Current Status: Published **Data as of:** 7/3/2024 10:59:26 AM

Organization Information

Organization Address and Contact Information	
Organization Name:	Newton-Wellesley Hospital
Address (1):	2014 Washington Street
City, State, Zip:	Newton, Massachusetts 02462
Web Site:	www.nwh.org
Contact Name:	Lauren Lele
Contact Title:	Senior Director
Contact Department:	Community Health
Telephone Num:	(617) 243-6330
Fax Num:	(617) 243-5363
E-Mail Address:	llele@mgb.org
Contact Address (1): (If different from above)	2014 Washington Street
City, State, Zip:	Newton, Massachusetts 02462

Organization Type and Additional Attributes	
Organization Type:	Hospital
For-Profit Status:	Not-For-Profit
Health System:	Mass General Brigham
Community Health Network Area (CHNA):	Not Specified
Regions Served:	Natick, Needham, Newton, Waltham, Wellesley, Weston,

CB Mission

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

Target Populations

Name of Target Population	Basis for Selection
Child & Adolescent (youth)	CDC Risk Behavior Surveys; MetroWest Youth Risk Behavior Survey; local community Youth Risk Behavior Surveys
Older Adults	Emergency Department data sources; local Senior Center community assessments; Town/City assessments.
Low Income	Community Health Needs Assessment; local Housing Department data; Food and Housing Insecurity data
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
Not Specified

Hospital/HMO Web Page Publicizing Target Pop.

Not Specified

Key Accomplishments of Reporting Year
Among community dwelling elders, fall-related injuries are the most common type of injury. In FY23, 20 elders participated in the Matter of Balance program, bringing the total number of participants since the program inception in 1997 to 2000. 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 three Senior Community Living Forums with Assisted Living Facilities and Independent Living Facilities with 25 attendees at each Forum.

In FY23, the Domestic Violence/Sexual Assault Program at NWH provided free, voluntary, and confidential services to over 288 survivors of domestic, family, or sexual violence.

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

DSV program staff facilitated support groups that encompassed mindfulness and meditation, self-care, empowerment, play and yoga as a few forms of expressive therapies. Provided 216 consultations to community providers and NWH staff and providers.

Facilitated the SANE Tele-nursing Center at NWH served twelve pilot sites across the nation on a 24/7 basis, providing real-time consultation to clinicians serving survivors of acute sexual assault at military installations, on Native American reservations, and in rural parts of the country. Provided technical assistance and education to ten Massachusetts hospitals using TeleSANE services.

Provided 2 in-person CPR and First Aid trainings allowing 30 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 FY23, facilitated 3629 rides through the Modivcare/Lyft platform for ease of access to and from hospital care.

Provided assistance to 103 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

two Population Health Community Resource Fairs with 20 community agencies participating.

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

In FY23, NWH administered 107 flu vaccines at a variety of community locations. Provided interpretation during each clinic.

In FY 23, 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 FY23, held 5 virtual educational programs in the Senior Webinar Series. Topics focused on exercise and wellness, heart health, nutrition, chronic disease, and advanced care planning. 530 seniors attended.

In FY23, 5600 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.

With a focus on youth mental health, engagement with more than 1,800 participants through educational outreach, clinical consultation, small group programming, and professional development talks. Provided 70 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 200 participants.

The Resilience Project had a presence in 18 middle and high schools in the NWH communities.

In FY23, NWH continued distribution of Narcan to community agencies/partners. NWH dispensed 48 naloxone kits to patients in the NWH Emergency Department with diagnosis of opioid overdose.

Substance Use Service clinicians completed 2600 patient visits. 69% for alcohol use and 16% for opioid use). Referrals were 56% from the Emergency Department and 33% from primary care.

SUS Recovery Coach conducted twice weekly group support sessions (one virtual, one in-person). 150 groups have been held in FY23. There is, on average, 6-15 people per group who are between the ages of 20-75 years old.

For the fifth year, 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. Middlesex District Attorney Marian Ryan participated in the event at NWH for the second year.

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

Hired 22 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 Joint Center, Diagnostic Radiology, and

Cardiology. 6 Medical Innovation and Career Exploration Sessions were held for the interns with 25 staff taking part.

In FY22, the Volunteer Vocational Program affiliated with 6 schools and organizations with 17 volunteers who contributed 943 hours of service. Participants interacted in a work- based learning environment and develop social skills and built on employment skills.

Continued programming for exposure to a wide array of careers with a variety of educational and financial commitments required. The program also included careers requiring a two-year degree, certificate programs. or alternative training as well as highlighted high vacancy healthcare positions.

Newton-Wellesley Hospital and Lasell University graduated 16 students out of the newly created Surgical Technology Program. Students have passed exams and are employed in placements throughout the hospital

Launched the Central Sterile processing training program with 4 students being placed at NWH for their clinical externship.

To address maternal mental health, grew the Post-Partum Mood and Anxiety Disorder Program with 2125 patients referred since the program began in May 2019. 33-64 new patients were seen monthly and communication with 40 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.

Sustained the NWH/Community Nutrition Security and Equity Work Group.

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

Provided $10,000 grant funding to the Waltham Boys and Girls Club for the Summer Eats Program, serving 28, 752 meals. Sponsored healthy meal options at the Newton Food Pantry (NFP) during National Nutrition Month. Included with sessions visits from with NWH dieticians with interpretation available and providing recipe cards translated in 3 languages.

In FY23, NWH conducted screenings for the community related to illness to include mammograms, lung cancer screening day, and a colon cancer screening outreach project.

Educational forums were held for all members of the community on breast cancer and lung cancer.

Continued the Firefighter Heart Health Initiative to focus on a high-risk community population for cardiovascular disease. The multi-part program focuses on assessment, exercise, nutrition, and monitoring. Took place at Newton, Waltham, Needham, and Weston Firehouses.

The Small Steps Heart Health Program was held at six sites with 185 participants.

The Walk and Talk Health Program took place at community locations throughout the NWH towns and cities. 900 individuals participated.

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 2023 Boston Marathon.

Provided 24,113 completed Interpreter Service requests, including face-to-face, telephonic, video, ASL. A 39% 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 200 community and staff members. Each Council has leadership from a Community Co-Chair and a Hospital Champion. The Collaborative strives to address unmet needs of the community for their focus area through the development of programs/service/initiatives as well as community-wide education and awareness.

Provided grant funding to for organizations within the Newton-Wellesley communities to expand capacity in supporting refugees and immigrants.

Provided sustaining support to the Waltham Welcome Center that served over 43 household in FY23 of new arrivals in the Waltham community and school system, the majority of whom arrived in the US in the last three years.

Hosted a Community Health Day for 38 newly arrived students to receive needed healthcare access for school entry. In conjunction, in partnership with 6 community agencies to conduct a resource fair for families. Bi-lingual and interpreter services were available throughout the day.

Continued to support Wraparound Waltham an initiative developed to address ethnic and cultural disparities in dropout rates for students in Waltham. The DON/CHI is now completed.

Of the 181 Wraparound students, 79% progressed academically and 8.8% graduated.

During the 2022-2023 School Year, 232 Newcomer Waltham High School students and 27 Newcomer McDevitt Middle School students participated in Wraparound programming.

Wraparound held 4 cohorts of the Welcome Class with 85% identifying Guatemala as their country of origin.

99% of Wraparound students met individually with the Academic Case Manager at least once; 15 middle school students participated in Doc Wayne programming; 18 Wraparound students participated in Children's Charter programming; and 79 (a 65% increase) Wraparound students and their families received direct services from The Right to Immigration Institute.

135 newcomer students, representing 98 families, reeved referrals and supports through the Welcome Center.

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 services to 803 housing on the NWH priority communities.

During the second year of the grant, WATCH CDC and Metro West CD provided non-housing related case management, including more than 1800 actions, to 780 households.

Job and Financial Planning Clinic services were provided to 237 housing clients. In addition, the clinic provided 64 workshops â€“ 21 focused on job support and 36 on financial planning topics) offered in both Spanish and English. All volumes are an increase over the previous year.

In the second year of the grant, WATCH CDC 132 clients were referred to mental health providers.

Continued to address challenges presented in the 2022 Community Health Needs Assessment and act on priorities identified in the NWH Strategic Implementation Plan. Formally expanded the Community Benefits Committee with additional community members who represent diverse populations, sectors, and backgrounds.

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

The monitoring and evaluation of strategies within each of these priority initiatives are in collaboration with the community benefits committee, the hospital's Strategic Leadership Team, Board of Trustees, and the NWH Community Collaborative.

The completion of the most recent Newton-Wellesley Hospital community health needs assessment being in conjunction with the needs assessment completed across the Mass General Brigham healthcare system allows common priority areas to be address at a system level. This will allow for leveraging resources but at the same time adapting action and response to meet the specific needs and challenges being experienced within the NWH communities.

Evaluation of outcomes related to the NWH Housing Initiative DON/CHI will continue throughout 2023-24 with plans to communicate findings to broader audiences. The Housing Initiative grant is being carried out by WATCH Community Development Corporation (WATCH CDC) and MetroWest Collaborative Development (Metro West CD) ($1.9 million grant). The initiative focuses on target populations (immigrant, communities of color, and Latinx) in Natick, Needham, Newton, Waltham, Wellesley, and Weston. Included in this work are aspects to address societal inequities and needs related to the social determinants of health.

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

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

Community Benefits Process

Community Benefits Leadership/Team
Not Specified

Community Benefits Team Meetings
Not Specified

Community Partners
Not Specified

Community Health Needs Assessment

Date Last Assesment Completed and Current Status

11/2022

Consultants/Other Organizations

Not Specified

Data Sources

Community Focus Groups, Community Health Network Area, Interviews, Surveys,

CHNA Document - PDF format NWH CHNA REPORT 2022 (2).PDF

Implementation Strategy (optional)

File Upload (optional) NWH STRATEGIC IMPLEMENTATION PLAN (SIP), 2022 (2).

Community Benefits Programs

Access to Care/Health Navigation	
Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	N/A,
DoN Health Priorities (optional)	N/A,
Target Population	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Health Indicator:** Social Determinants of Health-Access to Health Care, • **Sex:** All, • **Age Group:** Adults,

	• **Ethnic Group:** Hispanic/Latino, White, • **Language:** English, Spanish,

Goal Description	**Goal Status**
Make appointments for those in need of accessing clinical services for either primary or specialty care.	In FY23, 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 18554 calls (a 73% increase over FY22).
Provide Community Health Workers to support patients and create resources and linkages with the community.	In FY 2023, provided NWH Community Health Workers support/services to the communities of: Waltham, Wellesley, Newton, Needham, Natick, Weston, and Walpole. CHW's provide navigate access to necessary services both clinical related, but predominantly within the areas of the social determinants of health for a total of 89 SDOH referrals. The most frequent of which are: Food insecurity, Financial Hardship (Utility Bills/Medications), Housing Insecurity, Transportation, Care for Elder/Disabled, and Childcare, Job search/training. and issues with insurance. CHW's are educated and have successfully formed partnerships with local community service organizations. A bi-weekly Resource Guide has been created to enhance access to resources in the community related to SDOH categories such as food, housing, shelter options, and senior service supports. The Guide includes for details on each of the resources. The Resource Guide is distributed to clinical and non-clinical providers and to broader community partners.
Provide transport options to facilitate transition to and from hospital care.	In FY2023, facilitated 3629 rides through the Modivcare/Lyft platform for ease of access to and from hospital care. Among areas using this service are the Emergency Department, ICU, Rehab Services, Cancer Center, and Integrated Care Management Program. A 50% increase over FY22.
Provide primary care to children and adolescents who are uninsured or present other challenges interfering with direct entry into school and/or meeting school health requirements. Goal to enhance access to primary care and specialty care as needed.	In FY23 held a health clinic and provided care to 38 adolescent uninsured patients so as not to delay school entry and meet entry requirements. Held in partnership with Waltham Public Schools. 11 families seen in Patient Financial Counseling - 7 enrolled in MA Health, 4 with MA Health questions. Referrals for ENT, Neurology, dentist and other clinical services. Involved over 15 NWH clinical and nonclinical staff members. 10 interpreters devices were utilized. Community Resource Fair was held in conjunction with the Health Day with 6 community agencies, representing housing, WIC, Welcome Center, immigration Rights, and mental health services. Covid 19 test kits, masks, and grocery gift cards were given to the families. The Waltham Welcome Center assisted in the translation of materials and documents into Spanish as well as conducting the appointment sign-up, registration, and reminder communications in Spanish.
Provide access to equipment and supplies to at-risk communities to enable quality and safe patient care.	In FY23, provided, over 28 different forms of supplies and equipment.

Partners

Partner Name, Description	**Partner Web Address**
Circulation	Not Specified
Waltham Public Schools	Not Specified

Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330
Detailed Description	To assist with access challenges, NWH develops for and supports various community agencies with transportation support to facilitate client access to needed healthcare. NWH facilitates access to providers and resources for patient needs. NWH regularly convenes community health departments, community agencies, higher education institutions and living communities to engage in discussion and strategy development for improved access to healthcare.

Certified Application Counselors

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	N/A,
DoN Health Priorities (optional)	N/A,
Target Population	• **Regions Served:** All Massachusetts, • **Health Indicator:** Social Determinants of Health-Access to Health Care, • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	**Goal Status**
Provide information about the full range of insurance programs offered by EOHHS and the Health Connector.	Ongoing

Partners

Partner Name, Description	**Partner Web Address**
Not Specified	Not Specified

Contact Information	Tina Tavares, Project Manager
Detailed 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.

Child and Adolescent Mental Health Services at Newton-Wellesley Hospital

Program Type	Not Specified

Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	Mental Illness and Mental Health,
DoN Health Priorities (optional)	N/A,
Target Population	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Health Indicator:** Health Behaviors/Mental Health-Mental Health, Social Determinants of Health-Access to Health Care, • **Sex:** All, • **Age Group:** Children, Teenagers, • **Ethnic Group:** All, • **Language:** All,

Goal Description	Goal Status
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 FY23 through increased patient volume, enhanced school collaborations (to include lower age levels), additional community partnerships (40 community partners), and expansion of offerings and participants attending community and parent programs. Developed a mission, vision, and theory of change for The Resilience Project, and launched an ambitious three-year strategic plan aimed at maximizing access, efficiency and impact.
Create a regular platform for parent and community education and awareness on the topic of mental health.	In FY23, 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 welcomed over 2000 participants. The Series had topics related to mental health, parenting, and educator's professional development. Topics presented included learning about autism and sensory needs, the benefits of enhancing and expanding book sharing with young children, supporting kids and teens through back-to-school-related anxiety and avoidance, understanding the pressures of adolescence, supporting students with language-based learning disabilities.
Address parenting education and the development of skill-building tools for mental health and resilience.	In FY 23, held 4 small-group parent workshops - Raising Resilient Kids and Raising Resilient Teens. The workshops served dozens of families through education, connection, and community. This psychoeducational, seven-week workshop for parents and caregivers of teens and kids, are led by a child and adolescent psychiatrist and a clinical psychologist. 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.
Create school-specific mental health programming to include a clinical consultation service and training.	"In FY22, provided more than 70 psychoeducational and professional development presentations to the community, including schools, parents, and medical professionals. Double the number provided in FY21. 1800 people engaged in the presentations. Provided 5 professional development talks to pediatricians and medical students.
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 8th Annual Educational Summit, a professional development program, for local educators. The 2023 Educational Summit was held in August prior to the school yar to help prepare educators as well as to make it easier for staff to carve out time to attend.
Support local initiatives focusing on mental health.	In FY23, NWH clinical staff was represented on numerous local committees, and task forces across communities that focus on mental health in adolescents.
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 27 community and hospital members, met three times in FY23 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.
Provide mental health care services to patents in the Child and Adolescent Clinic and in the Emergency Department.	In FY23, 5600 children were seen for visits in the Child and Adolescent Clinic (23% increase from FY21) and 736 consults were provided (19% increase from FY21). In reaction to the overwhelming need for pediatric mental health need in the community and being experienced in the Emergency Department, the division continued 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 and providing care near the home and in the most optimal setting as possible.
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 patient'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 child's routine, and shoring up additional family supports Implementing practical strategies to manage common challenges including hair loss, hospital visits, and communication with children's schools In FY23, PACT provided 104 free individual consultations for 82 patients. PACT continued its new team approach with 3 clinicians including leadership from a medical director to continue to meet the growing need for support and guidance for parents with cancer. PACT clinicians continued a PACT virtual, open support group for parents which provided more than 40 patient encounters. Over the fiscal year PACT providers also provided 6 educational talks for clinical students to include medical students and physician assistants. about the PACT model and applications. "
Provide specific outreach to the schools in the NWH communities.	"In FY23, the School Outreach program allows for engagement with over 18000 students in the 18 local middle and high schools in the NWH communities. Successfully, integrated early elementary curriculum to expand the reach of service, education, and outreach to younger age groups and expanding the breadth of the Resilience

Project impact across the ages.
Expanded the Resilience Project team with the addition of an operational consultant to support the creation and implementation of the strategic plan and enhance marketing, recruitment and outreach efforts. school liaison clinician to further support local public schools.
"

Partners

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

Contact Information	Liz Booma, MD, Chief, Child & Adolescent Psychiatry, 2014 Washington St., Newton; 617-243-6490
Detailed 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.

Community Emergency Preparedness

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	N/A,
DoN Health Priorities (optional)	Violence,
Target Population	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Health Indicator:** Other-Emergency Preparedness, • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	Goal Status
Convene community partners for emergency management planning. Serve in leadership capacity for local emergency management and disaster planning.	NWH Emergency Preparedness/Security are active members of the LEPC, and attended the 2023 tabletop exercise held by the LEPC. NWH hosts the majority of the monthly regional HMCC meetings with emergency managers from across the region.
Conduct community-wide emergency management exercises and drills for Mass Casualty Incidence (MCI).	Held a functional exercise focused on preparing NWH to manage an influx of patients to the ED from a mass casualty in the community. This is part of continued work to prepare the hospital to maintain operations during an emergency in the community.
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.
Collaborate, coordinate, and communicate with community partners related to emergency planning efforts.	NWH participation in Region 4AB Load Balancing Meetings. Have been occurring at different frequencies since the pandemic (weekly, every other week, etc.) depending on the state of the region.
Participate in HazMat Incident Planning.	NWH collaborates with Newton Fire to plan for and respond to hazardous materials incidents in the region through quarterly trainings at the hospital.

Partners

Partner Name, Description	Partner Web Address
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

Contact Information	Sid Allendinger, Manager, Emergency Preparedness

Detailed 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.

Community Health Needs Assessment (2022)

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	N/A,
DoN Health Priorities (optional)	Social Environment,
Target Population	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Health Indicator:** 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, • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	Goal Status
Demonstrated on-going active involvement by the Hospital's Community Benefits Committee by maintaining and expanding representation of committee membership to align with areas within the SIP.	NWH Community Benefits committee consists of 30members. Added representation from sectors of disabilities, LGBTQ, Senior Services, and Transportation. Gave opportunities for lending voice to these areas during the meetings.
Demonstrated on-going active involvement by the Hospital's Community Benefits Committee by maintaining and expanding representation of committee membership to align with areas within the SIP.	NWH Community Benefits committee created two Committee Work Groups: Advocacy and a Youth Task Force. Goal for Advocacy Work Group is to create a "white paper" communication tool for leaders and others in the areas identified in the NWH CHNA/SIP. Housing was the first focus area, and a communication plan is being developed. The Youth Task Force Work Group set as goals 1. to welcome youth representation on the NWH Community Collaborative Resilience Council and Work Force Development. 2. To hold an event where students presented to hospital providers and clinicians the results of the Youth Risk Behavior Survey, gave insights, and responded to questions. Format is a Round Table discussion. Conducted in partnership with a community-based organizations from one of the NWH communities.

Partners

Partner Name, Description	Partner Web Address
Not Specified	Not Specified

Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330
Detailed 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.

Direct Outreach/Health Navigation

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	N/A,
DoN Health Priorities (optional)	N/A,
Target Population	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Health Indicator:** 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, • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	Goal Status

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.	"Three Senior Community Living Forums were held this year with approx. 25 attendees at each Forum. The forum includes multidisciplinary representatives from Newton-Wellesley leadership, including the Chief Medical Officer, Physician Hospital Organization Medical Director, Case Management leadership, and members of the Population Health, Mass General Brigham Home Care and Community Health teams. Each forum is focused on a specific topic that is applicable to attendees across the continuum. Topics at this year's forum were: Infectious Disease, Frailty and End-Of-Life. At each Forum, a NWH clinical provider and a leader from a Senior Living Facility presented information, tips, and a case study. Question and Answers followed. Resources and supportive materials were shared with participants after the Forum. The Forum invitees include leadership from Assisted Living Facilities, Independent Living Facilities, Skilled Nursing Facilities, and local public health nurses. As a result of the Forum, relationships with senior living facilities have improved and has now resulted in consistent communication with the hospital. Ideas for future Forums are also solicited from attendees.
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 103 patients in the categories of food, lodging, technology, safety, furniture, supplies, and others. Rent/Housing/Furniture/Cleaning was again the highest use areas. Patients receiving support are at points of crisis and resources provided enable a transition plan to be created. Situations are often in the categories of financial hardship, abusive relationships, caregiving needs, housing hardships, and mental health conditions. 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.
Convene and collaborate with local health departments on a regular basis.	NWH convened eight meetings per year with local health departments. Goals are to communicate challenges, share best practices, review services, and strategize solutions on access and types of care, in hospital and in community. Public health nurses also participate in the meetings and others are invited, as needed. Topics discussed include substance use, behavioral health, capacity, infectious disease protocols, immunizations, home care, housing/shelter needs, school based and senior care. new arrival public health impact, and safety. Having the structure already in place helps to facilitate ease of consistent communication and solution building. Clinical staff serve as presenters and open discussions. NWH Emergency Department data is provided on a quarterly basis to a wide array of community partners in the areas of top five diagnosis, overdose, behavioral health, and falls.
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, Waltham and Newton YMCA's, SDOH related Advisory Boards, and others. Post-pandemic, participation and presence at these networks continues to be significant for on-going communication and providing a liaison relationship between the hospital and partners within our communities, particularly as health issues continue to persist. This engagement also enables the hospital to understand the challenges being experienced in the community. It is often cited by partners how critical it is for this level of hospital engagement.
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 16 hospital and community members and welcomed two new members this year. Members are dedicated to advocating for the importance of holding serious illness conversations when discussing care. They are ambassadors and develop opportunities for community education on the topic of advanced care planning and provide support for the training of clinicians on having conversations with patients. The Council's overall goal is to increase access and awareness for palliative care for patients, families, and the community.
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.	"Two Community Resource Fairs were held in 2023. In Spring 2023, the resource fair was Behavioral Health focused. At this fair, 10 community vendors from the behavioral health field presented. In the fall, the Resource Fair was focused on resources that support patients with their social determinants of health-related needs. At this fair, 9 community vendors presented. At both fairs, the organizations shared information on their services and programs and how to refer. Time was provided for participants to ask questions and engage in discussion. The audience for both fairs 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 attended each session. The successful outcome of the fair was the further development of bi-directional relationships among providers and community partners. "

Partners

Partner Name, Description	Partner Web Address
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
Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330
Detailed 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.

Employee Assistance Services to City of Newton Employees

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	Mental Illness and Mental Health,
DoN Health Priorities (optional)	N/A,
Target Population	• **Regions Served:** Newton, • **Health Indicator:** Health Behaviors/Mental Health-Stress Management, Social Determinants of Health-Access to Health Care, • **Sex:** All, • **Age Group:** Adults, • **Ethnic Group:** All, • **Language:** All,

Goal Description	**Goal Status**
Provide Employee Assistance Services to City of Newton employees.	Enabled ease of access to EAP services for City of Newton employees. CMG Associates are very responsive to the needs of Newton employees, and it is an invaluable employee assistance program. 24/7 access is provided which has become a critical component of supporting staff throughout the myriad of stressors.
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. Work with CMG when there is an identified increased need due to a trauma. (i.e., a near drowning last summer at the public pool). A customized support plan was developed. This year there was an increase in mental related leaves of absence and the City and CMG was able to brainstorm ways to connect school staff with the needed supports.

Partners

Partner Name, Description	**Partner Web Address**
CMG Associates	www.cmgassociates.com
Newton Health and Human Services	Not Specified
Contact Information	Amy Ryals, Senior Director, Human Resources
Detailed Description	Employee Assistance Program services through CMG Associates provides service and resources to City of Newton employees.

Fall Prevention Among Community Seniors

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	N/A,
DoN Health Priorities (optional)	N/A,
Target Population	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Health Indicator:** Chronic Disease-Alzheimer's Disease, Chronic Disease-Osteoporosis, Health Behaviors/Mental Health-Physical Activity, Injury-Other, • **Sex:** All, • **Age Group:** Elderly, • **Ethnic Group:** All, • **Language:** All,

Goal Description	**Goal Status**
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 FY23, two (8-week sessions) Matter of Balance Programs were held that served 20 participants for a total of 2000 since the program's inception in 1997. The sessions were held in collaboration with local senior centers. Sessions resumed in person in 2023.
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. Participants learn the benefits of stretching, good posture, and overall benefits of exercise for healthy aging. Instruction and follow-up communications include motivational techniques and recordings of class content. Classes create a support and a sense of community-building among class members. Positive participant feedback is expressed on a consistent basis. Launched in 2023 was a Pilates for Octogenarians class focused on mobility & strength exercises for 80-year-olds. The class is held virtually held once per month with approx. 10 participants per class."
Conduct Tai Chi classes to promote	Tai Chi classes were held three times per week, virtually and open to the whole community.

balance. Provide an outlet for group interaction and socialization among seniors through Tai Chi.	20 attendees per class for a total of approximately 60 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.

Partners

Partner Name, Description	Partner Web Address
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

Contact Information	NWH Community Health Program Manager, Newton- Wellesley Hospital Wellness Center, 2014 Washington St. Newton
Detailed 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.

Housing Community Health Initiative (DON-CHI)

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	Housing Stability/Homelessness,
DoN Health Priorities (optional)	Housing,
Target Population	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Health Indicator:** Health Behaviors/Mental Health-Mental Health, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Homelessness, • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	Goal Status
Prioritize serving low-income tenants, particularly among communities of color and immigrant communities in Natick, Needham, Newton, Waltham, Wellesley, and Weston.	During the second year of this grant through November 30, 2022, WATCH CDC and MetroWest CD combined to serve 803 households residing in the hospital's priority communities. Nearly one-half of these client households (46%) included children under the age of 18; more than one-fifth (21%) included children under the age of 5; and 12% included members with special needs. More than three-quarters (76%) 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 628 clients that provided information on country of origin, 59% 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 (23% of all housing clients; 30% of clients reporting country of origin). Nearly one-half (43%) of all housing clients indicated Spanish as their preferred language spoken. Other primary languages spoken by housing clients included Haitian Creole, Portuguese, Luganda, Russian, and ASL. More than one-fifth of clients reported requiring a translator as part of services. The vast majority (86%) of clients served under this grant reside in Waltham and were provided housing and non-housing case management support services by WATCH CDC. The remainder of clients served through this grant resided in other communities surrounding the hospital and specifically, Newton, Natick, and Needham -- and were provided housing and non-housing case management support services by MetroWest CD.
Address immediate housing insecurity through provision of housing-focused case management and emergency financial assistance needs.	Households working with WATCH CDC and Metro West CD face a multitude of challenges. Overall, 86% experienced housing insecurity, nearly half of which reported 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 1,800 housing related documented actions, to 780 households. The wide range of actions can be categorized into the following three categories: provision of information and resources, completing and submitting applications, and providing referrals and advocacy support. These actions resulted in the following financial impacts: -Provided 295 Tenant Assistant Fund (TAF) grants, totaling approximately $145,000, used for utility, and rent arrears, emergency housing, and first, last and security deposits to 220 households. The NWH Housing Security CHI grant provided approximately three-quarters of these dollars. - Submitted Residential Assistance for Families in Transition (RAFT) emergency housing assistance applications. As a result, 57 households received RAFT grants equaling more than $270,000. - Submitted applications resulting in many households receiving fuel assistance, first/last

	month rental assistance and security deposit, and utility bill assistance. In addition to financial impacts listed above, clients reported the following improved housing/living conditions as result of working with WATCH and Metro West CD: -Avoided Eviction - Delayed Eviction - Negotiated with Landlord - Found New Housing - Found Emergency Shelter - Fixed Repairs / Code Violations "
Provide non-housing/basic needs support services to reduce inequities in housing security of low-income tenants.	Households working with WATCH CDC and Metro West CD staff face a multitude of challenges. Overall, 45% requested non-housing / basic needs assistance, with approximately one-half reporting not having enough money to buy food. Other no housing assistance reported include: needing help accessing ESL/citizenship/GED classes, immigration questions and concerns, needing internet access, facing non-housing legal issues, needing critical household items and furniture, requesting disability resources or special needs supports, childcare challenges, mental health challenges, and experiencing domestic violence. During the second year of the grant, WATCH CDC and Metro West CD provided non-housing related case management support, including more than 704 actions, to 439 households. Specific non-housing / basics needs related actions taken included: -Provided information and resources on a range of supports including, but not limited to, accessing SNAP/free food resources, Internet Essentials program, household items, education (ESL, GED), and voter registration. -Provided referrals to other community and state agencies for non-housing related financial assistance, educational supports, legal support, immigration help, disability / special needs support, mental health services, domestic violence support, childcare and youth services, and tax assistance. As a result of these actions, many received food/food stamps, internet access, legal/immigration help, and support fleeing domestic violence. Finally, WATCH and Metro West's support resulted in 39 households accessing nearly $50,000 non-housing related financial assistance from other local and state sources. "
Reducing the impact of housing insecurity on client's mental health.	The grant prioritizes strengthening awareness of and support for the mental health needs of clients experiencing housing insecurity. Through this grant, WATCH CDC contracted the services of a mental health consultant, a Children's Charter bilingual licensed mental health counselor (LMHC), to accomplish the following: - Revised client intake protocol to incorporate two mental health related screening questions. - Identified at least 15 local mental health providers who accept MassHealth as well as information on whether accepting new clients, providers intake process, services offered, and languages spoken. The grant prioritizes strengthening awareness of and support for the mental health needs of clients experiencing housing insecurity. Through this grant, WATCH CDC contracted the services of a mental health consultant, a Children's Charter bilingual licensed mental health counselor (LMHC), to accomplish the following: - Revised client intake protocol to incorporate two mental health related screening questions. - Identified at least 15 local mental health providers who accept MassHealth as well as information on whether accepting new clients, provider's intake process, services offered, and languages spoken. - Provided a staff mental health workshop refresher, Housing Insecurity & Anxiety: How to best respond to clients in distress. - Provided client mental health workshops, Managing Stress, in both Spanish and English about how to manage ones stress related to managing rent, housing situations, and their finances as well as to find community mental health resources. One-third (267) of all clients completing the housing intake forms/process indicated that they needed help with stress, anxiety, or depression related to housing or financial difficulties. As a result, WATCH CDC and Metro West CD staff provided all clients indicating mental health needs with information on mental health resources and supports. Moreover, staff referred 132 clients to local mental health providers based on the severity of mental health needs determined through screening questions and follow-up discussions.
Support client's economic independence using an employment / financial coaching and mentoring model.	In addition to housing and non-housing / basic needs support, many clients served under this grant needed job search and financial planning assistance. - 36% requested job support, including searching for jobs, gaining employment-related supports, creating resumes, applying for jobs, completing online applications, and practicing for job interviews. - 37% requested financial planning assistance, including needing help with paying off dept, reducing expenses, making a budget, improving their credit score, making a rainy-day fund, and opening a checking or savings account. To address this need, WATCH 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 in the first year of the grant providing both one-on-one counseling sessions and group workshops. Job support activities and topic areas covered included job search, creating and updating resumes, completing online job applications, practicing for job interviews, and accessing job training, certification programs, and school opportunities. Financial planning topics included improving credit score, opening a checking or savings account, making a budget, making a rainy-day fund, paying off debt, and reducing expenses. During the second year of the grant, the coordinator piloted providing computer literacy classes, offered in both English and Spanish. During the second year of the grant, 237 housing clients participated in Job and Financial Planning Clinic services, receiving one-on-one individual support from the coordinator. In addition, the clinic provided 64 workshops, 21 focused on job support, 36 on financial planning topics, and 7 on computer literacy offered in both Spanish and English. The NWH Housing Security CHI grant enabled the distribution of nearly $9,000 to support

	the economic independence of housing clients through the following: - 22 Back to Work (BTW) grants, of up to $500 each and totaling nearly $7,500, to 21 clients for removing barriers to work, including bus passes, tools, equipment, training programs, computers, and childcare. - 30 financial incentives, totaling nearly $1,500, to 30 clients for participation in Job and Financial Planning Clinic services. Preliminary employment related outcomes for participation in the Job and Financial Planning Clinic include: - 237 received job support guidance - 85 applied for a job - 67 got a job - 60 created or updated their resume - 47 got an interview - 13 attended job training - 12 attended a job fair Preliminary financial planning and money management related outcomes for participation in the Job and Financial Planning Clinic include: - 28 reduced their expenses - 26 made a budget - 8 paid off debt - 2 improved their credit score - 1 opened a checking and savings account
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. Metro West CDC's advocacy work focuses primarily on creating more affordable units. During the second year of the Housing Security CHI, Metro West CD proposed to purchase and/or develop 117 affordable units in Natick, Newton, and Waltham. To date, Metro West CD has been successful in moving forward with 75 of these units. -Newton: Applied for and received zoning approvals for West Newton Armory as well as submitted and received state funding to create 43 units of 100% affordable intergenerational rental housing. Metro West CD is currently working towards a closing and construction start in 2024. - Natick: Applied for and selected as developer for town-owned site to create 32 units of 100% affordable rental housing for Extremely Low Income and Very Low Income households. The development agreement was signed in July 2023 and the community process began in August 2023. Permitting will continue through the spring of 2024. WATCH CDC has continued its community organizing and advocacy efforts in support of the Tenant Rights Notification Act. If successful, this local ordinance would require landlords to notify tenants of legal and financial resources when they are facing eviction. In support of this goal, WATCH CDC's efforts during the second year of the Housing Security CHI included: - Organized a highly attended citizens input meeting with over 100 participants, empowering and training individuals to testify in favor of the ordinance. - Consistently held monthly Tenant Action Group (TAG) meetings, averaging 20 attendees each month, and ensured the executive TAG meeting convened regularly throughout the year. - Ongoing support and outreach through canvassing and tabling events spearheaded by WATCH's TAG leaders and members. Through these efforts, support for the ordinance continues to grow, with over 500 signed cards, 900 online petition signatures, 19 letters of support from landlords, and backing from 20 agencies. Finally, WATCH CDC noted this year's significant achievement of successfully securing three sponsors for the Tenant Notification Ordinance.

Partners

Partner Name, Description	**Partner Web Address**
Watch CDC	Not Specified
Metro West Collaborative Development	Not Specified

Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330
Detailed 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.

Interpreter Services

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	N/A,
DoN Health Priorities (optional)	N/A,
Target Population	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Health Indicator:** Social Determinants of Health-Access to Health Care, Social Determinants of Health-Language/Literacy, • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	**Goal Status**
Provide Interpreter Services (face-to-	Provided 24,113 completed Interpreter Service requests (face-to-face, telephonic, video,

face, telephonic, video and ASL) to the Newton-Wellesley Hospital patient and visitor populations.	ASL). A 39% increase over FY22. The top five languages by usage were: Spanish, Russian, Portuguese, Chinese-mandarin, and Haitian-Creole.
Ensure that Interpreter Services are available in all areas of the hospital.	"Continued to use a combination of in-person, video, sign language and translations platforms for interpreter services. Feedback continues to be that the array of options and variety of device to use expands access and efficiency of service. The top five hospital departments utilizing interpreter services were Emergency, Medicine, Surgery, Urgent Care Walk-In and ICU. Implemented signage, in multiple languages around the hospital that includes violence prevention messaging, respiratory illness guidance, and patient visitation protocols. Utilize the Patient and Family Guide during registration/admission to share information in multiple languages. Spanish, Vietnamese, Portuguese, Russian, Chinese, Haitian Creole, Luganda that offers assistance to patients who do not use English as a primary language or who are deaf or hard-of-hearing. At each entrance in various languages, information is provided regarding care of patients in the home who have the flu. The Patient Rights and Responsibilities posters, displayed throughout the hospital and off-site locations were updated. Materials are available in multiple languages for programs such as Domestic Abuse and Sexual Violence programs, financial services, and all COVID related information including vaccine information, flu, and RSV programs. In response to the increase in numbers of new arrivals as patients, visitors, and family members to the hospital, Interpreter resources were expanded to include additional vendors. More ipad devices were also deployed to high need areas such as the Mother/baby unit, ICU, and Ambulatory. "
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. Set a regular cadence of communications hospital-wide on use and access to interpreter services and the importance of providing interpreter access for patient and community care. "
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. "

Partners

Partner Name, Description	Partner Web Address
Cross Cultural Communications, Inc	https://embracingculture.com/
Language Line Solutions	www.languageline.com

Contact Information	Jouel Gomez, Manager, Telecommunications
Detailed 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.

Mass General Brigham â€" Mental Health, Behavioral Health, and Substance Use

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities (optional)	N/A,
Target Population	• **Regions Served:** All Massachusetts, • **Health Indicator:** Health Behaviors/Mental Health-Depression, Health Behaviors/Mental Health-Mental Health, Substance Addiction-Opioid Use, Substance Addiction-Substance Use, • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	Goal Status
Expand & support the behavioral health workforce with a focus on provider diversity	469 behavioral health students across 8 college/universities have been supported
Expand & support the behavioral health workforce with a focus on provider diversity	136 students now working in the behavioral health field in MA
Expand & support the behavioral health workforce with a focus on provider diversity	53 clinicians recruited & retained in community health centers with loan repayments and salary supplements.

Partners

Partner Name, Description	Partner Web Address

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 Work	Not Specified
Salem State School of Social Work	Not Specified
Bunker Hill Community College	Not Specified
U of Mass School of Nursing	Not Specified
Contact Information	Tavinder Phull, MPH, MBA, Vice President, Community Health Regulatory
Detailed Description	In FY23, Mass General Brigham continued implementation of system-wide strategies that address needs prioritized by our hospitals Community Health Needs Assessments, focus on leading causes of death and health inequities, and build on the long history of impactful programs across our system. Our work in mental health, behavioral health and substance use disorder focuses on expanding the behavioral health workforce with a focus on provider diversity; and increasing access to behavioral health and substance use disorder services and treatment.

Mass General Brigham Access to Care and Services

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities (optional)	N/A,
Target Population	• **Regions Served:** All Massachusetts, • **Health Indicator:** Not Specified • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	**Goal Status**
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.
Increase access to care and services in Mass General Brigham CHNA prioritized communities.	The MGB Community Care Van Program provided 2200 vaccines and 4100 blood pressure visits in prioritized communities. 38% of encounters were with patients who identify as Black or African American, 33 % of encounters were with patients who identify as Hispanic.
Increase access to care and services in Mass General Brigham CHNA prioritized communities.	Provided $1.1M to Lynn Community Health Center and $450K to North Shore Community Health per the terms of the FY23 affiliation agreements
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, including providing funding for the Health Care for All Helpline. Additionally, advocated for state legislation around expanding MassHealth coverage to all children regardless of immigration status, mandating language access and inclusion services for state agencies, and behavioral health workforce investments. We also supported the Massachusetts 1115 waiver amendment that includes provisions that will eliminate coverage gaps while also increasing access to affordable health insurance for more Massachusetts residents.

Partners

Partner Name, Description	**Partner Web Address**
Hospitality Homes	Not Specified
Health Care for All	Not Specified
Health Law Advocates	Not Specified
Mass League of Community Health Centers	Not Specified
Health Care Without Walls	Not Specified
Lynn Community Health Center	Not Specified
Whittier Street Health Center	Not Specified
North Shore Community Health	Not Specified
The Pine Street Inn	Not Specified
Uphams Corner Health Center	Not Specified
New Commonwealth Fund	Not Specified
Contact Information	Tavinder Phull, MPH, MBA, Vice President, Community Health Regulatory

Detailed Description	In FY23, Mass General Brigham continued implementation of system-wide strategies that address needs prioritized by our hospitals Community Health Needs Assessments, focused on leading causes of death and health inequities, and building on the long history of impactful programs across our system. Our work to improve access to care and services focuses on partnerships with community health centers, bringing care into the community, and supporting organizations and policies aimed at reducing access barriers.

Mass General Brigham New Migrant Emergent Needs

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	N/A,
DoN Health Priorities (optional)	Built Environment, Employment, Social Environment,
Target Population	• **Regions Served:** All Massachusetts, • **Health Indicator:** Chronic Disease-Hypertension, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Education/Learning, Social Determinants of Health-Environmental Quality, Social Determinants of Health-Homelessness, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Nutrition, Social Determinants of Health-Public Safety, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of Health-Violence and Trauma, • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	**Goal Status**
Connect newly arrived migrants to urgent medical and social services	Established partnerships with community organizations to coordinate response to the arrival of new migrants to the Commonwealth
Support community organizations to meet the essential needs of newly arrived migrants	Distributed over $500K in grants to seven organizations supporting the needs of newly arrived migrants

Partners

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

Contact Information	Tavinder Phull, MPH, MBA, Vice President, Community Health Regulatory
Detailed Description	In FY23 Mass General Brigham collaborated with the State, local municipalities, and many community-based organizations to address the urgent medical and social needs of the newly arrived migrants in Massachusetts. In addition to providing medical care, our work focused on providing over $500,000 to seven community-based organizations working to support the needs of recently arrived migrants to the Commonwealth.

Mass General Brigham Nutrition Equity

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	N/A,
DoN Health Priorities (optional)	N/A,
Target Population	• **Regions Served:** All Massachusetts, • **Health Indicator:** 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, • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	**Goal Status**
Increase SNAP and WIC enrollment.	Established a Nutrition Equity Working Group that meets monthly to discuss and implement strategies for improvement.
Increase access to nutritious food.	Provided support to food pantries and other community food resources in increase food access.
Support community educational opportunities related to nutrition.	Supported the development of teaching kitchens and learning hubs in MGB priority communities.

Partners

Partner Name, Description	**Partner Web Address**
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

Contact Information	Anne Fox, Senior Program Manager, Community Health
Detailed Description	In FY23, Mass General Brigham continued implementation of system-wide strategies that address needs prioritized by our hospitals Community Health Needs Assessments, focus on leading causes of death and health inequities, and build on the long history of impactful programs across our system. Our work in Nutrition Equity focuses increasing 1) access to nutritious food, 2) community educational opportunities related to nutrition, and 3) SNAP and WIC enrollment and awareness.

Maternal Mental Health

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	Mental Illness and Mental Health,
DoN Health Priorities (optional)	N/A,
Target Population	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Health Indicator:** Health Behaviors/Mental Health-Mental Health, Maternal/Child Health-Parenting Skills, Social Determinants of Health-Access to Health Care, • **Sex:** Female, • **Age Group:** Adults, • **Ethnic Group:** All, • **Language:** All,

Goal Description	Goal Status
Identify patients who are experiencing depression and/or anxiety during pregnancy and postpartum that affects 10-15% of the NWH maternal patient population.	Continued the growth of the Perinatal Mood and Anxiety Disorder Initiative. 2,125 patients have been referred to the PMAD social worker since the program began in May 2019. On average, receiving 33-64 new patients monthly, communicating with 40 plus patients a week. 100% on-site. Seeing 5-8 patients a week for billable virtual and in-person visits.
Provide outreach and intervention by a clinical social worker (LICSW).	Launch of the STEPS for PPD Study. Began enrolling patients in research study. Completed training for additional social worker team members for maternal social work role to cover at-risk population geographies. Developed a Patient Navigator Role for wrap-around services.
Extend the post-partum screening tool further after pregnancy.	Collaboration with 3 OB practices using The Edinburgh Postnatal Depression Scale (EPDS) to screen pregnant and postpartum patients at the initial prenatal visit, between 24-30 weeks prenatally, 6 weeks postpartum, and 6 months postpartum. NWH is the first Partners hospital to screen at 6 months postpartum. To respond to increase in patient referrals, social work hours has increased to 30 hours. Conducted a pilot: The EPDS is completed at the first prenatal visit allowing for identification, education and referral to resources around perinatal mood and anxiety disorders at the beginning of pregnancy. Took on a process improvement project to look at completion rate of EPDS given at the initial prenatal visit and improved documentation around positive EPDS scores.
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 is not just for anxiety and depression, but also include fetal demise, elective termination, substance use, domestic violence, homelessness, unplanned pregnancy, and traumatic delivery. Expanded relationship with community partners for collaboration of resources and support services.
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 are related to both mom and baby care. with content experts speaking on toxics such as, i.e., pediatric dentistry, sleep deprivation, nutrition, diabetes, exercise, family dynamics, etc. Approx. 8-12 new moms attend each session with most attendees attending greater than 8 sessions. When surveyed most 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: "It has really helped me with postpartum depression, and new mother struggles. I would be lost without it. I was able to get through my depression and anxiety because of the group." "Connects us with other moms to talk through common issues or concerns. I also enjoy heating from doctors and specialist. This is a great resource." "For some this may be their only outlet for socialization. My wife looks forward to them and having so many women provide collective insight on their experiences can make one feel less isolated."
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 28 hospital and community members and meets quarterly. Five new members joined this year. The Council evaluates strategies on how best to meet the needs of women and families and engaging related community and hospital services to enhance care. The Council is led by Community Co-Chairs and a Hospital Champion.
Provide opportunities for community education on post-partum depression and maternal wellness.	"Held a community-wide webinar titled: Journeying Through Pregnancy and Postpartum hosted by the NWH Collaborative Maternity Services Council. Four professional panelists focused on maternal mental health, breastfeeding, pelvic floor, exercise. Over 80 attendees that included pre- and post-partum and partners. Resources were provided at, and in a communication following the event.

	Participated in the Needham Harvest Fair and provided maternal mental health resources and opportunities to participate in mothers support group. "

Partners

Partner Name, Description	Partner Web Address
Jewish Family & Children's Services	https://www.jfcsboston.org/
MCPAP	https://www.mcpapformoms.org/

Contact Information	Buffy Sheff-Ross, Clinical Social Worker, LICSW
Detailed 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.

NWH Community Collaborative

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	N/A,
DoN Health Priorities (optional)	Social Environment,
Target Population	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Health Indicator:** 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, • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	Goal Status
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 act 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 ambassadorship 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 roles and have a cadence for meeting to drive strategic direction for the NWH Collaborative. In FY23, a Collaborative Oversight committee was established and led by NWH Hospital President with involvement from nurse and medical leadership, as well as community members. All Collaborative Leadership (Oversight Commitee members, Community Co -Chairs and Hosptial Champions) meet five times per year to set the direction for the Collaborative, track metrics, explore new initiatives, and to share best practices. All leaders provide input.
Established Community Collaborative Councils that address identified health needs.	Maintain 8 community-focused councils: Heart Health and Wellness Council, Domestic and Sexual Abuse Council, Elder Council, Maternity Services Council, Palliative Care Council, Resilience Project Council, Substance Use Council, Workforce Development Council. Each Council has approximately 22 members and meets 3 times per year. In FY 23, 30 community members joined The Collaborative and became a new member on one of the 8 Councils. The four objectives of the Councils are: Ambassadorship/advocacy, Community education and outreach, philanthropy, and programmatic impact.
Involve community in the NWH Community Collaborative.	The Collaborative has a total of 200 community members involved across all 8 councils. The community members include those who have expertise on the subject for their council, those who have personal experience and those who are 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. In FY 23, a comprehensive Council member on-boarding packet was created to lend clarity to the goals of the Collaborative within the Hospital, for the Council itself, and in the community. The role of an On-boarding Liaison was created.
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 23 a total of 28 Council program events were held.
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 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 access into high vacancy areas within healthcare; 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 and Emergency Department; and the Heart Health and Wellness Council that promotes cardiac wellness and preventive healthcare through its multi-faceted engagement with community members, employees, and patients with education and evidenced-based initiatives.
"

Partners

Partner Name, Description	Partner Web Address
Not Specified	Not Specified

Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330
Detailed 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.

NWH Immigrant Health Support and Navigation

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	N/A,
DoN Health Priorities (optional)	N/A,
Target Population	• **Regions Served:** Dedham, Framingham, Newton, Waltham, • **Health Indicator:** Chronic Disease-Diabetes, Health Behaviors/Mental Health-Mental Health, Maternal/Child Health-Reproductive and Maternal Health, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of Health-Violence and Trauma, • **Sex:** All, • **Age Group:** Adults, • **Ethnic Group:** Not Specified • **Language:** English, Haitian Creole, Portuguese, Spanish,

Goal Description	Goal Status
Create access for new arrivals to access supports, services, and resources in the community. Provide services in the native language of the immigrant community.	NWH provided sustaining support to the Welcome Center located in the Waltham community. The Center is a bilingual welcoming space and referral hub dedicated to supporting newcomer immigrant families with children in the Waltham Public Schools district. WPY and Waltham Public Schools staff provide culturally sensitive support in Spanish, helping families access basic needs and services via 1-1 meetings and community events. In FY23, 78 individual students were served for a total of 43 households. The languages of those seeking services were Spanish, English, Haitian-Creole, and Russian. Of those served 46 had arrived in the US within the last three years. 20 arrived just in 2023. Assistance with Immigration/legal services was the most common request. Other assistance was for food and housing, healthcare, mental health, school enrollment and processes.
Provide access to healthcare and support resources in the community for new arrival families and students.	NWH hosted a Community Health Day at our Waltham Walk-In location. Partnered with Waltham Public Schools to welcome dozens of students, many of them recent immigrants who had not previously had access to annual physicals, a critical part of staying healthy, both physically and mentally. NWH and Newton-Wellesley Medical Group convened a multi-disciplinary team of clinicians, including physicians, nurses, and medical assistants, as well as support staff from several departments across the organization. This team worked collaboratively to design and implement a comprehensive program to support these students and their families, including advance outreach to families conducted in Spanish to schedule appointments and provide reminders and lists of required documentation. This Community Health Day provided 38 students with easy access to important medical care, video interpretation services, and connections to community partners to help educate and provide additional resources in areas such as housing, nutrition access and mental health services. Clinicians made several referrals for ENT, neurology, dental and other specialty services, and connected families with primary care providers for ongoing care. Patient Financial Counselors (who were bi-lingual) helped seven families enroll in MassHealth and assisted another four families with MassHealth-related questions. Those who attended were also given COVID-19 test kits, masks, and $25 grocery gift cards to take home with them, among other items. Resource tables were hosted by community representatives to include access points for food, housing, federal programs, mental health services, the school system, and immigration/legal services, All representatives spoke Spanish and materials were available in Spanish. All information for the event was provided in Spanish and appointment and reminder calls were conducted in Spanish. NWH partnered with the Waltham Welcome Center to facilitate the relationship with those who attended. "
In response to the growing number of new arrivals in the communities	Created a NWH Migrant New Arrival Response Team in August 2023. Expanded distribution of the NWH Community Resource List. Continuously met and

surrounding NWH, Newton-Wellesley Hospital launched a response team to provide support and resources, stand up practices and protocols for patients, families, visitors and the community at large to ensure access to healthcare services and basic needs, serve as a partners to community organizations working in this space and collaborate on response initiatives and solutions.	partnered with community organizations such as the Department of Public Health, Office of Refugee and Immigrant Services,, Charles River Community Health Center, shelter specific sites, food pantries, and others. Developed signage in multiple languages to ensure a welcoming environment for new arrival patients. Created ""just in time"" resources so that providers had the appropriate reference materials to care for new arrival Individuals and families. These included a Trauma Informed Reference Guide and a Tool Kit for Cross-Cultural Communication. Established patient flow and access points to ensure process matched patient need. This included language access, insurance enrollment, and established access to on-going care for individuals and family units. Addressed Basic Needs with gift cards for essential items, expanding supply and resources for car seats, and provided clothing. Incorporated New Arrival response into the Emergency Preparedness protocols. In FY24, in collaboration with community partners, will be launching a job readiness pilot program to meeting need for workplace skill development and pursuit of economic security.
To support the basic, social and health related needs of vulnerable populations, particularly those newly arrived to the United States and who are currently within the Newton-Wellesley Hospital community.	In FY 23, a total of $125,000 in grant funding was provided to Family Aid - Newton (@$100,000) and Waltham Welcome Center - Waltham (@$25,000). The grants assisted these organizations to expand capacity in supporting refugees and immigrants through providing needed housing, access to resources, opportunities for success, and connection within our surrounding communities. Results and impact of the funding will be collected in FY24. "

Partners

Partner Name, Description	Partner Web Address
Waltham Partnership for Youth â€“ Welcome Center	Not Specified
Waltham Public Schools	Not Specified
Family Aid	Not Specified

Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330
Detailed Description	Provide culturally centered health care access, support resources, linkages to community partners and organizations. Foster and create trusted environment to newcomers to the community setting - adults, children and family units. Navigate the healthcare system and basic needs for those just arriving in our communities.

NWH Nutrition Security and Equity

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	N/A,
DoN Health Priorities (optional)	Social Environment,
Target Population	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Health Indicator:** 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, • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	Goal Status
Convene community partners on aspects of nutrition security and equity. Representation on community organizations focused on food access.	Sustained the NWH/Community Nutrition Security and Equity Work Group. Includes organizations providing food access (schools, senior services, public health, food pantries, health services, community farms, faith, and community organizations) in the NWH geographic area of Waltham, Wellesley, Weston, Natick, Needham, and Newton. The work group also includes NWH leadership and clinicians. Met three times per year. Topics discussed were service delivery and distribution, increase in client needs and client populations, non-food supports needs, increase of immigrant populations, availability of cultural relevant food selections, space constraints, and access to support programs. Also discussed was 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, opportunities and sharing of best practices related to nutrition security and equity. Continued representation on the Newton Food Pantry Advisory Board. On-going partnership of NWH and Healthy Waltham.
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 14 sites throughout Waltham and last year served 28,751 meals (a 30% increase since 2019) 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."
Establish community partnerships and conduct outreach efforts to expand community knowledge of nutrition education. Conduct outreach to at risk populations. Conduct education in	"Conducted community education on hypertension (162 registrants); Nutrition Tips in for Cancer Risk (100 registrants). Conducted two outreach events with the Newton Food Pantry during National Nutrition Month. Events included consultations with 4 NWH dieticians to discuss meal planning tailored to specific health needs (25 pantry clients). Blood pressure checks by a NWH nurse team (40

identified strategic health conditions related to nutrition such as diabetes, hypertension, etc.	participants). Primary Care providers lists were also shared. A series of recipe cards were developed by the NWH Nutrition and Food Service staff utilizing heart healthy, vegetarian and gluten-free items available in the food pantry. All recipe cards were translated into five languages. Grocery gift cards were also distributed. A total of Participated in the Empty Bowls program to raise awareness about food insecurity on college campus. Bring the community together and promote available resources and support to address on average of 30% college students on campus being food insecure. Held a community outreach/education event at the Waltham boys and Girls Club for middle school campers. (30 campers). Participation from NWH pediatrics, nutrition and food, and community health. Instruction and hands-on guidance were given for the students to make three nutritious recipes. Education of healthy food choices and options were provided as well. The campers were then responsible for serving and speaking to the elementary age campers (50 campers) about what they had learned. Recipe cards in multiple languages were provide to the student after the program and to bring home to their households. "

Partners

Partner Name, Description	Partner Web Address
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

Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330
Detailed 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 ethnically diverse residents, and to many of Newton-Wellesley's target populations of youth, seniors, and recent immigrants.

Preventive Health/Health Engagement

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities (optional)	N/A,
Target Population	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Health Indicator:** 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, • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	Goal Status
Conduct community flu clinics.	In FY23, NWH held four community flu clinics all within the Waltham community to include the Healthy Waltham site for food distribution. NWH administered 107 flu vaccines. Promotion of the flu clinics were communicated in Spanish and a NWH provided an on-site Spanish interpreter.
Representation and involvement on local community boards and activities.	Over 15 NWH clinicians and staff served on organized local community boards and offered their specialized perspectives on strategic initiatives. These included health departments, youth organizations, business chambers, social service, safety agencies, and non-profit agencies.
Support local initiatives that promote health and wellness.	NWH had various levels of staff participate in education and wellness programs held by community organizations. Topics ranged from mental health, wellness, stress management, youth mental health, substance use, senior wellness, and medical innovation (robotics) others.
Provide a source of health education and socialization for local seniors in the community.	Held 5 virtual senior events with focused on exercise, staying healthy, nutrition, heart health, and chronic conditions. 530 seniors attended. Also held ongoing virtual group fitness classes including tai chi, stretch and strengthen and balance classes for those over 50 years old. Over 200 participants per week. In FY23, two sessions of the Matter of Balance program were held at senior centers and had 24 participants.
Cancer Care Preventive Health: Provide health awareness and disease prevention programs.	"In FY23, NWH conducted 3 virtual education events for the community on cardiovascular heart health. Focused on hypertension and reducing risk of stroke, options for heart health wearable-apps., and small steps to better heart health curriculum. (165 attendees). Participated in community outreach events for schools, senior centers, and civic organizations. In FY 23, launched a focus on AED and CPR instruction and demonstration to at risk populations in the community. To begin, conducted one in person session at the Needham Senior Center with 40 attendees. Used the American Heart Association training

	video. and engaged a NWH RN Educator as a partner in the presentation. In FY24 the instruction and demos will be rolled-out to highs school and college students in the surrounding NWH communities. As part of the focus on instruction and awareness for youth, purchased 16 AED Trainers for Waltham High School. "
Cardiovascular Preventative Health: Provide health awareness and disease prevention programs.	In FY23, NWH conducted screenings for the community related to illness to include mammograms (34 conducted), lung cancer screening day (4 patients screened), and embarked on a colon cancer screening outreach project through American Cancer Society ECHO initiative. Educational forums were held for all members of the community on breast cancer, lung cancer (108 registrants), survivorship, and being nutritionally healthy during cancer care and reducing risks of 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 education and screening awareness at several community-wide onsite events. Interacted with over 1000 community members. Conducted cancer survivorship events focused on support, education, and well-being. Began a partnership with the American Lung Cancer Screening Initiative (ALCSI) and a local college to advocate and raise awareness for reducing barriers for lung cancer screenings. This focus on advocacy work will continue into FY 24.
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 FY23, a 6-week PAVING program focused on the needs of black women with breast cancer was held in collaboration with another healthcare institution. There were 10 women who participated. Also, this year, NWH hosted 3 concomitant PAVING the Path to Wellness groups, with approx. 45 participants. In the Spring of 2023, 2 groups were held with 30 participants each.
Cardiovascular Health: The Heart Health and Wellness 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 Heart Health and Wellness Council, comprised of 27 community and hospital members (6 new members welcome in FY23), met three times in FY23 year. The Council promotes cardiac wellness through its multi-faceted engagement with community members, employees, and patients with education and evidenced-based initiatives. 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.
Cardiovascular Health: Address the increased risk of cardiovascular disease among First Responders - Firefighters. Cardiovascular disease is responsible for 45% of on-duty deaths in the United States. Conduct the Heart Health Initiative to provide interactive education in modifiable risk areas that impact cardiovascular health. Self-identify risk factors to manage their own cardiovascular health. Incorporates a Risk Evaluation, Nutrition Assessment, and Exercise program.	The Heart Health Initiative has been rolled out in to all six of the NWH community firehouses. Program started in Waltham and now includes Weston, Needham and others. Over 200 participants. All three sessions were conducted on site. Session one Cardiovascular Risk Evaluation American Heart Association Cardiovascular Risk Assessment Blood Pressure Screening Functional Movement Screening Stress, Sleep & Relaxation discussion and techniques Session two, Nutrition Rate Your Diet Assessment Heart healthy nutrition education Recipe adaptation for heart health Cooking demonstration and tasting Session Three, Exercise Godin Leisure-Time Exercise Questionnaire Exercise program based on Functional Movement Assessment with modifications for different abilities. "
Cardiovascular Health: Walk and Talk Health actively engages the community in exercise, movement activity, and health education. It also provides a source of socialization and interaction for at risk populations such as seniors in the community.	During FY 23, all six of NWH communities took part in Walk and Talk Health (Waltham, Newton, Needham, Natick, Weston), with Waltham holding 4 sessions. The session took place in community setting locations. A total of 900 individuals participated.
Cardiovascular Health: Conduct the Small Steps for Better Health Program and offer it to a variety of at-risk populations. Curriculum is comprised of educating on food selection, how stress is handled, and the importance of exercise Content and discussion emphasize the importance of making small changes to have a large, positive effect on health.	"The Small Steps Program was held at 6 community sites - Senior centers, libraries and living communities. In FY 23 the focused population was seniors and a total of 185 individuals participated. Discussion covered highlights of a heart healthy diet, took a look at key ingredients that nourish the heart, reviewed the latest physical activity recommendations and looked at how resiliency techniques can help manage stress."
"Cardiovascular Health: Address Heart Disease in the South Asian community who are clinically at high risk. Heart	"120 visits were conducted by staff that included cardiology clinicians, exercise instructors, and dieticians, Provided interactive education at a Test Kitchen located in the community.

Disease is the number one killer of South Asians worldwide. South Asians represent 25% of the world's population and account for 60% of heart disease patients. 25% of heart attacks among South Asians occur before age 40 years and 50% occur before age 50. South Asians are 2x more likely to die of heart disease compared to non-Hispanic white counterparts. "	Create a specialized patient education program/ South Asian Heart Health cookbook in collaboration with the American Heart Association. "

Partners

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

Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330
Detailed 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.

Research

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities (optional)	N/A,
Target Population	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Health Indicator:** Chronic Disease-Cardiac Disease, Health Behaviors/Mental Health-Mental Health, Infectious Disease-COVID-19, • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	Goal Status
Conduct research studies related to Covid-19 to explore the safety, effectiveness of treatments.	This study seeks to understand if new drugs help patients in the hospital with COVID-19 get better faster. Getting better faster includes getting off oxygen and going home from the hospital. This study will enroll up to 2000 people at up to 100 sites.
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.
Conduct research study related to chronic disease management for pain.	Study seeks to find out if adding a web-based artificial intelligence (AI) application for self-management of pain to usual medical care can improve quality of life and help reduce pain symptoms for adults with chronic pain.
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.

Partners

Partner Name, Description	Partner Web Address
Not Specified	Not Specified

Contact Information	Maureen Dwyer, Director, Office of Clinical Research
Detailed 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.

Senior Wellness

Program Type	Not Specified

Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	N/A,
DoN Health Priorities (optional)	Social Environment,
Target Population	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Health Indicator:** Chronic Disease-Stroke, Injury-Other, Other-Senior Health Challenges/Care Coordination, Social Determinants of Health-Access to Health Care, • **Sex:** All, • **Age Group:** Adults, Elderly, • **Ethnic Group:** All, • **Language:** All,

Goal Description	Goal Status
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 FY23, 5 programs were held with 530 participants. Topics included nutrition, wellness, lung cancer, chronic disease, heart health, hypertension, and health care access. Many of the programs were held in collaboration with community agency partners and hospital service line clinical experts.
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 a combination of virtual and in person to provide options and maximize program participation. Tai Chi sessions are held three times per week. In FY23, The Matter of Balance Program was held in-person sessions at two of the community senior centers. Two 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 and encouraged to participate.
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 150 total participants. Participant feedback to program instructor: ""I have always admired and appreciated your dedication to keeping us healthy and fit and inspiring us to keep moving. ""
The Council's members view needs through the lens of elders themselves, healthcare providers, home caregivers, municipal professionals, and others. They are devoted to respecting the goals of community elders and valuing programs that increase independence, safety, and happiness throughout life. The areas of navigating care for elders and enhancing caregiver knowledge of the availability of and how to access resources. Understanding the care continuum and impacts of dementia are also of particular focus for this Council.	The Elder Care Council is comprised of 22 hospital and community members, welcoming 9 new members in FY23. The Elder Care Council is led by a Community Chair from one of our senior living communities. and a Hospital Champion who has expertise in the areas of inpatient and outpatient services, population health, and the care continuum. The Council meets three times per year. The needs of our elders are unique and require tailored strategies. The Council explores solutions and evaluates options through the lens of elders themselves, health care providers, home caregivers, municipal professionals, and others. Areas of concentration are social isolation among seniors, opportunities for enhanced engagement, addressing risks related to falls, delirium, and needs related to the care continuum.
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.

Partners

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

Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330
Detailed 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.

Substance Use Outreach, Treatment and Education

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	Substance Use Disorders,
DoN Health Priorities (optional)	N/A,
Target Population	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston,

	• **Health Indicator:** Substance Addiction-Substance Use, • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,
Goal Description	**Goal Status**
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 can 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 FY23, NWH provided doses of Narcan to local community partners, police and fire, public health, schools and shelters. Provided training to community partners, as necessary. Conducted Narcan training for the 25 summer youth interns. Assoc. Director of the Substance Use Clinic provided hands-on Narcan training along with the distribution.
Provide preventive substance use resources to Emergency Department patients and families.	In FY23, NWH dispensed 48 naloxone kits to patients in the Emergency Department with diagnosis of opioid overdose.
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. "
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: ""Fostering Teen Resilience Through Community Conversations: Healthy Minds, Substance Use Prevention, and Our Youth"" "" (128 attendees) and ""The Benefits of Exercise for Recovery and Mental Health"" (300 attendees). Resources and treatment options were highlighted as part of event content and follow up information was provided after each program. Events were conducted virtually and in-person. Additional education forums were provided to various organizations in the community. Numerous clinicians provided education to school programs with virtual audiences of youth, parents and educators. "
Provide education and training to clinicians, 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. A Combined Grand Rounds weas held for discussion on caring for patient with substance use disorders in the preoperative period. Substance Use Services clinic leadership presented at noon conference to NWH House staff on a regular basis, conducted a pain management training course to medical students, and were involved in the on-going Substance Use & Pain medical student longitudinal curriculum initiative. Clinicians also took part in additional lectures and fellowship programs to further educate trainees. "
Provide resources to community partners for needed substances.	Provided 400 doses of Epipens to local fire departments, schools, and colleges.
Use the hospital as a site to increase public awareness on the opioid epidemic and decrease stigma around substance use.	For the fifth 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 2023 ceremony included Marian Ryan, Middlesex County District Attorney, Meaghan Langlois from the Boston Bulldogs Recovery Running Club, and members of SOAR Natick a support group for parents with children suffering from opioid addition. The Purple Flags were on display during September and October 2023 on the front lawn of NWH. In addition to the annual remembrance event, additional awareness events and resources were shared to focus on the need for reducing stigma associated with substance use. An on-going awareness campaign was conducted throughout Recovery Month for the community, employees, and visitors. Social media was leveraged to bring attention to substance use disorders and addiction.
Provide care to substance use patients in the SUS clinic.	SUS front-line clinicians (MD's, PA, Recovery Coach and Social Worker) completed 2600 patient visits. Highest Referral Reasons were: 69% alcohol and 16% opioid. Most Frequent Referral Sources: Emergency Department (56%) and Primary Care (33%) clinicians.
Collaborate with various local multi-community, and state-wide agencies to address the opioid crisis.	In FY23, 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 (appointed into leadership role), in addition to others. The hospital continues to partner with the Middlesex District Attorney's office for the Charles River Regional Opioid Task Force. 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 health regularly participated and presented at the meetings.
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 30 community and hospital members, represent both clinical and societal perspectives. Four new members joined in FY23. 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.

Increase resources for primary care physicians to address substance use issues in patients.	In FY 23, 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 annual lectures were held: "My Patient is Taking Opioids for Chronic Pain: What Should I Do?" and "Motivational Interviewing for AUD and Referral Process for SUS." In addition, the SUS team conducted a peer-review publication and utilized the content as a teaching tool for trainees, providers, and community. The title of the article/podcast is "Caring for Our patients with Opioid Use Disorder in the Preoperative Period."
Provide support options for those experiencing substance use addiction.	Recovery Coach conducted two weekly group support sessions (virtual and in-person). In FY 23, a total of 150 group sessions were held. The sessions took place both in-person and virtually, with 35 joining per week. Group participants are between the ages of 20-75 years old. Some participants have been participating since the support programs started three years ago.

Partners

Partner Name, Description	Partner Web Address
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

Contact Information	Catharina Armstrong, MD, Associate Director, Substance Use Service; 617-243-6142
Detailed 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.

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

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	N/A,
DoN Health Priorities (optional)	Violence,
Target Population	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Health Indicator:** 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, • **Sex:** All, • **Age Group:** All, • **Ethnic Group:** All, • **Language:** All,

Goal Description	Goal Status
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 FY23, the program served over 288 distinct survivors of violence and abuse. With a continued increase in demand for direct services, but also in complexity, lethality, and acuity. In FY 2023, staff were able to successfully refer clients to appropriate external partner organizations.
Expand Domestic Violence services in the community and to Spanish-speaking, immigrant survivors of partner abuse.	In FY 2023, NWH continued its collaboration with REACH Beyond Domestic Violence to better serve the needs of Spanish speaking survivors through a $50,000 grant. In addition to graduating a cohort of 16 survivor peer leaders through the LKYR program, REACH advocates supported 297 Spanish speaking survivors by providing economic assistance with food, transportation, rental, moving, and medical assistance. Since the grant was first initiated in FY 2019, it has allowed the partnership to directly serve over 400 Latina survivors in Waltham, ensuring that dozens of families received emergency rental assistance, support with relocation, utilities, and access with other basic needs such as food.
Continue to increase safety, health and well-being of patients and employees by providing comprehensive consultation and training to clinicians,	In FY 2023, provided 216 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.

providers and community partners serving those experiencing domestic and sexual violence.	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
Continued participation in implementation of the DOJ- funded National SANE Tele-nursing Center. The hospital provides space for the Center & technical expertise and education to providers across the country.	"The National Telenursing Center (NTC) was established in 2012 with a Department of Justice (DOJ) grant. NWH partnered with MA DPH SANE Program, Boston Area Rape Crisis Center, US Navy, National Indigenous Women's Resource Center, amongst others, to begin utilizing telemedicine to export specialized forensic nursing expertise to areas of the country disproportionately impacted by sexual assault. NWH added 4 more Tele SANE positions in FY 2023. Initial pilot sites included: - Multiple military sites, including 29 Palms, CA - Indian Health Services facility in Polacca, AZ - Rural critical care access hospitals, CO & CA NTC staff are on a Technical Assistance (TA) Team with the International Association of Forensic Nurses (IAFN) providing TA to 4 demonstration sites which are launching TeleSANE services with DOJ/Office for Victims of Crime (OVC) grant funding. The 4 sites include: - Avera Health in South Dakota (also serving Nebraska and North Dakota) - University of Arkansas Medical Center - Texas A&M University - Tundra Women's Coalition in Alaska Currently, NTC staff/MA DPH SANE are supporting Rhode Island in their development of a regionally based SANE Program, based on the MA model. Initial sites include Rhode Island Hospital, Miriam Hospital, Newport Hospital and Hasbro Children's Hospital. NTC staff/MA SANE are now also offering TeleSANE services to 10 MA hospitals thanks to a DOJ/OVC Technical Assistance (TA) grant: - Martha's Vineyard Hospital, - Nantucket Cottage Hospital - North Shore Medical Center - Baystate Franklin Medical Center - Good Samaritan Medical Center - MetroWest Medical Center - Athol Hospital - Sturdy Memorial Hospital - Beverly Hospital - Saint Anne's Hospital - Indian Health Services facilitate, Polacca, AZ In FY 23, DSVA program staff stepped up to fill in the gap for the administration of the Sexual Assault Nurse Examiner (SANE) and Domestic Violence Billing Safety initiative. "
Work to build options for support and empowerment groups through alternative modalities.	"The program continues working to build options for support and empowerment groups this year. Program staff offered 12 support groups in collaboration with our community partners. Those support groups included the following: The DV/SA Program implemented 3 support groups in partnership with REACH Beyond Domestic Violence and the Latinas Know Your Rights (LKYR) Program - Fall 12-week Parenting Journey Psychoeducational and Process oriented group offered participants the opportunity to: o Learn about what intergenerational trauma is and how the cycle of violence can impact individuals and family systems. o Share and build insight on how their own experiences of trauma shaped their parenting styles. o Practice alternative parenting styles to interrupt cycles of violence. - Spring 7-week LKYR Leadership Program for Immigrant Mothers offered participants the opportunity to: o 16 survivors graduated! SUPPORT GROUP WITH THE SECOND STEP in FY23: Program staff co-created and co-facilitated a 9-week healthy relationships curriculum with The Second Step - Participants learned about patterns of abuse, in addition to the signs of healthy relationships and ways to cope and heal in the aftermath of having experienced interpersonal violence. Topics covered included: o Identifying the Signs of an Unhealthy Relationship o Sustainable Coping Strategies o Self-Esteem and Self-Acceptance o Self-Advocacy Skill-Building o Identifying the Signs of a Healthy Relationship SUPPORT GROUPS WITH THE SAHELI in FY23: Program staff co-facilitated three support groups in partnership with Saheli. - Fall 6-week skill building support group with children ages 7-12 who have witnessed Domestic Abuse in their home. o Participants engaged in social skill building and emotion regulation through engaging in group discussion, mindfulness exercises and play therapy activities. - Spring 8-week skill building group for parents and their children. o Parents and Children practiced co-regulation techniques, relationship-building and engaging in safe connections through effective communication and boundary-setting. - Spring 7-week skill building group with children ages 7-12 who have witnessed Domestic Abuse in their home. o Participants practiced, pro-social behaviors and emotion regulation through storytelling, play therapy activities, yoga, and mindfulness exercises. TRAUMA-SENSITIVE YOGA GROUPS in FY23:

	Staff facilitated two gender-inclusive 6-week Trauma-Sensitive Workshops in the Fall and the Spring. - 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. MINDFULNESS AND MEDITATION GROUPS in FY23: Staff facilitated two gender-inclusive Mindfulness and Meditation Groups. - Fall 5-week Mindfulness Support Group. - Spring 7-week Mindfulness and Meditation Support Group. o Groups offered survivors of intimate partner violence, abuse, and trauma an opportunity to learn the basics of mindfulness and incorporate meditative and reflective practices in their day-today lives within a supportive, peer setting. SELF CARE SUPPORT GROUP SESSIONS FOR PARTNERS OF MALE SURVIVORS in FY23: Program staff supported MenHealing with piloting a 7-session, Self-Care Support Group series with hopes to expand the offering by creating a peer facilitation model for future groups. - Due to the success and ongoing interest after the initial 3 sessions, the series was expanded to 7 sessions. - The process-oriented and psychoeducational support group allowed participants to: o Share the impact that their partners experience of sexual trauma has had on their mental health and their relationship dynamic. o Receive validation and gain peer and community support. o Learn about ways to take care of themselves as they continue to support their loved ones."
The Domestic and Sexual Abuse Council, within the Community Collaborative, is focused on enhancing access for survivors who face linguistic and cultural barriers and providing increased awareness and education on domestic and sexual abuse.	"The Domestic and Sexual Abuse Council, comprised of 20 members, with 7 new members joining this year. The Council meets three times per year. The Council has been instrumental in disseminating emergency resources to victims of abuse, developing support programming, fostering networks, and reacting to community and partner needs. This year, the Council has reacted to a number of DSV related incidents in the NWH immediate community. "
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.	"Program staff took part in multiple forums and offered expertise in the aeras of DSV. These included: - A panel discussion hosted by Emerson Hospital: Supporting Victims and Families Impacted by Domestic Violence in the Perinatal Hospital Setting in October. - Program staff presented at the International Institute of New England on Mental Health regarding The Impacts of Trauma in Immigrant and Refugee Communities. - Program staff presented on Understanding Healthy Relationship Dynamics within the BIPOC Community at The Women's Center at Harvard College. - Program staff presented Dynamics Women of Color Face in Relationships hosted by the Asian Student Union at Wellesley College. DV/SA Program, co-sponsored a 3-week session webinar series titled: Caring Conversations about Sexual Violence: Using NARCC's SEECK Model from Initial Response to Treatment. Promoted and participated in activities related to Domestic and Sexual Violence related Awareness Months. Including: Domestic Violence Awareness, Trans Awareness, Stalking Awareness. White Ribbon Week, Sexual Assault Awareness, Abuse in Later Life Awareness, and Reproductive Justice Awareness. At each, resource materials and outlets for support were made available during all awareness activities."
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 2 in-person CPR and First Aid trainings. - This not only allowed area non-profits to save on costs, but ensures that DV/SA survivors would not be negatively impacted by organizational staffing shortages caused by delays in CPR and First Aid recertification compliance. - 30 Advocates and staff from partnering DV/SA agencies were re-certified in FY 2023. 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 2023, with the generous support of the NWH Community Benefits and Development Team, program staff were able to secure a $2,500 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 2023, 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. Held 5 events. - Program staff continue to partner with MAWOCN, JDI, and culturally specific DV/SA agencies across the state to advocate for equitable services delivery models. - Resource materials were provided to MAWOCN. "
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 across the lifespan. - Program staff co-facilitated a Level2 Advanced Weekend of Recovery (WOR) in-person

	Retreat to support MenHealing's mission to expand its services to historically marginalized communities. - Program staff continued to support the advancement of several projects and supporting efforts to adopt culturally appropriate practices in an effort to expand outreach and programming to marginalized communities and to increase participation among men of color who are survivors of sexual assault. With a $2,500 grant from the NWH Community Benefits Program, MenHealing the ""Just healing"" MensHealing podcast Series was launched. - The podcast Illuminates the healing journeys of male survivors of sexual harm. - Over 5 episodes were aired with over 700 plays. NWH is supporting Saheli Boston (DV Organization that specializes in serving South Asian and Arab women and families) in its mission to become a dual domestic violence and sexual assault program. - With funding support from the NWH Community Benefits Program, DSV program staff co-facilitated three support groups in partnership with Saheli. - In the Fall a 6-week skill building support group with children ages 7-12 who have witnessed Domestic Abuse in their home was held. o Participants engaged in social skill building and emotion regulation through engaging in group discussion, mindfulness exercises and play therapy activities. In 2023, the NW DV/SA Program continued its second year partnership with BARCC to provide ongoing trauma-informed clinical and structural guidance to better serve survivors of sexual violence and abuse. "
To expand and advance Domestic Violence and Sexual Abuse programs across the region through partnerships, advocacy, development of system policies, networking, and collaborations. Hold roles and leadership positions in efforts that build capacity for DV/SA programs.	"The NWH DV/SA program is a member program of Jane Doe, Inc., The Massachusetts Coalition Against Sexual Assault and Domestic Violence - a convening of 57+ domestic violence and sexual assault programs from across Massachusetts. NWH Program staff is involved in JDI's Policy Advisory Committee which includes budget advocacy, legislation, statewide regulations, system policies/practices as well as other state, local, and national policy-related issues that impact survivors of domestic violence and sexual abuse. Program staff supported the Conference of Boston Teaching Hospitals (COBTH) by partnering with the Massachusetts Department of Public Health to pilot and create the infrastructure for a peer led DV/SA Advocate's Networking Collaborative specifically for advocatesproviding direct services to DV/SA survivors in healthcare settings. NWH Program staff held leadership positions in organizations to building capacity for DV/SA, i.e., Co-chair the Masscachusetts Woemen of Color Network and Co-Chair of the Domestic Violence Council within the Conference of Boston Teaching Hospitals (COBTH)."

Partners

Partner Name, Description	**Partner Web Address**
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

Contact Information	Rehana Rahman Manager, DSV Program
Detailed 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.

WorkForce Development

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	N/A,
DoN Health Priorities (optional)	Employment,
Target Population	• **Regions Served:** Natick, Needham, Newton, Waltham, Wellesley, Weston, • **Health Indicator:** Social Determinants of Health-Income and Poverty, • **Sex:** All, • **Age Group:** Teenagers, • **Ethnic Group:** All, • **Language:** All,

Goal Description	**Goal Status**
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 150 youth. Involved 25 NWH staff participating in the weekly programs. Focused on both clinical and non-clinical roles and medical innovations and technology advancements in healthcare.
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 healthcare professionals in a mentor/mentee relationship.	"In FY23. hired 22 Waltham High School students through the Waltham Partnership for Youth Summer Internship program with the goal of providing paid opportunities that cultivate professional skills and allow for the exploration of future career interests. This was the largest number of students sponsored by one organization. Placements included a wide array of clinical and non-clinical departments that included Radiology, Women's Imaging, MRI, Gastroenterology, Surgical Practice, Environmental Services, Transport, Volunteer Services, Public Safety, Patient Experience, Joint Center, Cardiology, Primary Care, Sterile Supply, and Ambulatory Services. In addition, over the 6 weeks, the students attended weekly hospital career focused sessions with panelists from all different areas of the hospital. A total of 25 NWH staff participated in the career exploration/medical innovation sessions.

	Several students were also able to shadow and speak with staff in areas of their interest. Of the NWH intern cohort, 58% were of Hispanic or Latino backgrounds. 14 distinct ethnicities were represented. Transportation was provided to students to reduce barriers for participating in the program. For goals achieved, the students felt they learned to manage their time better. get along with others, managed projects, adapted to change, worked hard, communicated more effectively, among others. A Peer Leader Intern was hired into a new role developed by NWH. The inaugural position was held by an alumni intern. This intern took on a leadership role to be a resource and liaison for the whole program, conducted intern sessions, and consistent communication. The Peer Leader also attended hospital wide meetings and completed a project. At the completion of the internship students shared ""Word of Wisdom"" that will be shared with the next cohort of interns during the summer of 2024. Some words stated were: ""Give 100% effort""; ""Don't hold back on asking for advice.""; ""Ask questions""; ""Know that even the smallest actions mean something""; and ""Be open to learning as much as possible."" The 22 NWH intern placements is 20% of the entire WPY intern program of 106 students. "
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. In reaction to the need to expose students to the field of mental health as well as the need to grow the workforce in this area, NWH expanded sponsorship to also include the Career Exploration and Traning Mental Health & Healthcare Professionals of Tomorrow Coordinator."
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. In FY23, there were 3 student vocational program partnerships with 12 participating students who contributed 635 hours of service. n FY23, 3 adult vocational program partnerships with 5 individuals took part and contributed 308 hours of volunteer service. All placements offered opportunities for the development of work place skills, interaction with a healthcare team, exposure to and growth in understanding the healthcare environment, work expectations and overall job responsibilites. "
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.	"As part of the Healthcare Career Exploration Series program conducted a virtual skills based program title: ""Zooming to Success: Leveraging Virtual Technology for Career Growth and Development."" A panel of four professionals spoke to the 240 attendees which was comprised of high school and college students, adult learners, career-changers, and NWH employees. The format was a keynote speaker with a panel who provided personal insights. An extensive question and answer session was conducted with significant engagement from those attending. Very positive feedback as to program content and offering of helpful and practical tips and tools. "
Provide community outreach to student populations to expose individuals to healthcare careers	"Provided placements for five of Newton interns at NWH. The students were placed in multiple aras of the hosptial to incldue transport, patient ambassador, and outpatient clnics. The students also attended weekly career exploration sessions held throughout the summer. Sesssion presenters were a variety of hospital staff in all levels of healthcare. Provided a summer paid internship placement in Child and Adolescent Psych for the purpose of exposure in the field of mental health. Student focused on the development of resources, and content for further educating youth about the field. Participated in 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. "
The Work Force Development Council, within the Newton-Wellesley Community Collaborative, focuses on expanding potential career options, through training, education and career development. Providing opportunities for both youth and adults to enhance family financial security and, importantly, provides a ready pool of talent for local businesses. A strong local economy can positively and more broadly impact health and wellness.	The Work Force Development Council, comprised of 25 community and hospital members. with 2 new members joining this year. The Council meets three times per year and focuses on key initiatives that include Waltham summer youth intern program, student and community exposure to healthcare careers across all levels, and opportunities for building career-based networks. A focus in FY23 has been to focus on high vacancy areas within healthcare and opportunities for training and education into those fields. The Council continues to promote health care options that require a two-year degree or less, certification programs and direct entry options. The goal is for the hospital to serve as a career hub, through collaborations and partnerships that can provide opportunities for youth to enhance family financial security. Council meetings include a speaker related to current trends and new programs offered in the community. WFD Community Chair and Hosptial Champion work actively with the Community Collaborative Leadership to promote the mission.
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.
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 serve on the Waltham High School Health Assisting Program Advisory Committee Meeting and the Waltham High School - School to Career Work Team. NWH provided the academic course materials for the Health Assisting Program to include the Home Health Certification materials to ensure resources for professional licensure. Provided additional supplies, resources, and additional connections to the hospital setting. Began the development of a structured clinical and co-op placement in nursing for Health

	Assisting students. Assignments will be on the nurisng units. Program will launch in Janaury 2024."
Develop an innovative surgical technologist training program in collaboration with higher education partners that incudes flexible classroom curriculum, on-site clinical training, and direct school-to-employment track.	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 initiative an extension of Lasell's Health Sciences degree program combines classroom and lab-based learning with hands-on clinical experience at NWH that includes rotations in the main Operating Rooms, GI unit, Sterile Processing, Outpatient Surgery Center, Cardiovascular Center, and Labor and Delivery. It is also designed to support career advancement for a diverse student population, providing flexible scheduling, support for tuition and fees, and a clear path to a Bachelor of Science degree. Students enrolled in the Surgical Technology Program complete laboratory-based coursework in the Lasell University state of the art Science and Technology Center and complete 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 prepare for the certification exam offered by the National Board of Surgical Technology and Surgical Assisting. In FY23, the first cohort had 6 students who graduated and who are now all NWH employed surgical technologists. 3 have passed the certification exam, 2 are enrolled in nursing programs, 1 is employed at the Outpatient Surgical Center.. In the second cohort, 8 more students graduated - 4 advancing professionally from within NWH and 4 Community registered students. A third cohort are in the interviewing phase and will be employed in the areas of Gastroenterology, Labor and Delivery, Outpatient Surgical Center and the Operating Room. Three more cohorts are in process with 8 students in each. The program passed the accreditation survey and review with flying colors and no findings."
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 opportunities to become employed in high vacancy areas such as lab tech, pharmacy tech, medical assistant, patient care assistant, and surgical tech. Provided information in multiple languages to access populations of all backgrounds. Attended multiple events held in the community, such as the Career Pathways Event with the Newton Dept of Health and Human Services, and a Healthcare Career Day in partnership wth the Boys and Girls Club. Collaborated with community partners to promote healthcare placements of at all levels and for both adults and youth. "
Develop an innovative Central Sterile Processing Program in collaboration with community partners that incudes flexible classroom curriculum, on-site clinical training, and direct school-to-employment track.	In FY 23, NWH launched a Central Sterile Processing (CSP) Training program to address the vast opportunities existing in the field. A partnership was formed with Jewish Vocational Services to identify individuals to patriciate and attend the training. The initial cohort is 4 students who are in the phase of completing their 400 hours of clinical externship at NWH. The students are rotating through 4 different areas within the NWH CSP department. Upon completion students have the opportunity for a employment into a long-term placement. Plans are in place to start additional cohorts during FY24.

Partners

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

Contact Information	Lauren Lele, Senior Director, Community Health and Volunteer Services; 617-243-6330
Detailed 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.

Wrap Around Waltham

Program Type	Not Specified
Statewide Priority	Not Specified
EOHHS Focus Issue(s) (optional)	N/A,
DoN Health Priorities (optional)	Social Environment,
Target Population	• **Regions Served:** Waltham, • **Health Indicator:** Health Behaviors/Mental Health-Mental Health, Social Determinants of Health-Education/Learning, Social Determinants of Health-Income and Poverty, • **Sex:** All, • **Age Group:** Teenagers, • **Ethnic Group:** Hispanic/Latino, • **Language:** Spanish,

Goal Description	Goal Status
Address disparities in high school persistence, grade advancement, and graduation rates among Waltham newcomer students by providing	2023 marks the fourth and final year of a four-year grant to Waltham Partnership for Youth (WPY) to implement Wraparound Waltham. Designed as a multiagency 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

individualized supports that address both the academic and non-academic needs of students and their families.	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 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 2023, 309 Latinx newcomer high school students participated in Wraparound Waltham across the four years of the grant. The number of Wraparound high school students participating annually increased dramatically during the third and fourth years 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, Wraparound's new referral and engagement strategy, the Welcome Class, and the expansion to McDevitt Middle School were key factors for the significant increase in the number of students served during the third and final years of this grant. In the first two years of the program, 39 students were enrolled. In contrast, 270 students were enrolled in the last two years of the program."
Facilitate access to school and community information, resources, and services."	In addition to academic supports and Wraparound services, 55% of Wraparound high school students and 100% of Wraparound middle school students received non-academic / basic needs supports or referrals during SY2022-2023. 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. In September 2022, WPY hired a full-time Welcome Center Coordinator, effectively doubling Welcome Center hours. Operating four days each week (Monday through Thursday) from 3:30 - 6:30 p.m., the Welcome Center increased access to working families who could only attend during the evening. In addition, the Welcome Center Coordinator increased access to Welcome Center resources for high school students by offering one-on-one meetings at the WPY office, co-located at WHS. 135 newcomer students, representing 98 families, received referrals and support services through the Welcome Center during SY2022-2023. The 98 families served represented at least 191 individuals (including student parents/caregivers and siblings), who benefited from Welcome Center services."
Increase high school persistence, grade advancement, and graduation among newcomer students.	"Academic outcomes were tracked for 228 WHS students who were active in SY2022-2023. The remining 4 Wraparound high school students moved out of the district prior to the end of the academic year. Of the 228 Wraparound high school students, 92% progressed academically. Specifically: -181 persisted and advanced to the next grade (79%) -20 graduated (8.8%) -10 persisted but are repeating their grade (4.4%) The 17 students who did not progress academically are comprised of 15 students who chose to not attend school and withdrew from school and 2 students who were unenrolled due to lack of attendance."
Support emerging bilingual newcomer students and their families from Latin America.	During the 2022-2023 School Year (SY2022-2023), 232 Newcomer Waltham High School (WHS) students and 27 Newcome McDevitt Middle School (McDevitt) participated in Wraparound programming. Of these, 53% were first-time participants, enrolled through the Welcome Class. The remaining 47% were participants from previous school years who continued to access services. Of the total 232 WHS participants: -100% were newcomers -99% Latinx or Latin American - 99% were native Spanish speakers -32% were 9th graders -39% 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 school, and raise student and family awareness of school and community resources and supports. Throughout SY2022-2023, Wraparound held 4 WHS Welcome Class cohorts. Each of the cohort starting in October, December, February, and April and ran for 8 weeks. In total, 110 newcomer high school students participated in the Welcome Class during SY2022-2023. Of these: - 84% were 9th or 10th graders (60% were 9th graders) - 85% identified Guatemala as their country of origin In addition, 27 McDevitt Middle School students participated in one of three Welcome Class cohorts. Of these, - 48% were 7th graders - 87% identified Guatemala as their country of origin
Provide academic and non-academic	" Funding for Wraparound Waltham supports the salary of a WHS Academic Case Manager

supports to newcomer students fostering school and community belonging, emotional safety, and well-being.	(ACM) to work with newcomer students. In addition to co-teaching the Welcome Class, the ACM conducts one-n 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, 99% of Wraparound high school students met individually with the ACM at least once. The average number of meetings was 3 but varied significantly across students, with the number of meetings ranging from 1 to 10. In addition to academic supports, high school and middle school students received services from Wraparound partner organizations. Specifically: - 15 middle school students participated in Doc Wayne programming during SY2022-2023. - 18 high school students participated in ChildrenÃ¢â‚¬â„¢s Charter programming during SY2022-2023. 13 students participated in group sessions, 4 students participated in individual sessions, and 1 student participated in both. - 79 Wraparound students and their families received direct services from The Right to Immigration Institute (TRII), including immigration representation and advice. 62 were new Wraparound students/families and 17 were continuing to receive services from previous years."

Partners

Partner Name, Description	**Partner Web Address**
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

Contact Information	Olivia Mathews, Ex. Director, Waltham Partnership for Youth, Liz Homan, Assistant Superintendent, Waltham Public Schools, Lauren Lele, Sr. Director
Detailed 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.

Expenditures

Community Benefits Programs

Expenditures	Amount
Direct Expenses	Not Specified
Associated Expenses	Not Specified
Determination of Need Expenditures	Not Specified
Employee Volunteerism	Not Specified
Other Leveraged Resources	$3,246,357.12

Net Charity Care

Expenditures	Amount
HSN Assessment	$7,055,802.98
HSN Denied Claims	$74,945.29
Free/Discount Care	$494,947.06
Total Net Charity Care	$7,625,695.33

Corporate Sponsorships	Not Specified
Total Expenditures	$16,799,570.12
Total Revenue for 2023	$0.00
Total Patient Care-related expenses for 2023	Not Specified
Approved Program Budget for 2024 (*Excluding expenditures that cannot be projected at the time of the report.)	Not Specified
Comments:	Not Specified

Optional Information

Community Service Programs

Expenditures	Amount
Direct Expenses	Not Specified
Associated Expenses	Not Specified
Determination of Need Expenditures	Not Specified
Employee Volunteerism	Not Specified
Other Leveraged Resources	Not Specified
Total Community Service Programs	Not Specified
Link to Hospital Formatted PDF Community Benefits Report:	Not Specified

Bad Debt:	Not Specified	Not Specified
Optional Supplement:	Not Specified	

Current Status: Published

Data as of: 7/3/2024 10:59:29 AM