Fire Department	Not Specified
Wellesley Fire Department	Not Specified
Weston Fire Department	Not Specified
Boston Athletic Association	Not Specified

Community Health Needs Assessment (2022)

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

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Conduct community health needs assessment.	Collected primary and secondary data (both quantitative and qualitative) to identify unmet health needs in the six NWH service communities (Natick, Needham, Newton, Waltham, Wellesley, Weston) from a variety of sources and inventory programs currently available to address those needs. Held 8 Focus Groups (62 participants) and 10 Community Leader and Stakeholder Interviews. Sessions were held in English, Spanish, Mandarin and Russian. Process considered health needs broadly and include data and analysis on social, behavioral, and environmental factors that impact health in the community. Special emphasis during the community health needs was placed on identifying health disparities, and particular types of health differences that are closely linked with economic, social, or environmental disadvantage. This CHNA was completed a year after the previous CHNA to align the NWH and MGB system CHNA cycles.	Process Goal	Year 1 of 3
Create a Strategic Implementation Plan (SIP) after the Community Health Needs Assessment is complete. The SIP supports, specific programs or activities that are associated with significant needs identified in the Community Health Needs Assessment. Needs Assessment, and establishes measurable short and long-term goals for each program or activity.	Created a Strategic Implementation Plan with four target populations identified. Four distinct priorities (Housing Affordability; Mental Health and Substance Use; Access to Quality care; and Transportation were established with four Goals. Thirty-one strategies were established along with specific success measures. In addition, community partnerships were identified with the associated priority and timelines were outlined.	Process Goal	Year 1 of 3
Demonstrate active involvement and as a key decision maker by the Hospital's Community Benefits Committee and all required sector representation throughout the entire CHNA and SIP process.	Expanded the NWH Community Benefits committee with 11 additional community leaders and advocates who were invited to work alongside the established 22 members of the NWH Community Benefits Committee (CBC) to provide strategic oversight of the CHNA-SIP process. Enhanced the opportunity to bring in "the voice of the community" and a broader perspective from diverse sectors, populations, and geographies. Four meetings were held throughout the process for active engagement on sources of primary and secondary data, identification of key stakeholders, and establishing connections and coordination for focus groups. In addition, communicated and solicited input on key findings. Significant engagement took place on the development of the SIP to include priority areas and target populations. The Committee had community representation with members who are racially, culturally, and ethnically diverse. In addition, the composition of hospital leaders	Process Goal	Year 1 of 3

	and staff are from a number of different operational groups, as well as clinical and non-clinical areas.		
Communicating out the results of the Community Needs Assessment and Strategic Implementation Plan to hospital and other leaders and to the broader community. Demonstration by hospital leadership for support of the Implementation Strategy.	CHNA was presented at the July 2022 Board of Trustee meeting. SIP was presented at the November 2022 Board of Trustee meeting. Board members asked questions and gained a better understanding of the process and the content of the findings. The Board fully endorsed the Implementation Plan. Presented to the Strategic Leadership Team in November 2022 and to other Hospital and Community Leaders and the NWH Collaborative Councils throughout the first months of 2023. Presented at NWH Community Forum in October 2022. Solicited feedback and comment. 66 attendees. Conducted a post-survey from the Forum. Attendees gave the highest rating for gaining a better understanding of NWH community health initiatives, and for how well NWH was addressing primary health/social-economic needs.	Process Goal	Year 1 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	Social Environment,
Health Issues	Cancer-Breast, Cancer-Colorectal, Cancer-Lung, Chronic Disease-Cardiac Disease, Chronic Disease-Overweight and Obesity, Health Behaviors/Mental Health-Bereavement, Health Behaviors/Mental Health-Physical Activity, Injury-Other, Maternal/Child Health-Reproductive and Maternal Health, Other-Cultural Competency, Other-Emergency Preparedness, Other-Senior Health Challenges/Care Coordination, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Education/Learning, Social Determinants of Health-Homelessness, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Nutrition, Social Determinants of Health-Public Safety, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of Health-Violence and Trauma, Substance Addiction-Alcohol Use, Substance Addiction-Opioid Use, Substance Addiction-Smoking/Tobacco Use, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** All, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Disability Status, Domestic Violence History, LGBT Status, Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
Health Resources in Action, Inc.	Not Specified

Direct Outreach/Health Navigation

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

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Convene a Senior Living Community Forum for local assisted living and independent living, and as appropriate, long term care facilities. Provides an opportunity to share content expert information, relay best practices and align services.	Four Senior Community Living Forums were held this year with approx. 25 attendees at each Forum. Forum has multidisciplinary leadership with the Chief Medical Officer, Medical Director, Physician Health Organization, Case Management, Population Health, and Community Health. Focus this year was on the 4Ms Framework of an Age-Friendly Health System. The 4Ms Ã¢â‚¬â€ What Matters, Medication, Mentation, and Mobility were all presented at the Forum. In addition to topics such as Guardianship and Delirium. A NWH clinical provider and a living facility leader presented materials and a case study at each Forum. Question and Answers followed. Resouces and supportive materials were shared with participants after the Forum. The Forum invitees was expanded to include long term care facilities and local public health nurses. In addition, the number of assisted living and independent living facilities engaged and invited to the Forums continues to expand. 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 1 of 3

Provide resources for assistance with basic needs related to patients' medical and social conditions when no resources or alternative options are accessible.	Provided assistance to 136 patients in the categories of food, lodging, technology, safety, furniture, supplies, and others. 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. 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.	Outcome Goal	Year 1 of 3
Convene and collaborate with local health departments on a regular basis.	NWH convenes eight meetings per year with local health departments. Goals are to communicate challenges, share best practices, review services, and strategize solutions on access and types of care, in hospital and in community. 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, and safety. Having the structure already in place helped to facilitate ease of communication and solution building during many of the recent Covid-19, Flu and RSV surges, as well as other community crisis challenges such as a health needs and intake for the high volume of in-coming immigrant residents. NWH Emergency Department data is provided on a quarterly basis to a wide array of community partners in the areas of top five diagnosis, overdose, and behavioral health.	Process Goal	Year 1 of 3
Direct Newton-Wellesley Hospital engagement with community networks and coalitions for the purpose of information sharing and providing a hospital liaison.	Consistent clinical and administrative hospital leader representation and active engagement at the Waltham Interagency Network, Needham Community Crisis Intervention Team, Waltham Homeless Assistance Coalition, Waltham and Newton Chambers of Commerce and others. 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, i.e., Flu, RSV, etc. 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 1 of 3
Expand overall understanding for Palliative care that it not only improves the quality of life of patients and their families but reduced mental and physical distress and discomfort.	The Palliative Care Council is comprised of 18 hospital and community members. 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, and serious illness and advanced care planning.	Outcome Goal	Year 1 of 3
Conduct a Community Resource Fair focused on providing information and detail on elder care services in the community. Create a bi-directional opportunity for providers and community partners to learn about each other's organizations and to make connections.	Held a Community Resource Fair in the Spring of 2022. 11 community organizations that care for elders in the community participated. Organizations gave presentations on their services and their program structure. Time was provided for participants to ask questions and engage in discussion. The audience for the meeting was members of the following teams: iCMP Care Management and Behavioral Health team, Community Health Workers, Transitions Team, IP Case Management and oncology CRS. 50 employees attend the session. The successful outcome of the fair was the further development of bi-directional relationships among providers and community partners.	Outcome Goal	Year 1 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 Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Disability Status, Domestic Violence History, Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
2Life Communities	Not Specified
Benchmark Senior Living	Not Specified
CareOne	Not Specified
Lasell Village	Not Specified
Natick Department of Public Health	Not Specified

Needham Police Department	Not Specified
Needham Public Health	Not Specified
Newton Health and Human Services	Not Specified
Newton-Needham Chamber Commerce	Not Specified
Scandinavian Living Center	Not Specified
Waltham Health Department	Not Specified
Waltham Police Department	Not Specified
Waltham West Suburban Chamber of Commerce	Not Specified
WATCH CDC	Not Specified
Wellesley Health Department	Not Specified
Weston Health Department	Not Specified

Employee Assistance Services to City of Newton Employees

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	Employee Assistance Program services through CMG Associates provides service and resources to City of Newton employees.
Program Hashtags	Prevention, Support Group,
Program Contact Information	Amy Ryals, Director, Human Resources

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide Employee Assistance Services to City of Newton employees.	Enabled ease of access to EAP services for City of Newton employees.	Process Goal	Year 1 of 3
Create a customized EAP program that meets the needs of the City of Newton.	Provided resources and services that include domestic violence, substance use, work/life wellness, financial assistance resources, etc.	Process Goal	Year 1 of 3

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

Partners:

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

Fall Prevention Among Community Seniors

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

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
The Matter of Balance has the goals of reducing the fear of falling by increasing participants confidence that they can better manage falls risks and that they can take action to help reduce the risk of falling. class utilizes a variety of activities to address physical, social, and cognitive factors affecting fear of falling and to learn fall prevention strategies. The activities include group discussion, problem-solving, skill building, assertiveness training, videotapes, sharing practical solutions and exercise training.	In FY22, three (8-week sessions) Matter of Balance Programs were held that served 24 participants for a total of 1,900 since the program's inception in 1997. The sessions were held in collaboration with local senior centers. Sessions resumed in person with plans to expand in person sessions going forward.	Outcome Goal	Year 1 of 3
Provide a group experience to reduce maladaptive ideas and beliefs about falls. Set realistic goals for increasing activity. Change their environment to reduce fall risk. Promote exercise to increase strength & balance.	Stretch, Pilates, Strength, and Balance classes taught 5 times per week. 25 attendees per class; 125 attendees. Held virtually and open to the community. Designed to enhance safe movement and balance. Classes creates a support and a sense of community-building among class members. Participant feedback: ""I just wanted to tell you that I love the balance exercises. I so much need as I get older.	Process Goal	Year 1 of 3
Conduct Tai Chi classes to promote balance. Provide an outlet for group interaction and socialization among seniors through Tai Chi.	Tai Chi classes were held three times per week, virtually and open to the whole community. 25 attendees per class for a total of approximately 75 participants per week. Continued positive feedback from program participants. Has enabled patients and caregivers to interact in new ways despite disease related conditions and to foster better overall balance.	Process Goal	Year 1 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	N/A,
Health Issues	Chronic Disease-Alzheimer's Disease, Chronic Disease-Osteoporosis, Health Behaviors/Mental Health-Physical Activity, Injury-Other,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** Elderly, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

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

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; llele@partners.org; 617-243-6330

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
	During the first year of this grant through November 30th, 2022, WATCH CDC and MetroWest CD combined to serve 692 client		

Prioritize serving low-income tenants, particularly among communities of color and immigrant communities in Natick, Needham, Newton, Waltham, Wellesley, and Weston.	households, representing at least 1,766 individuals, residing in the hospital's priority communities. More than one-half of these client households (53%) included children under the age of 18; nearly one-quarter (24%) included children under the age of 5; and 10% included members with special needs. More than three-quarters (78%) of the clients served through this grant were people of color; the majority of which identified as Latinx. Moreover, WATCH CDC and Metro West CD have successfully served the immigrant communities in the towns surrounding NWH. Of the 505 clients that provided information on country of origin, 71% reported being born outside of the United States. In fact, the housing clients served under this grant represent more than 40 nationalities with the most substantial proportion immigrating from Guatemala (26% of all housing clients; 36% of clients reporting country of origin). Approximately one-half (51%) of all housing clients indicated Spanish as their preferred language spoken. Other primary languages spoken by housing clients included Haitian Creole, Portuguese, Luganda, and Russian. Approximately one-fifth of clients reported requiring a translator as part of services. The vast majority (91%) of clients served under this grant reside in Waltham and were provided housing and non-housing case management support services by WATCH CDC. The average household income of WATCH's clients served through this grant was $18,378. The remainder of clients served through this grant resided in other communities surrounding the hospital - specifically, Newton, Natick, and Needham -- and were provided housing and non-housing case management support services by MetroWest CD. The average household income of MetroWest CD's clients served through this grant was $30,476.	Process Goal	Year 1 of 4
Address immediate housing insecurity through provision of housing-focused case management and emergency financial assistance needs.	"Clients working with WATCH CDC and Metro West CD face a multitude of challenges. Overall, 83% experienced housing insecurity, half of which report being behind on rent. Other challenges reported include receiving an eviction notice from court, written or verbal notice from landlord to leave, homelessness, living in poor conditions or overcrowding, and experiencing conflicts with their landlord. During the first year of the grant, WATCH CDC and Metro West CD provided housing-related case management, including more than 800 housing related documented actions, to 440 clients. Specific housing-related actions taken included: Ã¢â‚¬Â¢ Submitted Emergency Rental Assistance Program (ERAP) and Residential Assistance for Families in Transition (RAFT) emergency housing assistance applications for nearly one-third of these clients. Ã¢â‚¬Â¢ Provided Tenant Assistant Fund (TAF) grants of up to $3,000 to be used for utility and rent arrears, emergency housing, and first, last and security deposits for nearly one-third of these clients totaling more than $225,000. The NWH Housing Security CHI grant provided $100,000 of these dollars, directly funding 79 TAF grants to 55 housing clients. and Provided information and links for rent relief and utility arrears for approximately one-quarter of these clients. Other housing related actions included, but were not limited to, counseled clients on landlord/tenant law, provided information/links for public housing, submitted or gave information for lend-a-hand or other financial support, communicated directly with landlords, advocated for and provided referrals for EA Shelter, provided information on Sanitary Code/Health Department and scheduled inspections, provided support at Housing Court, filled out Housing Applications, referred to homelessness prevention programs, and answered court summons. When asked to highlight the impact of these services, WATCH CDC and Metro West CD staff provided the following examples: WATCH CDC: The effects of COVID were catastrophic, especially for those who lost their jobs and had no stream of income. One client was particularly burdened by the pandemic. Working as a caretaker for nearly 20 years, she lost her last client to COVID, which left her unable to pay her bills. She then experienced an insufferable amount of harassment from her landlord. She turned to the Housing Clinic. The clinic was able to help her apply for RAFT and apply for a new apartment. In July 2022, the client was able to move into her new apartment. Metro West CD: We helped a young mother who had a 6-year-old daughter and was pregnant expecting her 2nd child next year. She is currently living in a temporary affordable residence in the service area. Her work hours were decreased during COVID so she needed help paying her rent, electric and gas bill. She received funding to help cover her past due bills and was provided assistance with and information on how to find and apply for a more permanent affordable unit.	Outcome Goal	Year 1 of 4
	"Clients working with WATCH CDC and Metro West CD staff face a multitude of challenges. Overall, 53% reported non-housing / basic needs challenges, with nearly one-half requiring assistance with fuel and utility bills and one-third not having enough money to buy food. Other non-housing challenges reported include: needing critical household items and furniture, facing non-housing legal issues, childcare challenges, mental health		

Provide non-housing/basic needs support services to reduce inequities in housing security of low-income tenants.	challenges, immigration concerns, needing help accessing ESL/citizenship/GED classes, experiencing domestic violence, and needing health insurance or medical referrals. During the first year of the grant, WATCH CDC and Metro West CD provided non-housing related case management, including more than 575 actions, to 254 clients. Specific non-housing / basics needs related actions taken included: Provided information to more than one-quarter of these clients on SNAP/free food resources Provided information to more than one-quarter of these clients on fuel assistance program Provided information to one-fifth of these clients on Internet Essentials program Referred nearly one-fifth of these clients to ESL/GED/Citizenship classes Other non-housing related actions included, but were not limited to, accessing food, furniture, and household items; submitting applications for lend-a-hand, SNAP, and WIC; and making referrals to other community and state agencies for legal support, immigration help, mental health services, domestic violence support, childcare and youth services, tax assistance. "	Process Goal	Year 1 of 4
Reducing the impact of housing insecurity on client's mental health.	In addition to supporting clientsâ„¢ non-housing needs, the grant prioritizes strengthening awareness of and support for the mental health needs of clients experiencing housing insecurity. During the first year of the grant, WATCH CDC contracted the services of a mental health consultant, a Childrens Charter bilingual licensed mental health counselor (LMHC), to accomplish the following: Reviewed and revised client intake protocol and screening questions to include mental health related questions. Identified at least 15 local mental health providers who accept MassHealth as well as information on whether accepting new clients, providersÃ¢â‚¬â„¢ intake process, services offered, and languages spoken. Provided a staff mental health workshop, 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 oneÃ¢â‚¬â„¢s stress related to managing rent, housing situations, and their finances as well as to find community mental health resources. The staff mental health workshop was well received with 100% of WATCH CDC and Metro West CD staff agreeing that they can better identify signs of stress, anxiety, and mental health needs facing clients and have learned something that they plan to directly apply or use in their work. Staff reflections on lessons learned include: I am excited to apply what we learned about interacting with clients such as tone/speed of voice, overall being a non-anxious presence for the client. Learned to reflect on your own thoughts/feelings/posture while the client is sharing with you. I am excited/nervous to try this Ã¢â‚¬Å"dual perspectiveÃ¢â‚¬Â thinking in practice. To realize that people may need more than just the service or need they are calling for and that the fact they have this need is likely causing them added stress and anxiety that they could benefit from it being addressed. I work directly with people who have housing problems, I had an understanding of how much this affects their mental health, I was looking for resources to refer them and I am glad this workshop offered those to me so I could now provide that information to people who need more than just rental assistance. Sixteen individuals participated in the client mental health workshops with all those providing feedback agreeing that the workshop was useful and through it, clients learned new ways to help manage and reduce stress and learned about other mental health resources and providers available. Workshop participant reflections about information and lessons learned include: MÃƒÂ©todos para relajar e informaciÃƒÂ³n de recursos (Relaxing methods and resource information) Siempre buscar estar conectada con alguien para expresar sus sentimientos (Always seek to be connected with someone to express your feelings) Modos de respirar para calmar la ansiedad. TambiÃƒÂ©n usar mis 5 sentidos mÃƒÂis para poderme calmar. Muy buenas enseÃƒÂ±anzas. (Ways to breathe to calm anxiety. Also use my 5 senses to calm down more. Very good teachings.)	Outcome Goal	Year 1 of 4
	In addition to housing and non-housing / basic needs support, many clients served under this grant required job search and financial planning assistance. 20% need job support including searching for jobs, creating resumes, applying for jobs, practicing for job interviews, and accessing job training/certification/schooling. 10% need financial planning assistance with one-half needing assistance in making a budget and improving their credit score. Other challenges included paying off debts, reducing expenses,		

Support clients economic independence using an employment / financial coaching and mentoring model.	and opening a savings or checking account. To address this need, WATCH CDC hired a full-time Job and Financial Planning Coordinator to support and mentor clients to greater financial self-sufficiency. The bilingual coordinator launched the Job and Financial Planning Clinic 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 covered include 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 first year of the grant, 159 housing clients participated in Job and Financial Planning Clinic services, with more than one-half receiving one-on-one individual counseling sessions with the coordinator. In addition, the clinic provided 46 workshops 25 focused on job support and 21 on financial planning topics offered in both Spanish and English. Finally, the grant enabled the distribution of nearly $10,000 to support the economic independence of 67 clients through the following: 24 Back to Work (BTW) grants, of up to $500 each, for removing barriers to work, including bus passes, tools, equipment, training programs, computers, and childcare. 54 financial incentives, totaling $2,800, for participation in Job and Financial Planning Clinic services. Preliminary outcomes for participation in the Job and Financial Planning Clinic include: 47 individuals created a resume 41 applied for a job 36 got a job 13 made a budget 8 have reduced their expenses When asked to highlight the impact of these services, WATCH CDC and Metro West CD staff provided the following examples: WATCH CDC: The Job and Financial Management clinic provides one-on-one help with resume and cover letter writing, creating a budget, and debt management plans. A client received help with her resume and said, The Job and Financial Management Clinic Coordinator helped me start my resume from the start, step-by-step, when I was completely lost with what I was doing. We put together my whole resume through Zoom meetings and emails. The clinic also provided a lot of great material such as videos and presentations that provided a lot of insight. I'm grateful for all the help I received, and all the doors the clinic helped me open. Metro West CD: We counseled a woman who recently had a child and was a stay-at-home mother. But her husband lost his job and was having difficulty finding another. She was ready to return to work. A job referral was made to Carlos at WATCH CDC. She got her real estate license and was given Back-to-Work funds to help pay for interview clothes, gas, and her MLS listing services.	Outcome Goal	Year 1 of 4
Support client and community engagement to advocate for protection of low-income tenants facing evictions.	Both organizations are continuing their established efforts to expand the stock of affordable housing and increase protections for tenants through community organizing and advocacy. Waltham tenants have organized support for a local ordinance, the Tenant Rights Notification Act, that would require landlords to notify tenants of legal and financial resources when they are facing eviction. Information and planning around this ordinance is spearheaded by WATCH's Tenant Action Group (TAG) with members building support and outreach through canvassing and tabling events. Tenant leaders are very engaged in the campaign and much support has been built, including more than 250 letters written introducing the ordinance and more than 700 petitions signed in its support. Finally, while TAG has gained some organizational and landlord endorsements, they are still actively working to secure a sponsor for the ordinance from the local city council.	Process Goal	Year 1 of 4

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 Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
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 andÃ¯Â¿Â½deaf or hard of hearing individuals.
Program Hashtags	Community Education, Health Professional/Staff Training, Prevention,
Program Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide Interpreter Services (face-to-face, telephonic, video and ASL) to the Newton-Wellesley Hospital patient and visitor populations.	Provided 17,413 completed Interpreter Service requests (face-to-face, telephonic, video, ASL). A 34% increase over FY21.	Process Goal	Year 1 of 3
Ensure that Interpreter Services are available in all areas of the hospital.	"Continued use of the mobile video platform for interpreter services that as introduced last year. Feedback continues to be that these devices expand access and efficiency of service. Also provides a video alternative for American Sign Language. The top five hospital departments utilizing interpreter services were Emergency (5672 - a 51% increase over LY), Medicine, Surgery, Urgent Care Walk-In and ICU. Implemented signage, in multiple languages around the hospital that includes infection control messages. Utilize the Patient and Family Guide during registration/admission to share information in multiple languagesâ€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 and flu programs. "	Process Goal	Year 1 of 3
Provide training to medical/clinical providers, and staff including, but not limited to, effective use of all interpreters, use of equipment, cultural competency, patient health belief systems, health disparities.	"Nursing Education continued to train all new staff in the areas of interpreter resources and health inequities. Continuous training provided for staff on Audio/Video IPAD technology in all patient care areas, inpatient and ambulatory, as well as off-site locations. Reference and resource materials are available in all areas. "	Process Goal	Year 1 of 3
Provide patient information documents in translated languages.	"Provided translated documents for: discharge instructions, patient rights, menus, patient education, and patient guidebook. Through system-wide efforts, the patient portal has also been made available in multiple languages. Assessment in clinical areas with high multi-lingual patient populations is on-going to translate needed patient materials. NRC Patient Satisfaction Surveys are also sent out in the following languages: English, Spanish, Khmer, Arabic, Haitian Creole and Chinese with specific questions related to access and use of interpreter services. Through MGB system-wide initiatives the patient and employee portal are also available in multiple languages. "	Process Goal	Year 1 of 3

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

Partners:

Partner Name and Description	Partner Website

Cross Cultural Communications, Inc	https://embracingculture.com/
Language Line Solutions	www.languageline.com

Maternal Mental Health

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	One out of seven women experience depression or anxiety during pregnancy or postpartum. Untreated perinatal mood and anxiety disorders 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
Identify patients who are experiencing depression and/or anxiety during pregnancy and postpartum that affects 10-15% of the NWH maternal patient population. Provide outreach and intervention by a clinical social worker (LICSW).	Continued the growth of the Perinatal Mood and Anxiety Disorder Initiative. Over 1460 patients have been referred to the PMAD social worker since the program began in May 2019. On average, receiving 33-61 new patients monthly, communicating with 30 plus patients a week. 100% on-site. Seeing 5-8 patients a week for virtual and in-person visits.	Outcome Goal	Year 1 of 3
Extend the post-partum screening tool further after pregnancy.	Continued the collaboration with 3 OB practices using The Edinburgh Postnatal Depression Scale to screen pregnant and postpartum patients between 24-28 weeks prenatally, 6 weeks postpartum, and 6 months postpartum. NWH is the first Partners hospital to screen at 6 months postpartum. The social work position is at 28 hours and as placed within the population health area.	Process Goal	Year 1 of 3
Respond to referrals directly from MD's, MA's, RN's.	Referrals to social work are patients with a score of 10 or more on the Edinburgh Postnatal Depression Scale. Reason for referral are not just for anxiety and depression, but also include fetal demise, elective termination, substance use, domestic violence, homelessness, unplanned pregnancy, and traumatic delivery. Expanded relationship with community partners for collaboration of resources, referrals, and support services.	Process Goal	Year 1 of 3
Provide on-going methods of support for maternal patients.	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 with content experts, i.e., pediatric dentistry, sleep deprivation, nutrition, etc. Approx. 11 new moms attend each session with most attendees attending greater than 8 sessions. When surveyed the majority of attendees cited that after attending the group, they experienced a decrease in being anxious, having difficulty coping, and being in a depressed mood. Further survey responses revealed that attendees felt that taking part in the groups was important to their emotional well-being a s a new mom, increased satisfaction as a new family unit, and increased their partner's well-being. Attendees expressed positive feedback stating: "validated my experiences", "is inclusive", "listening without judging", development of friendships, and "is a vital resource."	Process Goal	Year 1 of 3
The Maternity Services Council, within the Community Collaborative, is focused on improving Maternity Services during pregnancy and after delivery with a special mission to increase awareness and improve treatment of pregnancy-related depression.	The Maternity Services Council is comprised of 29 hospital and community members and meets quarterly. The Council evaluates strategies on how best to meet the needs of women and families and engaging related community and hospital services to enhance care. A Hospital Champion was identified this year to lead the Council in collaboration with the Community Co-chairs.	Process Goal	Year 1 of 3
Provide opportunities for community education on post-partum depression and maternal wellness.	Held a three-part community-wide webinar: ""Put your Oxygen Mask on First: Thriving Through the Postpartum Period."". Over 50 attendees at each session. The Collaborative Council and staff attended community outreach events to educate and provide information on post-partum depression. Continued to expand presence on the web and social media platforms for on-going education and information and sharing. Presented to OB/GYN providers on perinatal mood and anxiety disorders and created a social worker training guide.	Process Goal	Year 1 of 3

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	N/A,
Health Issues	Health Behaviors/Mental Health-Mental Health, Maternal/Child Health-Parenting Skills, Social Determinants of Health-Access to Health Care,

Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** Female, • **Age Group:** Adults, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Domestic Violence History,

Partners:

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

Nutrition Security and Equity

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	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
Convene community partners on aspects of nutrition security and equity. Representation on community organizations focused on food access.	Established the NWH/Community Nutrition Security and Equity Work Group. Includes organizations providing food access (schools, senior services, food pantries, health services, community farms, faith, and community organizations) in the NWH geographic area of Waltham, Wellesley, Needham, Newton. The work group also includes NWH leadership and clinicians. Met three times per year. Topics discussed were service delivery and distribution, increase in client needs, non-food supports needs, increase of immigrant populations, discussion of the White House pillar strategy for hunger, nutrition and health, and expansion of subsidized program enrollment. 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, and opportunities related to nutrition security and equity. Continued representation on the Newton Food Pantry Advisory Board. On-going partnership of NWH and Healthy Waltham.	Process Goal	Year 1 of 3
Focus on the following three goals: 1. Support and expand existing commitment to food access 2. Build and support capacity and partnerships with internal and external organizations working to expand food access 3. Improve geographic reach of food access partnerships	Provided $10,000 grant funding to the Waltham Boys and Girls Club for the Summer Eats Program. Summer Eats is located at 12 sites throughout Waltham and last year served 28,770 meals and weekend grocery bag delivery to 440 households. Sponsored healthy meal options at the Newton Food Pantry (NFP) during National Nutrition Month. Provided three recipes (Russian recipe, one Latin recipe and one Asian recipe) incorporating items that clients could select from the pantry. The recipe cards were all translated into Russian, Spanish and Mandarin. The recipes were also published on the NFP website and newsletter.	Outcome Goal	Year 1 of 3
Establish the Food as Medicine Initiative for Newton-Wellesley Hosptial.	Food as Medicine established as one of the initiatives under the NWH Strategic Imperative of Community, stated as to "improve the health and well-being of the communities we serve." Created a Food as Medicine multidisciplinary hospital team. Conducted a FAM community education program, entitled Food as Medicine: Eating for Life. The program included a presentation from a dietician, an interactive live cooking demonstration and question and answers with clinical providers. Resource materials were sent to attendees at the conclusion of the event. There was a total of 515 individuals registered for the event. Created the FAM website with resources and reference materials. Began work to incorporate FAM programming across clinical disciplines such as cancer care and cardiovascular.	Process Goal	Year 1 of 3
	Began working with NWH WIC representatives to create a warm hand off from clinical care to community services for WIC. Expanded locations where WIC materials are provided to patients. Discussed with providers what workflow changes could be		

Expand enrollment in food insecurity benefit programs, i.e., WIC/SNAP programs.	established that would expand enrollment. Provided education at Resident Noon conference as to nutrition security and equity and opportunities to intervene with patients for needed support services. Discussion held with the NWH/Community Nutrition Security and Equity Work Group to raise the subject of expanded enrollment to WIC/SNAP. Several opportunities were brought forward for potential action.	Process Goal	Year 1 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	Social Environment,
Health Issues	Chronic Disease-Cardiac Disease, Chronic Disease-Diabetes, Chronic Disease-Hypertension, Chronic Disease-Overweight and Obesity, Health Behaviors/Mental Health-Mental Health, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Income and Poverty,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
Centre Street Pantry	Not Specified
Healthy Waltham	Not Specified
Newton Community Senior Center	Not Specified
Newton Food Pantry	Not Specified
Newton Health and Human Services	Not Specified
Waltham Boys and Girls Club	Not Specified
Waltham Public Schools	Not Specified

NWH Community Collaborative

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	The NWH Collaborative works within communities. Grounded in an ongoing assessment of priority needs, it brings an unrelenting focus to lessening healthcare disparities, strengthening the social fabric of support, and empowering residents to lead healthier lives. Its extensive programs are led by eight strategic councils, each dedicated to addressing community needs and the underlying social determinants of health. Their work embraces education, advocacy, engagement, and targeted programmatic initiatives. From the start, the Collaborative's success has grown from the leadership of passionate volunteers, the expertise of NWH staff and community partners, and the generosity of our community of donors.
Program Hashtags	Community Education, Health Professional/Staff Training, Health Screening, Mentorship/Career Training/Internship, Prevention, Support Group,
Program Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Expand upon the established NWH Community Collaborative model for enhanced community engagement, extension of outreach, and expanded services and partnerships in areas identified in the NWH community health needs assessment and to take action on initiatives identified in the SIP.	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 ambassador ship and advocacy. The Collaborative leadership includes a Director, and a program outreach manager. Council leadership is a dyad model with a community chair and a hospital-based clinical champion. All 8 councils have established leaders in all of the roles and have a cadence for meeting to drive strategic direction for the NWH Collaborative.	Process Goal	Year 1 of 3
Established Community Collaborative Councils that address identified health needs.	Maintain 8 community-focused councils: Cardiovascular Council, Domestic and Sexual Abuse Council, Elder Care Council, Maternity Services Council, Palliative Care Council, Resilience Project Council, Substance Use Council, Workforce Development Council. Each Council has approximately 20 members and meets 3 times per year. The four objectives of the Councils are: Ambassadorship/advocacy, Community education and outreach, philanthropy, and programmatic impact. The Councils meet three times per year and the Council leadership meets five times per year and includes hospital leadership.	Process Goal	Year 1 of 3
	Each council has approximately 20 members with a total of 160 community members involved across all 8 councils. The		

Involve community in the NWH Community Collaborative.	community members include those who have expertise on the subject for their council as well as those passionately engaged on the focus area. Chairs or Co-Chairs for each of the councils are community members. Each Council meets three times per year.	Process Goal	Year 1 of 3
Provide community programming and education through the Community Collaborative.	Each Council conducts community programming to provide education on 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 22 a total of 25 events were held with over 1200 individuals who attended the Council programs.	Outcome Goal	Year 1 of 3
Development of focus areas and initiatives of the 8 Collaborative Councils that address identified unmet health needs in the NWH communities.	Supported the work of 8 Councils: the Resilience Council - a school outreach initiative focused on mental health in youth and adolescents through community education and consultation and partnership with schools; the Palliative Care Council - focus on expansion of access to palliative care in inpatient and outpatient settings and education on advanced care illness; 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; the Domestic and Sexual Abuse Council - focused on multilingual and access to supports for victims of abuse; the Elder Care Services Council - focused on addressing fall prevention, social isolation, and the care continuum; the Work Force Development Council - providing employment to low-income youth in the surrounding community and providing opportunities and exposure for workforce entry at all levels; and the Substance Use Council - focused on reducing stigma through community and provider education and partnerships, and increasing access for services through providers, i.e., primary care clinicians.	Process Goal	Year 1 of 3

EOHHS Focus Issues	N/A,
DoN Health Priorities	Social Environment,
Health Issues	Chronic Disease-Cardiac Disease, Health Behaviors/Mental Health-Mental Health, Maternal/Child Health-Reproductive and Maternal Health, Other-Senior Health Challenges/Care Coordination, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Education/Learning, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Violence and Trauma, Substance Addiction-Opioid Use, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Domestic Violence History, LGBT Status, Refugee/Immigrant Status,

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

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, Health Screening, Prevention,
Program Contact Information	Kim Gerard, Senior Manager, Community Health; 617-243-6792

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Conduct community flu clinics.	In FY22, NWH administered 64 flu vaccines. All three clinics were held in the community at the Waltham Mobile Food Market on-site location. Promotion of the flu clinics located in Waltham were communicated in Spanish. NWH provided a Spanish	Outcome Goal	Year 1 of 3

	interpreter at all three clinics.		
Representation and involvement on local community boards and activities.	Numerous NWH clinicians and staff served on local community boards and offered their specialized perspectives on strategic initiatives. These included health departments, youth organizations, business chambers, social service and non-profit agencies.	Process Goal	Year 1 of 3
Support local initiatives that promote health and wellness.	NWH had various levels of staff participate in education and wellness programs held by community organizations. Topics ranged from mental health, Covid-19, senior wellness, and medical innovation (robotics) others.	Process Goal	Year 1 of 3
Provide a source of health education and socialization for local seniors in the community.	Held 6 virtual senior events with focuses on exercise, staying healthy, nutrition, heart health, chronic conditions, coping with loneliness and loss, heartburn, podiatry and advanced care planning. 650 seniors attended. Also held ongoing virtual group fitness classes including tai chi, stretch and strengthen and balance classes. 130 participants.	Outcome Goal	Year 1 of 3
Cancer Care Preventive Health: Provide health awareness and disease prevention programs.	In FY22, NWH conducted screenings for the community related to illness to include mammograms (24 conducted), lung cancer screening day (13 patients screened), and embarked on a colon cancer screening outreach project. Educational forums were held for all members of the community on breast cancer, prostate cancer, and lung cancer with a total of 350 attendees. 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 and awareness at a number of community-wide onsite events. Conducted cancer survivorship events focused on support, education, and well-being.	Outcome Goal	Year 1 of 3
Cardiovascular Preventative Health: Provide health awareness and disease prevention programs.	In FY22, NWH conducted 3 virtual education events for the community on cardiovascular heart health. 300 attendees. Participated in 3 community outreach events for schools, senior centers, and civic organizations. Provide donations of exercise equipment to a community organization serving an at-risk population. Developed 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 at the Newton and Waltham Firehouses. Created the Small Steps to Better Heart Health Program and presented at senior centers and for men's groups. Resource materials were provided to all program attendees for further detail and education.	Outcome Goal	Year 1 of 3
The Cardiovascular Council, within the Newton-Wellesley Community Collaborative, is community and health care leaders who are united through their passion to create a heart healthy community through community health programs encouraging physical activity and preventive health and disease management.	The Cardiovascular Council, comprised of 17 community and hospital members, met three times in FY22 year. The council works to advance initiatives and education, with a focus on key initiatives that include evaluating the impact of existing community resources and the potential of supplementary supports that could be interwoven to optimize hospital and municipal programs.	Process Goal	Year 1 of 3
Cancer Care Preventive Health: Conduct the PAVING the Path to Wellness Program for Breast Cancer Survivors.	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 FY22, two sessions were held in the Spring and the Fall with 24 participants.	Outcome Goal	Year 1 of 3

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities	N/A,
Health Issues	Cancer-Other, Chronic Disease-Cardiac Disease, Chronic Disease-Diabetes, Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Physical Activity, Health Behaviors/Mental Health-Stress Management, Injury-First Aid/ACLS/CPR, Injury-Other, Injury-Sports Injuries, Maternal/Child Health-Parenting Skills, Other-Senior Health Challenges/Care Coordination, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Homelessness, Social Determinants of Health-Nutrition, Social Determinants of Health-Violence and Trauma, Substance Addiction-Alcohol Use, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Natick Department of Public Health	Not Specified
Natick Senior Ceneter	Not Specified
Needham Council on Aging	Not Specified
Needham Public Health	Not Specified
Newton Community Senior Center	Not Specified
Newton Health and Human Services	Not Specified
Newton Public Schools	Not Specified
Waltham Council on Aging	Not Specified
Waltham Health Department	Not Specified
Waltham Public Schools	Not Specified
Wellesley Health Department	Not Specified
Wellesley Senior Center	Not Specified
Weston Health Department	Not Specified
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
Conduct research studies related to Covid-19 to explore the safety, effectiveness of treatments.	Conducting 2 research studies related to Covid-19. Various treatment are being explored through the studies as well as studies related to the rate of disease progression for Covid-19 patients. 1. This study seeks to collect information needed to understand if a potential treatment, convalescent plasma, might help patients who are sick with COVID-19 recover faster. Convalescent plasma (CP) is made from blood taken from persons who have recovered from COVID-19. 2. 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. The study will enroll up to 2000 people at up to 100 sites.	Process Goal	Year 1 of 3
Conduct research in the area of innovation in health.	A 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 1 of 3
Conduct research study related to chronic disease management for pain.	Conduct research study related to chronic disease management for pain.	Process Goal	Year 1 of 3
Conduct research related to chronic diseases.	On-going study being conducted to look at if adding another drug to the medical care that people with heart failure are already receiving could better control heart failure.	Process Goal	Year 1 of 3

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities	N/A,
Health Issues	Chronic Disease-Cardiac Disease, Health Behaviors/Mental Health-Mental Health, Infectious Diseaseâ€"COVID-19,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

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
Provide a source of health education and socialization for local seniors in the community.	Continued to conduct senior socialization programs virtually. Created a "community" for those who attended to ask questions and have conversation around health topic areas. Resources and support materials were provided after each session. In FY22, 7 programs were held with 750 participants. Topics included nutrition, podiatry, chronic disease, heart health, hypertension, advanced care planning, and health care access. Many of the programs were held in collaboration with community agency partners and hospital service line clinical experts.	Process Goal	Year 1 of 3
Enhance senior wellness, specifically related to balance through the Matter of Balance program and Tai Chi programming.	Programs held in partnership with local senior centers. Transitioned to virtual and expanded access to a larger number of individuals to participate. Tai Chi session are held three times per week. The Matter of Balance Program was held virtually for the first half of the year and in-person sessions resumed at one of the community senior centers. Three 8-week program sessions were held with a total of 24 seniors participating. Programs are promoted and all seniors in any of the six NWH communities are welcome ad encouraged to participate.	Process Goal	Year 1 of 3
Provide opportunities for physical exercise and wellness.	The NWH Wellness Center conducts all exercise and wellness programming free of charge to the community over a virtual platform. Classes include stretch and strength, Pilates, strength training, and tai chi. All programs are specifically geared to the senior community. Eight classes are offered per week with approximately 160 total participants. Participant feedback: ""I wish to thank you for including me in your Monday and Wednesday zoom classes! You are so good at cueing us in constantly with all the reminders so that we can move towards doing Pilates correctly and benefit from the exercises. IÃ¢â‚¬â„¢m beginning to know when IÃ¢â‚¬â„¢m engaging the muscles the 'right' way.	Process Goal	Year 1 of 3
The Elder Services Council, within the Newton-Wellesley Community Collaborative, is focused on the socialization of elders as well as falls prevention.	The Elder Care Council is comprised of 23 hospital and community members. The Collaborative identified an Elder Care Hospital Champion this year to provide leadership alongside the Council's Community Chair. The Hospital Champion 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, and needs related to the care continuum.	Process Goal	Year 1 of 3
Partner and support community efforts focused on Senior Wellness.	Collaborated with local senior centers, YMCA's, housing complexes, and others on health education and senior wellness activities. Program topics included nutrition, mental health, advanced care planning, heart health, chronic disease, health navigation and technology, and other subjects.	Process Goal	Year 1 of 3

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

Partners:

Partner Name and Description	Partner Website

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

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
Access and use of Narcan is an effective option of treating drug overdose. The use of this resource in the community is a need for various agencies. NWH is able to provide Narcan and training to our community partners to support their efforts of dealing with the opioid crisis.	Access and use of Narcan is an effective option of treating drug overdose. The use of this resource in the community is a need for various agencies. NWH is able to provide Narcan and training to our community partners to support their efforts of dealing with the opioid crisis. In FY22, NWH provided 231 doses of Narcan to local community partners Ã¢â‚¬â€œ police and fire, public health, schools and shelters. Provided training to community partners, as necessary.	Outcome Goal	Year 1 of 3
Provide preventive substance use resources to Emergency Department patients and families.	In FY22, NWH dispensed 62 naloxone kits to patients in the Emergency Department with diagnosis of opioid overdose.	Outcome Goal	Year 1 of 3
Provided a location for safe medication disposal within the hospital.	Maintained a MedSafe receptacle for the safe disposal of medications. Promote use among staff, the community and physician practices of this option. 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 1 of 3
Provide education and outreach on various forms of substance use, addressing stigma and prevention.	Conducted and participated in community wide lectures 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, personal story sharing, research. Topics included: ""Drug Use is on the Rise: How to Identify the Signs in Your Child or Loved One"" (44 attendees); stigma and despair associated with drug use; and addition among veterans. Resources and treatment options were provided at all events. 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 1 of 3
Provide education to clinicians and pharmacists and public health officials on role in pain management and addiction.	Expert Substance- Use service clinicians provided training in pain management and medical management of addiction. An annual substance use NWH medical grand rounds was held and open to the medical community. Substance Use Services clinic leadership presented at noon conference to NWH House staff on a regular basis, conducted a pain management training course to residents, and were involved in the on-going Substance Use & Pain medical student longitudinal curriculum initiative. Throughout FY22, NWH continued to offer Suboxone waiver trainings for Newton-Wellesley medical staff. The trainings are committed to helping clinicians to identify when Suboxone is appropriate and to help them to initiate, monitor and maintain treatment. The sessions were held four times in the year, virtually, and include lectures, interactive case-based discussions, and patient presentations on their road to recovery. The requirement for suboxone waiver training was eliminated in December 2022, as a result the SUS clinical team will shift focus to provide additional education and outreach to prescribers needed to demystify buprenorphine.	Outcome Goal	Year 1 of 3

Provide resources to community partners for needed substances.	Provided 179 doses of Epipens to local fire departments and colleges.	Process Goal	Year 1 of 3
Use the hospital as a site to increase public awareness on the opioid epidemic and decrease stigma around substance use.	For the fourth 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 2022 ceremony included Middlesex District Attorney Marion Ryan, two individuals who shared personal stories, and the Executive Director of the Boston Boys and Girls Club. The Purple Flags were on display during September and October 2022 and coincided with the Boston Marathon which takes place in front of NWH. In addition to the annual remembrance event, this brought additional awareness to the need for reducing stigma associated with substance use. An awareness campaign was also created with a webpage and infographic to bring attention to substance use disorders and addiction.	Process Goal	Year 1 of 3
Provide care to substance use patients in the SUS clinic.	SUS front-line clinicians (MD's, PA, Recovery Coach and Social Worker) completed 2700 patient visits (9.5% increase over last year). Referral reasons were: 70% alcohol and 20% opioid. Referral sources: Emergency Department (55%) and Primary Care (34%) clinicians.	Outcome Goal	Year 1 of 3
Collaborate with various local multi-community, and state-wide agencies to address the opioid crisis.	In FY22, 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 addition to others. The hospital continues to partner with the Middlesex District AttorneyÃ¢â‚¬â„¢s office for the Charles River Regional Opioid Task Force. The programs shifted to virtual with much success as it allowed for increased collaboration among community organizations for the purpose of education of community programming, sharing of data, and exchange of best practices. Members of the NWH SUS clinical team and community benefits regularly participated and presented at the meetings.	Process Goal	Year 1 of 3
The Substance Use Council, within the Newton-Wellesley Community Collaborative, is focused on the recognition and treatment of substance use, reducing stigma, and conducting outreach and education to the community and providers.	The Substance Use Council, comprised of 25 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. These initiatives currently include expansion of recovery coaches and psychiatry clinical expertise, and embedding treatment and preventive care throughout our community with enhanced primary care provider support and training.	Process Goal	Year 1 of 3
Increase resources for primary care physicians to address substance use issues in patients.	Numerous hospital-wide efforts continue around safe opioid prescribing under the direction of medical leaders and are championed within Primary Care leadership. These activities include the NWH Opioid Advisory Committee which works to monitor opioid prescribing patterns to help identify and support NWH clinicians needing additional support, standardized post-surgical opioid prescribing guidelines, and one-on-one PCP outreach to support chronic pain and substance use patients with physician-led support. Two specific lectures held were: "My Patient is Taking Opioids for Chronic Pain: What Should I Do?" and "Motivational Interviewing for AUD and Referral Process for SUS."	Process Goal	Year 1 of 3
Provide support options for those experiencing substance use addiction.	Recovery Coach conducted two weekly group support sessions (virtual and in-person). In FY 22, 88 groups have been held. There is, on average, 6-15 people per group who are between the ages of 20-75 years old. Some participants have been participating since the support programs started two years ago.	Outcome Goal	Year 1 of 3

EOHHS Focus Issues	Substance Use Disorders,
DoN Health Priorities	N/A,
Health Issues	Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Environments Served:** Suburban, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Domestic Violence History, LGBT Status, Refugee/Immigrant 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	Jospehine Pang, Manager, DSV Program

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provides free, voluntary, and confidential services to patients, employees and community members who are experiencing domestic violence, partners abuse, sexual assault/abuse, and/or stalking.	In FY22, the program served over 378 distinct survivors of violence and abuse. Following a 48% increase from FY 2020 to FY 2021, which not only saw a significant increase in demand for direct services, but also in complexity, lethality, and acuity. In FY 2022, staff were able to successfully refer clients to appropriate external partner organizations.	Outcome Goal	Year 1 of 3
Expand Domestic Violence services in the community and to Spanish-speaking, immigrant survivors of partner abuse.	In FY 2022 NWH continued its collaboration with the Latinas Know Your Rights (LKYR) Program which included the placement of a year-long bilingual social work intern while continuing to provide a $50,000 grant. Since the grant was first initiated in FY 2019, it has allowed the partnership to directly serve over 400 Latinx survivors in Waltham, ensuring that dozens of families received emergency rental assistance, relocation assistance, utility assistance, and assistance with other basic needs such as food.	Process Goal	Year 1 of 3
Continue to increase safety, health and well-being of patients and employees by providing comprehensive consultation and training to clinicians, providers and community partners serving those experiencing domestic and sexual violence.	In FY 2022, the program provided 223 consultations to community partners and NWH providers and staff. In addition, thousands of hours of additional time were devoted to community education, technical assistance training, policy development, and collaboration with community organizations. Program staff continued to facilitate trainings to advance practice nurses, recently graduated nurses, social workers, and physicians, both hospital-wide and work unit-specific. Topics included but were not limited to the following: - Safety Planning with Survivors of Violence and Abuse - The Impact of Children's Exposure to Violence - Post-Separation Violence and Abuse - Trauma-Informed Care - Best Practices for Documentation when patients disclose histories of sexual assault and/or intimate partner abuse	Process Goal	Year 1 of 3
	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. Initial pilot sites included:		

Continued participation in implementation of the DOJ- funded National SANE Tele-nursing Center. The hospital provides space for the Center & technical expertise and education to providers across the country.	- 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. NWH added 7 more TeleSANE positions in FY 2022. 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 WomenÃ¢â‚¬â„¢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 - Sturdy Memorial Hospital - Beverly Hospital - Saint Anne's Hospital - Indian Health Services facilitate, Polacca, AZ NWH formally signed an MOU with The Boston Area Rape Crisis Center (BARCC) to ensure that patients arriving at NWH's Emergency Department seeking Sexual Assault Nurse Examiner (SANE) Kits receive coordinated, comprehensive, and quality services from NWH's clinical team in coordination with BARCC's Medical Advocates who coordinate their arrival with SANEs.	Process Goal	Year 1 of 3
Work to build options for support and empowerment groups through alternative modalities.	Program staff implemented two separate support groups in partnership with REACH Beyond Domestic Violence and the Latinas Know Your Rights (LKYR) Program - Program staff co-facilitated processing and coping skill group for Spanish-speaking survivors of intimate partner abuse (Fall 2021). - Program staff co-facilitated Fostering Resilience Group, bilingual support group for children living in REACH Beyond Domestic Violence's shelter (Spring 2022). Program staff facilitated a multimodal, psycho-educational support group based on Dr. Janina Fisher's book: Transforming the Living Legacy of Trauma. - Series offered participants the opportunity to better understand the traumatized brain, honor the brain's creativity and ability to adapt, acknowledge the impact of abuse and trauma on coping and relationships and practice mind and body-based skills for healing and self-regulation. Program staff facilitated an expressive arts workshop series. - Survivors were able to engage in process-oriented art therapy exercises that supported survivors with challenging the 'inner critic'. Staff facilitated psychoeducational and coping skill - Building support groups: Impacts of Abuse Support Group. - Series offered participants the opportunity to learn about healthy relationships, acknowledge the impact of abuse and trauma on coping and relationships, engage in grounding and coping skill-building exercises, and practice self-care. Staff facilitated two Trauma-Sensitive Yoga Groups: Both workshop-style groups offered participants the opportunity to cultivate and strengthen their individual preferences and practices for self-compassion, acceptance, self-efficacy, and self-regulation, as well as internal and external boundary setting within a supportive and non-competitive environment. - Participants were provided substantive peri- and post-instructional materials to support their independent yoga practices. Program staff and MenHealing partnered with FORGE, a national transgender antiviolence non-profit organization that offers training, technical assistance, and resources to facilitate Voices of Healing: Trans & Nonbinary Survivors SPEAK OUT. - The project focused on using creative expression 'words, movement, art' to empower trans/nonbinary survivors to share their story, connect with others, and enhance healing for both themselves and the broader community. - The event featured 6 transgender and non-binary survivors of sexual assault who were able to showcase their art exhibitions on resilience and healing from the interpersonal and system traumas that they have each experienced.	Process Goal	Year 1 of 3
The Domestic and Sexual Abuse Council, within the Community			

Collaborative, is focused on enhancing access for survivors who face linguistic and cultural barriers and providing increased awareness and education on domestic and sexual abuse.	The Domestic and Sexual Abuse Council, comprised of 23 members, meets three times per year. The Council has been instrumental in disseminating emergency resources to victims of abuse and reacting to partner needs.	Process Goal	Year 1 of 3
Raise awareness and provide resources and supports related to Domestic and Sexual Violence. Focus both education both internally at the hospital, and in the community.	Conducted a community-wide educational program: "Recognizing Unhealthy Relationship and Finding Support". Focused on learning how to recognize abuse within intimate partner relationships and gain resources to support loved ones who might be in an unsafe relationship. Program was hosted by the Newton-Wellesley Hospital Domestic/Sexual Abuse Council in partnership with BARCC, The Second Step, Journey to Safety and REACH Beyond Domestic Violence, Inc. Feedback on the program included the following attendee story conveyed by one of the participating partner agencies: "We had a survivor call the intake line yesterday who is in the beginning stages of leaving an 18-year marriage. She said that the keynote last night is what encouraged her to reach out after so many years of abuse, and she was able to connect the information we presented with her own personal experiences. She said this is the first time she's reaching out to an organization, and the first time she's really shared her story with someone." Promoted and participated in activities related to Domestic and Sexual Violence Awareness Month - focused on male survivors of sexual violence, Substance Use and Domestic Violence Awareness - the intersections of Substance Use and Intimate Partner Abuse, and Gun Violence - focused on the intersection of intimate partner abuse and gun violence. Resource materials and outlets for support were made available during all awareness activities.	Process Goal	Year 1 of 3
Build on relationships with community DSV programs by providing resources, supports, training, and consultation.	The NWH Community Benefits Program and the DV/SA Program offered 4 in-person CPR and First Aid trainings. - This not only allowed area non-profits to save on costs, but it ensured that DV/SA survivors would not be negatively impacted by organizational staffing shortages caused by delays in CPR and First Aid recertification compliance. - 45 Advocates and staff from partnering DV/SA agencies were re-certified in FY 2022. Each year, TSS's Residential Housing team supports approximately 20 families in their transitional living housing program. The families that they welcome throughout the year are often transitioning from emergency shelters. Many do not have access to funds to purchase household items once they move out of a communal living setting. - In FY 2022, with the generous support of the NWH Community Benefits and Development Team, program staff were able to secure a $1,500 donation to TSS for their annual linen drive, ensuring that each family that arrives to their transitional living space will be warmly welcomed with bedsheets, pillows, blankets, curtains, and even new stuffed animals for families with infants and toddlers. Program staff continues to support the mission of the Massachusetts Women of Color Network (MAWOCN). By sharing knowledge, resources, peer-to-peer support and mentorship to Women of Color working in a domestic violence and sexual assault organizations, the goal of MAWOCN is not only to elevate the role of Women of Color in ending violence, but to also shed light on Institutional racism and to challenge systems that uphold and perpetuate oppression. - In FY 2022, program staff supported MAWOCN to intensify its focus to highlight and honor the incredible work that advocates of color have provided to their clients and communities throughout the COVID-19 crisis. - Program staff supported MAWOCN with submitting paperwork to formally become a 501(c)(3) nonprofit organization on Friday, Jun 24th, 2022.	Process Goal	Year 1 of 3
Establish partnerships with community based DSV organizations to build capacity with 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 during childhood or as adults. - Program staff attended annual 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: o Reviewing and adapting MenHealing Level 1 and Advanced Level 2 WOR Curriculums. o Co-facilitating Virtual Ã¢â‚¬Å“Days of Recovery' o 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 will be kicking off a podcast series: - The official launch date is Friday, September 30th, 2022 - The podcast will Illuminate the healing journeys of male	Process Goal	Year 1 of 3

	survivors of sexual harm and will be moderated by Richard Smith, MenHealing Anti-Racism Staff Educator. - Guests will include advocates, therapists, researchers, and survivors who will share their unique perspectives and personal stories of healing and the work that they are doing to create a more just and healed society. 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 the support of the NWH Community Benefits Program, staff provided Saheli with $1,000 to partner with BARCC to ensure ongoing trauma-informed clinical and structural guidance so that they can utilize their significant cultural and linguistic expertise to more fully serve survivors of sexual violence and abuse.		

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

Partners:

Partner Name and Description	Partner Website
Boston Area Rape Crisis Center	http://www.barcc.org/
Jane Doe, Inc.	http://www.janedoe.org/
Middlesex Co DA's Office	http://www.middlesexda.com/
REACH Beyond Domestic Violence	http://www.reachma.org/
The Second Step	http://www.thesecondstep.org/
Massachusetts DPH	Not Specified

WorkForce Development

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	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
Provide opportunities for youth to gain exposure to the health care environment and learn from professionals about career options.	Conducted 6 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 140 youth. Involved 25 NWH staff participating in the weekly programs. Focused on both clinical and non-clinical roles and innovations in healthcare.	Outcome Goal	Year 1 of 3
Provide paid employment opportunities to underserved youth in the community. Enhance exposure and opportunities for a career in the healthcare industry with varying levels of post-education. Engage with	Hired 17 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, Simulation Center, Gastroenterology, Surgical Practice, Environmental Services, Transport, Volunteer Services, Patient Experience, Central Sterile Supply, Ambulaory 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 25 NWH staff participated in the	Outcome Goal	Year 1 of 3

healthcare professionals in a mentor/mentee relationship.	career exploration/medical innovation sessions. For the entire WPY intern program (100 interns), 58% were from low- or lower-income households, and 70% identified as non-white race and ethnicity. Feedback from the interns: ""Yes, it has further confirmed my future plans of wanting to be in healthcare and working in a hospital setting." ""My relationship with all the staff was incredible and I hope every intern gets to experience it."		
Support on-going youth work force development initiatives in the community.	Continued sponsorship for the Career Exploration and Training Coordinator at the Waltham Partnership for Youth. 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 over 100 summer interns in the City of Waltham.	Process Goal	Year 1 of 3
Provide work-skill based opportunities for students and adults through the NWH vocational volunteer program.	Provided structure for individuals, both adult and youth, in vocational programs with separate, on-going, placement opportunities to learn, practice and be exposed to workplace skills. NWH Volunteer Services started back the program post-Covid with great success. Currently there are 5 affiliated organizations with on-going expansion underway. For FY22, a total of 15 vocational volunteers took part in the program and contributed 816 hours of volunteer service.	Outcome Goal	Year 1 of 3
Provide outlets for exposure to health-related educational and employment opportunities to those in the community and all levels to include youth, young adults, those in career transition, and those displaced from employment. Provide outreach to those with less economic stability and less of a means to pursue education opportunities.	Conducted a four-part virtual Healthcare Career Exploration Series over four evenings with 200 attendees. Made available to high school students, adult learners, NWH employees, and school guidance counselors. A keynote speaker, and career focused panels were a part of each program. In particular, departments and staff were chosen to represent healthcare areas that require less than four-year degrees, certificate programs or no formal schooling. 16 staff participated in the sessions. Staff shared details about the job field, their day-to-day work, pros and cons of their position, schooling requirements and personal career journey stories.	Process Goal	Year 1 of 3
Provide community outreach to student populations to expose individuals to healthcare careers	Provided placements for City of Newton interns at NWH. Participated in Newton Health and Human Services Youth Newtork with a variety community partners with the goal of fostering growth and empowerment among youth as well as career exposure and opportunities for advancement. Staff took part in numerous fairs, club meetings and spoke at events to educate attendees on healthcare career options.	Process Goal	Year 1 of 3
The Work Force Development Council, within the Newton-Wellesley Community Collaborative, focuses on expanding potential career options, through training, education and career development. Providing opportunities for both youth and adults to enhance family financial security and, importantly, provides a ready pool of talent for local businesses. A strong local economy can positively and more broadly impact health and wellness.	The Work Force Development Council, comprised of 28 community and hospital members, 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. 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. WFD Community Chair and Hosptial Champion work actively with the Community Collaborative Leadership to promote the mission.	Process Goal	Year 1 of 3
Form partnerships to promote youth development and leadership skills.	Partnered with SparkShare as a community facilitator with a goal of empowering young people to be change agents in their communities and in their own lives by listening, connecting, and building partnerships. Participated in two SparkShare Youth Summits, multiple consulting sessions, and engage on the SparkShare Partnership to Youth social media Hub. Participated in multiple planning sessions to created content development to optimize youth engagement.	Process Goal	Year 1 of 3
Engage with local school districts on opportunities to expand and think innovatively on the intersection of work place/career exposure and academic curriculum.	Newton-Wellesley staff representatives on the Waltham High School Health Assisting Program Advisory Committee Meeting and the Waltham High School - School to Career Work Team. Provided the academic course materials for the Health Assisting Program. Provided additional supplies, resources, and additional connections to the hospital setting.	Process Goal	Year 1 of 3
Develop an innovative surgical technologist training program in	Lasell University and Newton-Wellesley Hospital collaborated and designed a program to diversify the health care profession, create a pathway to professional-level jobs in the medical field, and help address the national shortage of skilled surgical technologists. The new and innovative initiativeâ€"an extension of Lasellâ€™s Health Sciences degree programâ€"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.		

collaboration with higher education partners that incudes flexible classroom curriculum, on-site clinical training, and direct school-to-employment track.	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 500 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 will prepare for the certification exam offered by the National Board of Surgical Technology and Surgical Assisting. There will be a new cohort started each cycle. The first cohort of 6 students are now in their clinical rotation phase and a new cohort has begun the academic portion of the program. Enrollments will be continuous. NWH provides full financial support for all those who participate in this program, in exchange for a commitment to work at NWH for three years.	Outcome Goal	Year 1 of 3
Provide community outreach to student populations to expose individuals to healthcare areas with high vacancies and direct training-to-employment programs.	Leveraged community networks to promote opportunities for employment in healthcare. Promoted training programs through multiple community agencies and within the MassGeneral Brigham System. Highlighted and opportunities becoming employed in high vacancy areas such as lab tech, pharmacy tech, medical assistant, patient care assistant, and surgical tech.	Process Goal	Year 1 of 3

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

Partners:

Partner Name and Description	Partner Website
Waltham Partnership for Youth	www.walthampartnershipforyouth.org
Newton Dept. Health and Human Services	www.newtonma.gov
SparkShare	www.sparkshare.org
Lasell University	lasell.edu

Wrap Around Waltham

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	NWH's 2018 Community Health Needs Assessment demonstrated that high school graduation rates among Waltham students are lower than that of other communities in the hospital's catchment area and of Massachusetts overall. The dropout rate in Waltham (3%) is nearly twice that of Massachusetts. Furthermore, graduation rates and dropout rates among Hispanic/Latino students and English Language Learners (ELL) are far worse. NWH operationalized a grant initiative made possible by the approval of two Determination of Need (DoN) Community Health Initiative (CHI) processes of Partners HealthCare System, Inc. Massachusetts General Waltham and Partners HealthCare System, Inc. Massachusetts General Physician's Organization Waltham. Wraparound Waltham, the resulting CHI is a collaborative of educators and service providers, led by Waltham Partnership for Youth (WPY) in collaboration with Waltham Public Schools (WPS), working to address disparities in high school persistence, grade advancement, and graduation rates among Waltham newcomer students by providing individualized supports that address both the academic and non-academic needs of students and their families.
Program Hashtags	Mentorship/Career Training/Internship, Prevention,
Program Contact Information	Kaytie Dowcett, Ex. Director, Waltham Partnership for Youth, Liz Homan, Assistant Superintendent, Waltham Public Schools, Lauren Lele, Sr. Director

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Address disparities in high school	2022 marks the third year of a four-year grant to Waltham Partnership for Youth (WPY) to implement Wraparound Waltham. Designed as a multiÃ‚Â¬agency collaborative led by WPY, Wraparound Waltham works in partnership with Waltham Public Schools to support newcomer students attending Waltham High School (WHS). Working with three community partners (Doc Wayne, Children's Charter, The Right to Immigration Institute) Wraparound aims to: -Support emerging bilingual newcomer students and their families from Latin America -Provide academic and non-academic supports to newcomer students fostering school and community belonging, emotional		

persistence, grade advancement, and graduation rates among Waltham newcomer students by providing individualized supports that address both the academic and non-academic needs of students and their families.	safety, and well-being -Facilitate access to school and community information, resources, and services -Increase high school persistence, grade advancement, and graduation among newcomer students As of August 2022, 172 Latinx newcomer high school students participated in Wraparound Waltham across the three years of the grant. The number of Wraparound high school students participating annually increased dramatically during the third year of the grant. The first two years of the grant coincided closely with the COVID-19 pandemic; remote/hybrid school and virtual programming impacted student participation and engagement in Wraparound. The return to in-person classes, alongside Wraparound's new referral and engagement strategy, the Welcome Class, were key factors for the significant increase in the number of high school students served during the third year of this grant.	Process Goal	Year 3 of 4
Facilitate access to school and community information, resources, and services."	In addition to academic supports and Wraparound services, 65% of Wraparound students received non-academic / basic needs supports or referrals during SY2021-2022. Community organizations providing these supports include Wraparound's program partners - Doc Wayne, Children's Charter, and TRII ' as well as other community partners, such as WATCH CDC, local food pantries, and REACH beyond Domestic Violence. In October 2021, Wraparound launched the Welcome Center as a central referral hub of information and resources for families, particularly Spanish-speaking immigrant families who have recently arrived in Waltham. The Welcome Center is located at the McDevitt Middle School and open to Waltham Public School families. Jointly staffed by WPY and WPS, the Welcome Center provides culturally sensitive support in Spanish, helping students and their families navigate the school community and access community resources. The Center offers Spanish-speaking students and their families a physical place to go for assistance with everything from accessing the school's online portal to enrolling in English language classes to obtaining community referrals. 150 newcomer WPS families received referrals and support services through the Welcome Center during its first year in operation. This number is based on available data and is likely an underestimate as information on Welcome Center services was not consistently collected during the months impacted by staff turnover (April - June 2022).	Process Goal	Year 3 of 4
Increase high school persistence, grade advancement, and graduation among newcomer students.	Academic outcomes were tracked for 126 students who were active in SY2021-2022. The remining 32 Wraparound students who were enrolled in WHS at the very end of the school year are not included in grade advancement and graduation outcomes data. Of the 126 Wraparound students, 96% progressed academically (n=121). Specifically: - 108 persisted and advanced to the next grade (86%) - 7 persisted but are repeating their grade (5.5%) - 6 graduated (4.5%) The five students who did not progress academically either transferred schools mid-year or chose to not attend school.	Outcome Goal	Year 3 of 4
Support emerging bilingual newcomer students and their families from Latin America.	During the 2021-2022 School Year (SY2021-2022), 158 Newcomer Waltham High School (WHS) students participated in Wraparound programming. Of these, 84% were first-time participants, enrolled through the newly established Welcome Class. The remaining 16% were participants from previous school years who continued to access services. Of the total 158 participants: - 100% were newcomers - 100% Latinx or Latin American - 99% were native Spanish speakers - 58% were 9th graders - 20% were 10th graders Beginning in Fall 2021, Wraparound began a new approach to student engagement 'the Welcome Class'. In this process, all Spanish-speaking Latinx newcomer students enrolled at WHS are invited to attend the weekly Welcome Class as part of their school schedule during their initial months at WHS. During this block, which is co-taught in Spanish by the WPY High School Wraparound Coordinator and the WHS Academic Case Manager, newcomer students are oriented to the school and community as a group using a structured and systematic approach. The Welcome Class is designed to connect students to trusted adults working at their school who speak their primary language, promote connections among newcomers, increase students' ability to navigate WHS, and raise student and family awareness of school and community resources and supports. Throughout SY2021-2022, Wraparound held 5 Welcome Class sessions. The first three sessions - starting in September, November, and February - ran for 8 weeks. The last two sessions - starting in April and May- were shortened to accommodate the substantial influx of newcomer students. In total, 133 newcomer students participated in the Welcome Class during SY2021-2022. Of these: - 88% were 9th or 10th graders (69% were 9th graders)	Process Goal	Year 3 of 4

	- 89% identified Guatemala as their country of origin		
Provide academic and non-academic supports to newcomer students fostering school and community belonging, emotional safety, and well-being.	Funding for Wraparound Waltham supports the salary of a WHS Academic Case Manager (ACM) to work with newcomer students. In addition to co-teaching the Welcome Class, the ACM conducts one-on-one check-in meetings with students after they have completed the Welcome Class, to continue relationship building, monitor students' academic and non-academic progress, and refer students back to the Wraparound Coordinator if the student would benefit from additional services. Throughout the year, 98% of Wraparound students met individually with the ACM at least once. The average number of meetings was 2 but varied significantly across students, with the number of meetings ranging from 1 to 15. In addition to academic supports, students received services from Wraparound partner organizations. Specifically: - 30 WPS students participated in Doc Wayne programming during SY2021-2022, including 18 high school students and 12 middle school students. - 34 Wraparound students participated in Children's Charter programming during SY2021-2022. 26 students participated in group sessions, 5 students participated in individual sessions, and 3 students participated in both. - 48 Wraparound students and their families received direct services from The Right to Immigration Institute (TRII), including immigration representation and advice.	Process Goal	Year 3 of 4

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

Partners:

Partner Name and Description	Partner Website
Waltham Public Schools	www.walthampublicschools.org
Children's Charter	https://www.key.org/programs/childrens-charter
Doc Wayne	https://docwayne.org/
The Right To Immigration	https://www.therighttoimmigration.org/
Umass Donahue Institute Test	https://donahue.umass.edu/
Waltham Boys and Girls Club	https://walthambgc.org/
Waltham Partnership for Youth	www.walthampartnershipforyouth.org

Expenditures

Total CB Program Expenditure **$5,308,448.00**

CB Expenditures by Program Type	Total Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
Direct Clinical Services	$45,374.00	$45,374.00
Community-Clinical Linkages	Not Specified	Not Specified
Total Population or Community-Wide Interventions	$4,211,074.00	$1,334,752.00
Access/Coverage Supports	$1,052,000.00	$430,969.00
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	$236,130.17	
Mental Health/Mental Illness	$1,367,423.05	
Housing/Homelessness	$7,381.75	
Substance Use	$362,119.40	
Additional Health Needs Identified by the Community	$3,335,393.63	
Other Leveraged Resources	$1,894,516.27	

Net Charity Care Expenditures	Total Amount
HSN Assessment	$7,517,815.99
HSN Denied Claims	$84,419.41
Free/Discount Care	$386,689.04
Total Net Charity Care	$7,988,924.44

Total CB Expenditures: $15,191,888.71

Additional Information	Total Amount
Net Patient Service Revenue:	$621,896,756.00
CB Expenditure as Percentage of Net Patient Services Revenue:	2.44%
Approved CB Program Budget for FY2023: (*Excluding expenditures that cannot be projected at the time of the report.)	Not Specified
Comments (Optional):	Not Specified

Optional Information

Hospital Publication Describing CB Initiatives: Not Specified

Bad Debt: Not Specified

Bad Debt Certification: Not Certified

MA AGO Community Benefit Reporting
Optional Supplement Template

Per The Attorney Generalâ€™s Community Benefits Guidelines for Non-Profit Hospitals published in February 2018, hospitals may submit an â€œOptional Supplementâ€.

From the guidelines:

â€œThis optional supplement allows for hospitals to provide a brief narrative on how they are leveraging their role as employers, purchasers, investors, and anchor institutions in their communities to advance health equity, reduce disparities, provide support for the social determinants of health in their communities, or advance other elements of their Community Benefits mission.â€

Additionally, from our conversations directly with the AGO and Webinars they have hosted, our recommendation is that you also:

1. Describe work ongoing from priorities identified in prior CHNAs. For example, cancer screenings or interpersonal violence.
2. Describe work ongoing from priorities areas identified through prior DoN Community Engagement processes.
3. Consider reporting expected direct expenses committed to your Implementation Strategy. This could be the same as the current reporting year direct expense amount, or another amount as determined by your team if that is possible.

The form below is intended to help us collect this information for submission with your report.

++++++++++++++++++++++++++++++++

1. Is your hospital engaging in Anchor Institution-related activities?
? No.
? Yes. Please describe any activities your hospital is engaged in that leverages your role as an employer, purchaser, investor, and anchor institution in your CHNA target populations to advance health equity, reduce disparities, or provide support for the social determinants of health.

Click or tap here to enter text.

2. Do you have reportable community benefit activities that are not within one of your current CHNA priority areas?
? No.
? Yes. Please describe the rationale for the inclusion of the(se) area of work. For example: prior CHNA priority; need identified through process other than CHNA (e.g. through partnership with external organization, data surveillance)

Note: You do not need to describe the programming itself as we will capture that in your program reports.

Click or tap here to enter text.

3. Do you have priorities supported by DoN CHI funds that are not priorities in your current CHNA?
? No.
? Yes. Please describe a description of the areas of work.

Note: You do not need to describe the programming itself as we will capture that in your program reports.

Click or tap here to enter text.

4. In responding to COVID, please describe your process for engaging your community/communities in developing responsive programming during the pandemic.

Optional Supplement:

Reference should be made to the NWH Self-Assessment Form which describes ways NWH has addressed SDOH needs, has taken an health equity approach, and has incorporated Total Population and Community-Wide interventions into their community efforts.

Described below are some examples for how responsive programming was developed and community engagement practices were enhanced over the past year. Additional and significant detail is within the NWH Programmatic Goals Section of the Annual Report.

A few areas that have been mentioned throughout the NWH reporting warrant further elaboration here.
1. NWH conducted back-to-back Community Health Needs Assessments and Strategic Implementation Plans in 2021 and 2022. As a result, we could immediately reflect on how we might change the process from one year to the next. Aspects included: (1) leveraging trusted community partners to organize focus groups and identify stakeholder interviews, (2) to conduct the focus groups in the community itself, (3) ensure that interviews and focus groups were conducted solely in the language of the participant(s), and (4) to include more local data sources in secondary data collection result. All of which resulted in much deeper engagement and the engagement of â€œvoices of the community.â€ Lastly, (5) NWH expanded the NWH Community Benefits Committee to include additional members (CBAC Plus) with diverse representation of sector, population, and community. This enhanced overall discussion and served to better guide the decision making for strategic priorities. We are now able to build off these actions to address one of the themes in our CHNA for sustained community engagement and empowerment. One of the positive results is that the CBAC has been permanently expanded to these new participants onto the Committee, to include those connected to the areas of disabilities, business (tech), immigration, and transportation.

Newton-Wellesley Hospital has built strong partnership over time which, in recent years (i.e., the pandemic), has served to be critical in responding to community need. At the base line, for being a liaison for the community to health services and of being a communicator of current health care trends. The Hospital is now sought out as a partner to help resolve and respond to community need. One example of this is the recent influx of immigrant families, and youth into the Waltham and Newton communities. Both the department communityâ€™s departments of public health and school departments reached out to NWH to look to how to resolve the concern that there was a delay in getting students the care needed for them to become or stay as active students. NWH has now relaunched (which had been in place pre-Covid) the new school immunization program for both Newton and Waltham. In addition, NWH is also responding to the lack of â€œmedical homesâ€ for these students as well as the need to provide services related to SDOH issues by setting up health days for this population of students in Waltham. The discussion and planning is in collaboration and partnership with the school system.

Newton-Wellesley has worked within the Mass General Brigham Community Health three over-arching priority areas of (1) nutrition security and equity, (2) development of workforce pipelines, and (3) interventions related to chronic disease management and prevention. NWH has stood up local initiatives in all of these areas and engaged community partners to collaborate and build out programs to further efforts in each.

As stated previously, NWH community health work consistently takes an equity lens. This has been achieved through multiple examples of community initiatives that are focused on populations to promote equity (see NWH Self-Assessment Ques #4b.). Over the year, there has also been growing intersection with community health and health equity efforts. The NWH structure for Diversity, Equity and Inclusion (DEI) has developed under Mass General Brighamâ€™s United Against Racism framework. This has included naming a Chief of DEI, creating a DEI Council of multi-disciplinary members at all staff-levels, developing a DEI Council Charter, conducting staff level trainings over multiple platforms, establishing a protocol for hospital policies to be reviewed through an equity lens, and conducting focus groups across staff levels groups with interpretation available, as needed. Further evidence of this intersection of work is that a DEI Resource Leadership Team has been created and includes leaders from Community Health, Chief of DEI, Human Resources, and Clinical Services. This work continues to evolve and grow within Newton-Wellesley Hospital and across the system.

5. Please provide a description of the â€˜resourcesâ€™ to be committed in the IS submitted with your report.

We predict that the resource allocation will be similar in future years.

Click or tap here to enter text.

Would you like to include a $$ amount with this narrative?
? No.
? Yes. Specify amount: _____