September 30, 2022

Newton-Wellesley Hospital

2022 Community Health Needs Assessment

Submitted to: Mass General Brigham Newton-Wellesley Hospital

Health Resources in Action
Advancing Public Health and Medical Research

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EXECUTIVE SUMMARY

Introduction and Background

Newton-Wellesley Hospital (NWH) is a full-service, comprehensive medical center and community-based hospital providing direct, high-quality inpatient and outpatient care in the Greater Boston community. Named one of America's 50 Best Hospitals by Healthgrades for three consecutive years, and with a 140-year history of serving our community, NWH places the patient and their family at the center of everything it does. NWH excels at prevention and wellness along with acute care and disease treatment. The hospital provides a wide range of services, including medical, surgical, including robotic and bariatric, primary care, obstetric and gynecological, cardiovascular, emergency, orthopedic, neonatal, pediatric, hematology/oncology, and psychiatric care—with a medical staff of more than 1,200 physicians. NWH is a member of the Mass General Brigham healthcare system—a nonprofit organization that includes academic medical centers Massachusetts General Hospital and Brigham and Women's Hospital. NWH is also a major teaching hospital for Tufts University School of Medicine and has established post-graduate training programs for residents of Massachusetts General Hospital and Brigham and Women's Hospital.

Amidst the ongoing COVID-19 pandemic and related immediate economic and healthcare needs of the community, in the spring of 2021, NWH decided to align their Community Health Needs Assessment (CHNA) and Strategic Implementation Planning (SIP) cycle with that of their parent health system, Mass General Brigham. By completing a brief update to their 2018 CHNA and developing an accompanying one-year plan, NWH could both align their CHNA-SIP cycle with that of the Mass General Brigham system, and also postpone longer-term planning efforts to when the acute phase of the COVID-19 pandemic would hopefully be over.

The current 2022 report includes the findings from the full CHNA process conducted in the summer of 2022, which aligns NWH with other facilities in the Mass General Brigham system. The CHNA used a participatory, collaborative approach and examined health in its broadest context, to examine the factors at multiple levels that shape a community's health. Communities included in this assessment comprise the NWH service area: Natick, Needham, Newton, Waltham, Wellesley, and Weston Massachusetts. To provide additional perspectives from the service area communities to guide the 2022 CHNA-SIP process, 11 community leaders and advocates were engaged to work alongside the established 22 members of the NWH Community Benefits Committee (CBC) to provide strategic oversight of the CHNA-SIP process. The CBC+ guided several parts of the assessment including the design of CHNA methodology, recommendation of secondary data sources, and participation of community voices during the data assessment process.

The assessment process included synthesizing existing data on social, economic, and health indicators from various sources, as well as incorporating feedback from Community Benefits Committee members regarding health and social challenges in their area and recommendations for how to address these concerns.

This CHNA aims to gain a greater understanding of the issues that residents within the Newton-Wellesley Hospital service area face, how those issues are currently being addressed, and where there are gaps and opportunities to address these issues in the future. This CHNA report provides the results from a mixed methods study aimed at identifying the most pressing social, economic, and health issues in the service area. The specific goals of this CHNA are to:

- Systematically identify the health-related needs, strengths, and resources of the service area to inform future planning,
- Understand the current health status of residents within the service area, as well as sub-populations within their social context, and
- Engage the community to help determine community needs and social determinant of health needs.

Methods

To identify the health needs of the service area, challenges to addressing these needs, current strengths and assets, and opportunities for action, the assessment process included: synthesizing existing data on social, economic, and health indicators in the NWH service area; facilitating eight focus groups with a total of 62 residents from specific populations of interest (e.g. older adults, youth, persons of color, immigrants, residents with mental health or substance use needs, and food pantry clients); and conducting key informant interviews with ten community stakeholders representing agencies serving low-income populations, immigrant residents, residents with disabilities, older adults, and young adults, among others. This assessment process also incorporated suggestions and feedback from CBC+ members regarding health and social challenges in their area and recommendations for how to address these concerns.

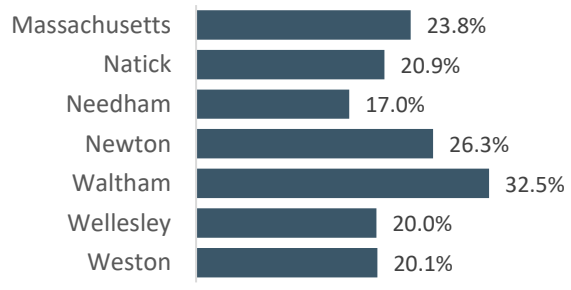
Findings

The following provides a brief overview of key findings that emerged from this assessment.

<u>Population Characteristics</u>

- The NWH service area comprises the cities and towns of Natick, Needham, Newton, Waltham, Wellesley, and Weston; spanning Middlesex and Norfolk Counties in Massachusetts. The area is generally affluent and well-educated, though variation exists.
- **Race/Ethnicity:** In 2016-2020, Waltham had the highest percent of Black (7.0%) and Hispanic/Latino (14.3%) residents, while Newton had the highest proportion of Asian residents (15.1%).
- **Language:** In 2016-2020, 26.3% of Newton residents over age 5, and 32.5% of Waltham residents spoke a language other than English at home. All

Percent of Population Age 5 and Over Who Spoke Language Other than English at Home, 2016-2020



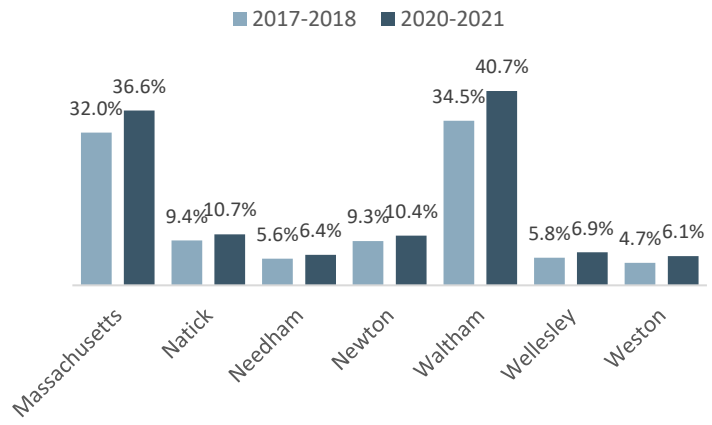
DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020

cities/towns in the service area had over 15% of residents speaking a language other than English at home.[1]

Community Social and Economic Environment

- **Housing:** Housing affordability was consistently noted as a top concern among interview and focus group participants. Concerns were expressed for the ability of seniors to age in place in their communities due to a lack of affordable housing. A household is considered to *be housing cost burdened* if >30% of monthly income is dedicated to housing costs. In the NWH service area, the percent of renters who were housing cost burdened in 2016-2020 ranged from 33.9% in Wellesley to 43.7% in Needham.[2]
- **Economic Hardship:** The percentage of economically disadvantaged students increased from 34.5% in 2017-2018 to 40.7% in the 2020-2021 school year in Waltham, which exceeded that for the state (32.0% to 36.6%). Among the other communities in NWH's primary service area, the percentage ranged from 6.1% in Weston to 10.7% in Natick during the same period. These increases likely reflect the economic reverberations of the COVID-19 pandemic.[3]

Percent of Public School District Students who are Economically Disadvantaged by State and City/Town, 2017-2018 and 2020-2021



DATA SOURCE: School and District Profiles, Massachusetts Department of Elementary and Secondary Education, 2017-2018, 2020-2021

- **Income Inequality:** In the Boston-Cambridge-Newton metro area, the top 1% of income earners make 32.2 times more than the bottom 99%, ranking the area 29th in income inequality out of 916 U.S. metro areas assessed. In 2015, the average annual income of the top 1% of earners was $2.3 million, compared to $71,000 for the bottom 99%.[4]
- **Transportation:** Interview participants noted the multiple health effects of transportation: "*the impact of our car-based system on air quality, the lack of safe alternative transportation contributing to cardiovascular disease (ex. no protected/safe walking or bicycling routes), impact on people's health of having a car culture just sitting in traffic and the lack of exercise, people can't live or afford to live where they work and that affects quality of life (ex. Less family time, sleep, etc).*" Lack of transportation options were also noted as a special concern among seniors in this area.

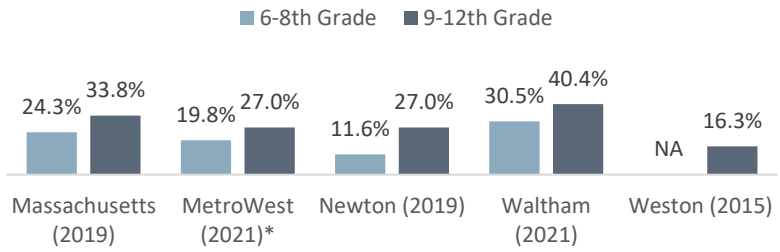
[1] US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020

[2] US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020
[3] School and District Profiles, Massachusetts Department of Elementary and Secondary Education, 2017-2018, 2020-2021
[4] Economic Policy Institute: The New Gilded Age: Income Inequality in the U.S. by State, Metropolitan Area, and County; July 2018.

Community Health Issues

- **Overweight/Obesity:** In 2019, approximately a quarter of 6 – 8th graders (25.1%) and 9 – 12th graders (29.0%) in Massachusetts were identified as being overweight or obese. In 2019, the prevalence of overweight or obese 6 – 8th and 9 – 12th graders in Waltham (41.3% and 34.8%, respectively) was higher compared to the same age groups in Newton (19.0% and 22.0%, respectively).[5]
- **Cancer Screenings:** In 2018, the proportion of female residents 50 to 74 years of age that reported receiving a mammogram in the past two years was lower in all four NWH service towns with data available (Needham: 81.8%, Newton: 80.9%, Waltham: 79.0%, and Wellesley: 81.6%) than breast cancer screening across Massachusetts (86.7%).[6] In 2018, fewer than three-quarters of residents 50-75 years of age from regions served by NWH reported receipt of colon cancer screening within the time frames recommended by the US Preventive Services Task Force. In contrast, more than three-quarters (81.1%) of Massachusetts residents reported colon cancer screening within the recommended schedule in 2020.
- **Mental Health:** Mental health was a topic that came up across all of the focus groups and interviews and was repeatedly identified by participants as a priority area for community improvement efforts. Participants discussed the broad impact of a lack of providers for and affordable mental health services, and stigma and silence around mental health in general. Focus group participants highlighted youth and young adults and seniors as key populations that are particularly impacted by mental health-related challenges.
- **Depression and Suicidality:** In 2015 - 2021, the percent of high school students reporting symptoms of depression was higher in Waltham (40.4%) compared to Newton (27.0%), Weston (16.3%), and the MetroWest region (27.0%) and Massachusetts (33.8%) overall. More than one-fourth of middle school students (26.0%) in Waltham reported suicide ideation in 2021, an increase from the previous CHNA (12.7%). This percentage was also considerably higher compared to Newton (8.2%), the MetroWest region (16.7%), and Massachusetts overall (11.3%).[7]

Percent of Students (Grades 6-8 & 9-12) with Symptoms of Depression by State and City/Town, 2015-2021



DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Health Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015

- **Substance Use:** Both quantitative and qualitative data suggest that substance use is a challenge for the communities in the NWH service area. In 2018, about one in five adults in Needham,

[5] Health and Use Risk Factors of Massachusetts Youth Survey, 2019; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021

[6] Massachusetts Department of Public Health, Office of Data Management and Outcomes Assessment, 2018

[7] Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Health Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015

Newton, Waltham and Wellesley reported excessive or binge drinking. Focus group participants identified stigma as a major barrier to accessing treatment and recovery services. One said, "Stigma is alive and well. Stigma continues to be the number one block in solving this issue."

Access to Services

- Access to services and a lack of healthcare providers was identified as a major issue by key informants and focus group participants in the service area.
- **Health Insurance:** In 2016-2020, approximately 5.5% of Black residents in Middlesex County did not have health insurance, compared to approximately 4.3% of Black residents in the state overall. During this period, a higher proportion of Black residents in Natick (4.3%), lacked health insurance relative to other towns within the service area. In Waltham, a higher percent of Hispanic/Latino (11.5%) residents lacked health insurance than any other racial group in the city. In Waltham, 4.5% of Asian residents lacked health insurance, a proportion that exceeded the state average (2.9%).[8]
- **Psychiatric Inpatient Capacity**: One focus group participant recounted: "Right now because of COVID, I have friends who are going through it very hard. I had a friend waiting 7 days in emergency room, waiting for bed in a facility… when she did a get a bed, it was in a bad place – so far away from family and friends and it was really sad… during COVID, so many psychiatrists and psychologists vacated their jobs or they retired. We need new people. And so its really sad."

> *"These days it takes months to get into a primary care appointment. I don't know if there's enough doctors. It's so difficult to schedule something. By the time you get in, whatever was ailing you is probably gone then. You just have to go to urgent care."*
>
> - Focus Group Participant

Community Vision for the Future

- When residents were asked to identify the top priorities for action in their community, transportation accessibility, affordable housing, mental health and substance use, access to care and services, chronic disease management and prevention, elder or senior care, and community investment and empowerment were the most frequently discussed. Among those discussions, addressing systemic racism was a cross-cutting and overarching focus discussed across these domains.

Suggestions for Future Programs, Services, and Initiatives

- **Transportation:** Transportation was identified as a priority concern in the NWH service area. The lack of accessible transportation options was cited as a barrier to accessing food and healthcare, particularly for seniors. Specifically, 62.8% of seniors in Weston, 45.6% of seniors in Wellesley, and 39.9% of seniors in Natick reported poor supermarket access, which is much higher than the state average of 29.3% of seniors. [9] Focus group participants suggested improvements to both the public transportation system and the active transportation or built environment. For example, in terms of improvements to the public transportation system, participants suggested creating protected bus stops, adding interconnected dynamic bus routes, ensuring reliability, and increasing accessibility for specific populations such as senior populations or folks living with

[8] US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020
[9] Massachusetts Healthy Aging Collaborative. 2018. "Community Profiles." https://mahealthyagingcollaborative.org/data-report/explore-the-profiles/community-profiles/

a disability. Additionally, suggestions for improvements to the active transportation system and built environment include safer walking paths, protected bike lanes, and functional green space.

- **Housing:** Accessibility and affordability of housing was among the most commonly discussed issues in focus groups and interviews. Participants noted limited affordable housing options for low to middle income individuals. They discussed how the definition of affordability often relies on the town's median income, which does not necessarily reflect their own economic circumstances. Therefore, they are shut out of "affordable" housing. Participants also mentioned that despite increasing development, these new developments are not geared towards low to middle income households but are built as luxury units. Suggestions were made to increase the development and availability of affordable housing units for specific populations such as seniors and low-income residents. Participants also suggested improvements to the subsidized housing program as the application and approval process can take up to ten years.

> *"When we're talking about affordable housing, it's tied to the median income of that town. If that's 200,000, it knocks a lot of people out of the category of affordability."*
>
> *"It's hard to afford housing here unless you're making six figures. It feels like they're trying to push the lower-income people out of Newton."*
> - Community Key Informants

- **Mental Health and Substance Use:** Availability of mental health and substance use services was identified by participants as a considerable pressing need. Participants across different domains suggested improvements to the mental health and substance use system to ensure that services were more affordable, culturally sensitive, and readily available. Improved availability of services was particularly important to youth as they noted seeing many issues in younger populations struggling with mental health and substance use. Participants also noted mental health issues among older populations and suggested volunteer programs for companionship care for seniors struggling with isolation. In addition to improvements to service delivery, a number of participants noted the need for more outreach and education related to mental health and substance use to reduce the stigma associated with those issues.

> *"The school and city didn't do much to teach kids how to handle stressful situations and what to do when they feel overwhelmed, depressed, anxious. We need to inform them of the various resources that are available (ex. Boys & Girls Club, YMCA). Instead, these kids rely on vaping, alcohol, and smoking weed."*
> - Community Key Informant

- **Access to Care:** Access to healthcare was another important priority for many of the participants. Participants discussed the difficulties of getting appointments in a timely manner for any health issues that came up. Many of them were only able to schedule months in advance and had to resort to urgent care or the emergency room. They also noted that the health system and health insurance can be complex and difficult to navigate, especially for immigrant populations who are unfamiliar with the system. For improvements to access to health care, participants highlighted the need to increase the availability of appointments, both in terms of offering more appointments generally and offering more appointments outside of normal

business hours (e.g. 9:00am – 5:00pm). Some participants also suggested either developing community-based health clinics or mobile health clinics to meet the community where they are.

- **Chronic Disease Management and Prevention:** Participants specifically noted the importance of chronic disease management and prevention. They mentioned the need for more proactive preventive screening efforts and improved built environments that were conducive to healthy living. For example, a participant discussed being at high risk of cancer to her provider and the provider was extremely proactive in ordering her the necessary screening and tests to monitor her health. The participants agreed that that level of care and concern is what they are looking for from the health system. They suggested that the root of the issue was that the health system prioritized profits over people, which lead to unsatisfactory care. They expressed the need for more one-on-one time with providers in order to build a trusted relationship where they know their provider has their best interests in mind. In addition to the health system, participants suggested improvements to the built environment to encourage healthier choices. Suggested improvements include safe and protected green spaces, walking trails, and sidewalks.

Key Themes and Conclusions

The NWH service area comprises cities and towns that are generally affluent, well-educated, and healthy. However, this general perception and overall well-being may mask difficulties faced by more marginalized members of these communities, especially in a time of such health and economic instability. The accompanying 2022 Newton-Wellesley Hospital Strategic Implementation Plan (SIP) will further detail the prioritization process for these priorities and the planning underway in the system to address these community needs.

System-Wide Priorities: Statement from Mass General Brigham

Mass General Brigham Community Health leads the Mass General Brigham system-wide commitment to improve the health and well-being of residents in the Mass General Brigham priority communities most impacted by health inequities. In addition to the priorities each hospital identifies that are unique to its communities, Mass General Brigham identified two system-level priorities: cardiometabolic disease and substance use disorder. These priorities emerged from a review of hospital-level data and prevalent trends in population health statistics that show Black and Hispanic individuals are disproportionately affected by disparities in health outcomes and excess deaths related to these conditions. Our efforts within these two areas will aim to reduce racial and ethnic disparities in outcomes, with the goal of improving life expectancy.

Community Priorities for Action

Prioritization allows organizations to target and align resources, leverage efforts, and focus on achievable strategies and goals for addressing priority needs. Through a systematic, engaged approach that is informed by data, priorities are identified through an iterative process to focus planning efforts. The prioritization process was multifaceted and aimed to be inclusive, participatory, and data-driven. It consisted of four steps:

Step 1: Input from Community Members and Stakeholders via Primary Data Collection
Step 2: Review of Previous Priorities and Current Related Initiatives
Step 3: Incorporation of System-Wide Priorities
Step 4: Priority Refinement and Input from Community Benefits Committee+

As a result of this process, the following priorities were selected:

- **Housing Affordability**
- **Mental Health & Substance Use**

- **Access to Quality Care, with a focus on:**
    - Chronic disease prevention and management
    - Integration of services and healthcare
- **Transportation**

It was recommended that all priorities be addressed with the following cross-cutting strategies:

- Health and Racial Equity
- Workforce Development
- Sustained Community Engagement and Empowerment

Finally, all priorities should specifically consider the special needs of the communities' most vulnerable populations:

- Older adults
- Youth
- Immigrants
- People of Color

The table shows the evolution of NWH CHNA-SIP priorities over time.

Newton-Wellesley Hospital CHNA-SIP Priorities: 2015, 2018, 2021, and 2022

<table>
<tr><th>2015</th><th>2018</th><th>2021</th><th>2022</th></tr>
<tr><td>Access to Care/ Transportation</td><td>Access to Care</td><td></td><td>Access to Quality Care (including chronic disease management & prevention)</td></tr>
<tr><td>Substance Abuse</td><td>Substance Abuse</td><td>Substance Abuse</td><td rowspan="2">Mental Health & Substance Use</td></tr>
<tr><td>Mental Health</td><td>Mental Health</td><td>Mental Health</td></tr>
<tr><td></td><td rowspan="2">Social Determinants of Health</td><td rowspan="2">Social Determinants of Health</td><td>Housing Affordability</td></tr>
<tr><td></td><td>Transportation</td></tr>
<tr><td></td><td>Chronic Disease Management & Prevention</td><td>Chronic Disease Management & Prevention</td><td></td></tr>
<tr><td></td><td>Other Community Needs</td><td></td><td></td></tr>
<tr><td>Elder Care</td><td></td><td></td><td></td></tr>
<tr><td>Emphasis on Waltham</td><td></td><td></td><td></td></tr>
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NEWTON-WELLESLEY HOSPITAL

2022 COMMUNITY HEALTH NEEDS ASSESSMENT

INTRODUCTION AND BACKGROUND

Overview of Newton-Wellesley Hospital

Newton-Wellesley Hospital (NWH) is a full-service, comprehensive medical center and community-based hospital providing direct, high-quality inpatient and outpatient care in the Greater Boston community. Named one of America's 50 Best Hospitals by Healthgrades for three consecutive years, and with a 140-year history of serving our community, NWH places the patient and their family at the center of everything it does. NWH excels at prevention and wellness along with acute care and disease treatment. The hospital provides a wide range of services, including medical, surgical, including robotic and bariatric, primary care, obstetric and gynecological, cardiovascular, emergency, orthopedic, neonatal, pediatric, hematology/oncology, and psychiatric care—with a medical staff of more than 1,200 physicians. NWH is a member of the Mass General Brigham healthcare system—a nonprofit organization that includes academic medical centers Massachusetts General Hospital and Brigham and Women's Hospital. NWH is also a major teaching hospital for Tufts University School of Medicine and has established post-graduate training programs for residents of Massachusetts General Hospital and Brigham and Women's Hospital.

Summary of Previous 2018 and 2021 Community Health Needs Assessments

In 2018, NWH completed a community health needs assessment (CHNA) of its primary service area (Natick, Needham, Newton, Waltham, Wellesley, and Weston) using a participatory, collaborative approach that examined health in its broadest context. The purpose of this CHNA was to provide an empirical foundation for future health planning of communities served by NWH. The 2018 CHNA also fulfilled the community health needs assessment mandate for non-profit institutions as put forth by the MA Attorney General and the IRS. The assessments process included synthesizing existing data on social, economic, and health indicators, as well as conducting six focus groups and eight interviews with a range of diverse individuals to identify the perceived health needs of the community, challenges to addressing these needs, current strengths and assets, and opportunities for action. The 2018 assessment identified the following areas of needs: **housing, transportation, mental health, substance use, access to care, and cancer.** Previously collected information on these health issues, as well as community assets and resources, can be found in the 2018 assessment report available on NWH's website: https://www.nwh.org/media/file/chna.pdf.

Amidst the ongoing COVID-19 pandemic and related immediate economic and healthcare needs of the community, in the spring of 2021, NWH decided to align their CHNA and planning cycle with that of their parent health system, Mass General Brigham. By completing a brief update to their 2018 CHNA and

developing an accompanying one-year plan, NWH could both align their CHNA-SIP cycle with that of the Mass General Brigham system, and also postpone longer-term planning efforts to when the acute phase of the COVID-19 pandemic would hopefully be over. The 2021 assessment process therefore involved synthesizing available data on social, economic, and health indicators. Focus groups and key informant interviews were not conducted. The 2021 assessment identified the following areas of needs, confirmed with the participation of the NWH Community Benefits Committee: **mental health, substance use, social determinants of health, and chronic disease prevention and management.** Information on these health issues can be found in the 2021 assessment report available on NWH's website: https://www.nwh.org/media/file/NWH%202021%20CHNA%20Report%20Final.pdf.

The new three-year cycle starts in 2022 with the development of this full, detailed CHNA and three-year Strategic Implementation Plan (SIP).

Summary of Previous Community Health Implementation Plans FY18-20 and FY21-22

Following its 2018 CHNA process, NWH developed a plan to address the following priority areas: mental health, substance use, access to care, social determinants of health, chronic disease management and prevention, and other identified community health needs. The 2019 plan is available on NWH's website: https://www.nwh.org/media/file/CHIP.pdf. Since the 2018 CHNA, NWH has developed and provided a variety of services and programming to address the identified key needs (see Appendix A).

NWH included six priority areas in its 2018 implementation plan to address the needs of its service area and the table in Appendix A reviews the impact of that work. It is organized by priority area and includes a description of activities, services, and programs. The impact of these activities in FY 2018, 2019, and 2020 is demonstrated by numbers of individuals served, services provided, and goals achieved.

Following the abridged 2021 CHNA process to update the 2018 CHNA, NWH developed a one-year plan to address the identified priority areas: mental health, substance, use, social determinants of health, and chronic disease prevention and management. The 2021-2022 plan is available on NWH's website: https://www.nwh.org/media/file/NWH%202021%20CHIP%20Final.pdf**.** Since the 2021 CHNA, NWH has continued to provide a variety of services and programming to address the identified issues (see Appendix B).

PROCESS AND METHODS

The following section describes how data for the 2022 CHNA were collected and analyzed. This section also provides an overview of the health framework that guided this assessment process. This CHNA conceptualizes health in the broadest sense and recognizes that factors at multiple levels shape the community's health. These include, for example, lifestyle behaviors (e.g., physical activity and smoking), clinical care (e.g., access to medical services and insurance), social and economic factors (e.g., employment opportunities, education, etc), and the physical environment (e.g., access to healthy food and safe neighborhoods).

Definition of the Community Served

The 2022 NWH CHNA focused on the six cities and towns that comprise the Hospital's primary service area. These communities are Natick, Needham, Newton, Waltham, Wellesley, and Weston (**Figure 1**).

Natick, Newton, and Waltham are part of Middlesex County; Needham and Wellesley are part of Norfolk County. While the CHNA process aimed to examine health concerns across the entire service area, there was a particular focus on identifying the needs of the most underserved population groups of the area, as well as further exploration of the key priorities identified by the previous CHNA.

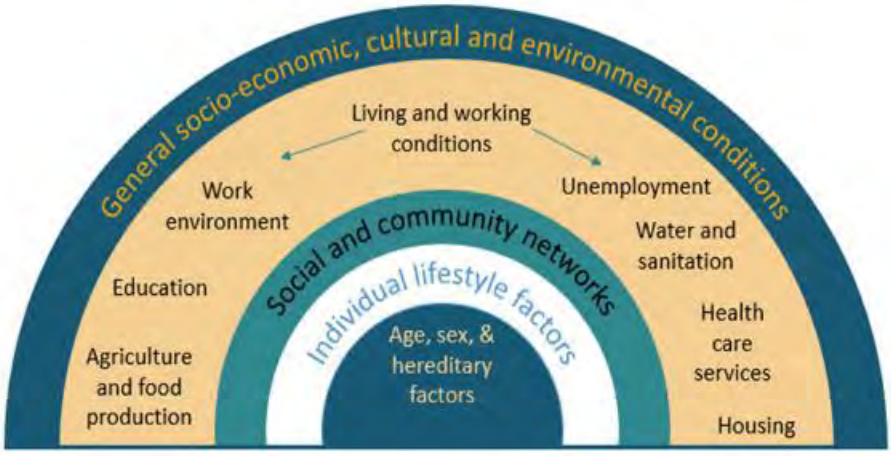
Figure 1: Map of Cities and Towns Located in the Newton-Wellesley Hospital Service Area

Approach and Community Engagement Process

Social Determinants of Health Framework

Figure 2 provides a visual depiction of the multiple factors that shape health. Individual lifestyle factors, located closest to health outcomes, are influenced by upstream social and economic factors such as housing, educational opportunities, and occupational factors. The beginning of the CHNA describes many of these social and economic factors, and reviews key health outcomes among residents of the Newton-Wellesley Hospital service area.

Figure 2. Social Determinants of Health Framework



DATA SOURCE: World Health Organization, Commission on the Social Determinants of Health, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health, 2005.

Community Benefits Committee Engagement

The CHNA used a participatory, collaborative approach and examined health in its broadest context. This was only possible due to the relationship-building with community partners that NWH has been dedicated to for years. In 2017, NWH started the Newton-Wellesley Collaborative for Healthy Families and Communities (now called the NWH Community Collaborative) to bring services and resources directly to communities in need in the NWH service area, and to lift up voices of community leaders to improve access to quality healthcare.

Following the 2018 CHNA-CHIP process, the NWH Community Collaborative, under the Community Benefits Leadership guidance, formed eight councils over the duration of the next few years around the focus areas identified by the 2018 CHNA. Each council has approximately 20 members and includes NWH health care providers, community partners, and volunteer community members; and have leadership from a Community Chair and Hospital Champion. The eight councils are:

- Cardiovascular Council
- Domestic and Sexual Abuse Council
- Elder Care Council
- Maternity Services Council
- Palliative Care Council
- The Resilience Council
- Substance Use Services Council
- Workforce Development Council

Each council meets three times per year to address community needs and implement community health priorities, informed by previous 2018 and 2021 CHIP strategies and 2018 and 2021 CHNA data. In particular, the health of Waltham residents was a priority area in the 2018 CHIP, so partnerships between community-based organizations in Waltham and NWH have been building since then. A silver-lining of the COVID-19 pandemic has been a strengthening of these partnerships, due to the urgent need for collaboration between communities and healthcare and service providers during this historic time.

For the 2022 CHNA-SIP, additional perspectives from the service area communities were sought to guide the process. Eleven community leaders and advocates were engaged to work alongside the established 22 members of the NWH Community Benefits Committee (CBC) to provide strategic oversight of the CHNA-SIP process. Together, the Community Benefits Committee Plus (CBC+) comprises community stakeholders from the hospital service area and NWH staff and administrators involved in strategic planning and community benefits efforts. A list of members can be found in Appendix C and D. The CBC+ guided several parts of the assessment including help designing the CHNA methodology, recommending sources of secondary data, serving as trusted community organizers for recruiting participants for focus groups and interviews, and voicing the needs and strengths of their communities during the prioritization process.

Quantitative Data

A comprehensive review of existing secondary data sources from national, state, and local sources was conducted. Data sources included but are not limited to the U.S. Census Bureau, American Community Surveys, County Health Rankings, the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS), the Massachusetts Department of Public Health, MetroWest Health Foundation, the Massachusetts Department of Elementary and Secondary Education, and the Federal Bureau of Investigation (see Appendix E. The types of data collected included demographics, vital statistics, public health surveillance data, as well as some self-reported health behaviors from large, population-based surveys conducted at the state level. The selection of secondary data points was generally based on the 2021 CHNA to allow for examination of trends over time. Some data from the Massachusetts Department of Public Health have not been updated from the previous CHNA due to limited availability of updated data. To visualize and compare key findings throughout the report, the municipal level data was compared to regional and state estimates when possible.

Qualitative Data

Between August and September 2022, interviews were conducted with ten community leaders and stakeholders, and eight focus groups (with a total of 62 residents) were conducted with residents of the service area in English, Mandarin, and Spanish. Interview and focus group guides can be found in Appendix F and G. These discussions were used to gather feedback on people's priority health concerns, community challenges to addressing these concerns, current strengths of the area, and opportunities for the future. Participants for the focus groups and key informant interviews were recruited by community partners and members of the CBC+, with the goal of engaging a diverse cross-section of residents, service providers, and community leaders. Health Resources in Action (HRiA), a nonprofit public health organization, provided facilitation and management of focus groups and key informant interviews.

The focus groups spanned varied age groups, geographies, and roles in the community. Groups represented a range of populations including older adults, youth, persons of color, immigrants, residents with mental health or substance use needs, and food pantry clients, among others. Key informant interviewees represented agencies serving low-income populations, immigrant residents, residents with disabilities, older adults, and young adults, among others. A list of the focus groups and interviews conducted, as well as the community organization that helped to organize the focus groups can be found in Appendix H.

Focus group and key informant interview notes were coded and analyzed thematically to identify the key themes that emerged across the different discussions. Frequency and intensity of discussions on a specific topic were key indicators for identifying main themes. Topics that were repeated throughout

multiple focus groups were also considered key themes. Selected quotes, without personal identifying information, were included in the report to further illustrate points within topic areas.

Limitations

As with all research efforts, there are limitations related to the assessment methods that should be acknowledged. First, for quantitative data sources, in several instances data for a given indicator could not be provided at the city/town level due to the small population size in the geographic region. Similarly, there were limited data available stratified by subgroups (e.g., race/ethnicity, age, etc.) for the communities in the NWH service area. In many cases data were only available at the county or state level.

For secondary data, we are limited to the use of racial/ethnic categories defined by survey administrators, usually Asian, Black, Hispanic, White, and Other. We acknowledge the limitations of categorizing people according to these heterogeneous racial/ethnic categories, as well as of using racial identity as a proxy for experiences of racism and discrimination. However, we believe it is vitally important to measure health and economic inequities by race and ethnicity, in order to address injustice and systemic racism.

While examining data across multiple time points provides important information about health patterns over time, there were some indicators for which data may not have been available for the same geographic unit (e.g., city vs. town; longitudinal data were not available for all towns) across multiple time points. There were also changes to the collection or reporting of a few indicators following the 2021 CHNA. Accordingly, direct comparisons across time points should be interpreted conservatively or with caution. For example, some data regarding patterns for middle school students were focused on different grade levels over time or across assessment communities (e.g., Grades 6-8 vs. Grades 7-8). Also, for students, data were not always available for the same year. Footnotes indicate any differences in the population or time period of focus across assessment communities.

Data based on self-report should be interpreted with caution. In some instances, respondents may over- or under-report behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked. In addition, respondents may be prone to recall bias—that is, they may attempt to answer accurately but remember incorrectly. In some surveys, reporting and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys analyzed in this CHNA benefit from large sample sizes and repeated administrations, enabling comparison over time.

Data collection for this CHNA was conducted in the summer of 2022, while the COVID-19 pandemic persisted in these communities along with its numerous effects on the economy and people's lives. The impact on people's ability to afford and access basic needs have changed lives and put people at greater risk for poor health. Data on the impact of the pandemic are limited for the communities in the NWH service area. Some of the secondary data collected for this report does not reflect the impact of the pandemic as it was collected before 2020.

Additionally, while efforts were made to engage a diverse cross-section of individuals, results are not representative of a larger population due to non-random recruiting techniques. Residents that provided feedback were individuals already involved in community programming. Because of this, it is possible that the responses received only provide one perspective of the issues discussed which limit the generalizability to the overall population. Lastly, it is important to note that data were collected during

singular moments in time, so findings, while directional and descriptive, should not be interpreted as definitive.

FINDINGS

Population Characteristics

Population Demographics

As shown in **Table 1**, cities/towns in the NWH service area range widely in size, from 88,322 residents in Newton to 12,103 residents in Weston in 2020. Data show that all the cities/towns in the NWH service area experienced total population growth between 2000 and 2020. During this time period, the town of Natick (12.0%) experienced a higher percent change in population than the state's overall population increase (8.3%), and that for Middlesex (9.6%) and Norfolk (8.2%) Counties.

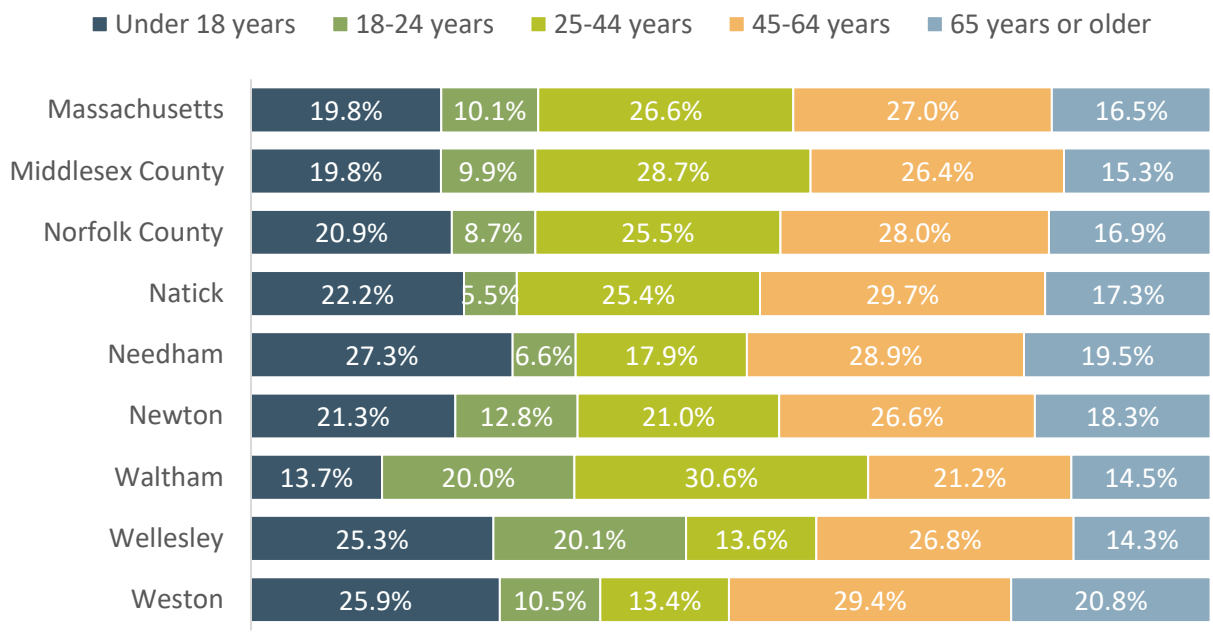
Table 1. Total Population by State, County, and City/Town, 2000 and 2016-2020

Geography	2000	2020	% Change
Massachusetts	6,349,097	6,873,003	+8.3%
Middlesex County	1,465,396	1,605,899	+9.6%
Norfolk County	650,308	703,740	+8.2%
Natick	32,170	36,044	+12.0%
Needham	28,911	31,177	+7.8%
Newton	83,829	88,322	+5.4%
Waltham	59,226	62,597	+5.7%
Wellesley	26,613	28,747	+8.0%
Weston	11,469	12,103	+5.5%

DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020

Similar to the 2021 CHNA, in 2016-2020, with the exception of Waltham (13.7%), all of the towns in the NWH service area had a higher percentage of children under 18 years of age compared to the state (19.8%) (**Figure 3**). The proportion of residents 18-24 years of age in Waltham (20.0%) and Wellesley (20.1%) was nearly double that for Massachusetts (10.1%). The towns of Weston (20.8%), Needham (19.5%), Newton (18.3%) and Natick (17.3%) had a larger proportion of residents aged 65 or over compared to the state (16.2%). These patterns generally reflect the age distribution across cities/towns in the NWH service area reported in the 2021 CHNA (data not shown).

Figure 3. Age Distribution by State, County, and City/Town, 2016-2020



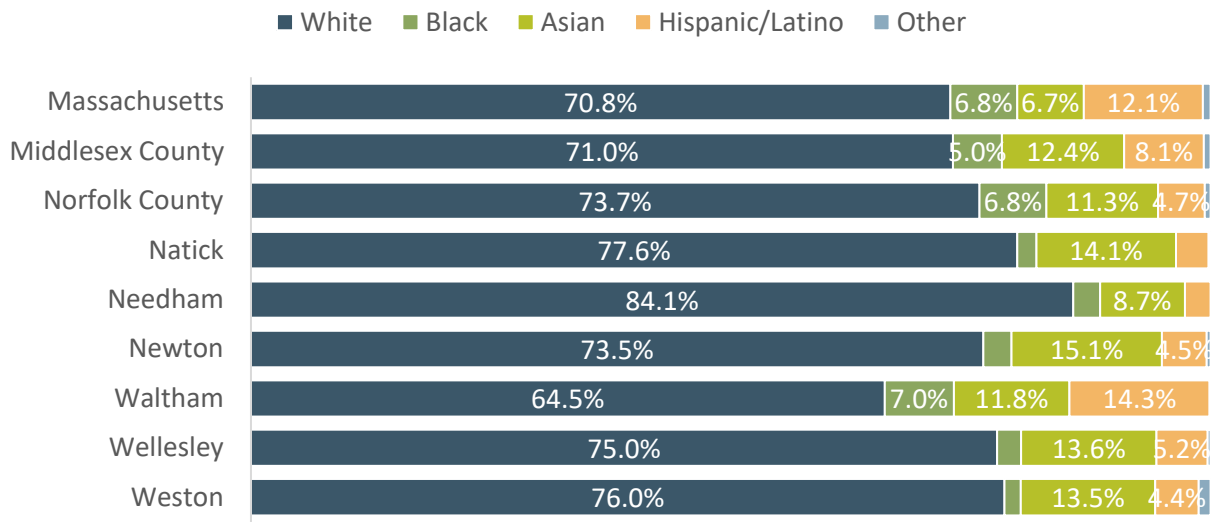
DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020

When discussing age in focus groups and interviews, participants highlighted senior and youth populations as experiencing unique circumstances related to their age that interact with other social determinants of health to produce barriers to health equity. Participants expressed concern around the realities of ageism in their communities: limited employment opportunities for seniors which was described as heightening the economic, housing, and food insecurity of low-income seniors, and a lack of respect for youth voices and opinions.

Racial, Ethnic, and Language Diversity

As shown in **Figure 4**, Waltham had the highest percent of Black (7.0%) and Hispanic/Latino (14.3%) residents in the NWH service area, relatively similar to the proportion of Black (6.8%) and somewhat greater to the proportion of Hispanic/Latino (12.1%) residents for Massachusetts overall in 2016-2020. The towns of Needham (84.1%), Natick (77.6%), Weston (76.0%), Wellesley (75.0%), and Newton (73.5%) had a higher proportion of White residents than the average for the state (70.8%) in 2016-2020. Newton had the highest proportion of Asian (15.1%) residents in 2016-2020, while Weston had the highest percentage of residents who identified their race/ethnicity as “Other” (1.2%).

Figure 4. Racial/Ethnic Composition by State, County, and City/Town, 2016-2020



NOTE: Values <4.5% not presented.
DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020

Throughout the focus group discussions and key informant interviews, varying perspectives led to contradicting perceptions of racial and ethnic diversity within their communities. Some participants acknowledged the diversity of their communities as a strength, describing their community as a "melting pot" that presents "a chance to meet people from almost all communities." In contrast, other participants highlighted a lack of racial and ethnic diversity within their communities. One participant said, "Unfortunately the Black community here is shrinking," another participant explained that their Black child left Newton in college because of its lack of diversity and stated, "there was nothing for me in Boston."

When discussing the challenges faced in their communities, racism – both systemic and individually mediated – was highlighted by focus group participants. Several participants described the greater community as exhibiting a disingenuous commitment to racial equity in which anti-racist statements made by community entities did not align with their actions. One participant described their account of systemic racism as disparities in the availability of food in grocery stores in White neighborhoods compared to Black neighborhoods during the pandemic.

In the community needs assessment of Newton residents, the impacts of challenges related to COVID such as meeting physical or mental health needs, lack of internet access, and finding work to make up income losses was more prominently reported by Black/African American and Hispanic/Latino respondents.[10]

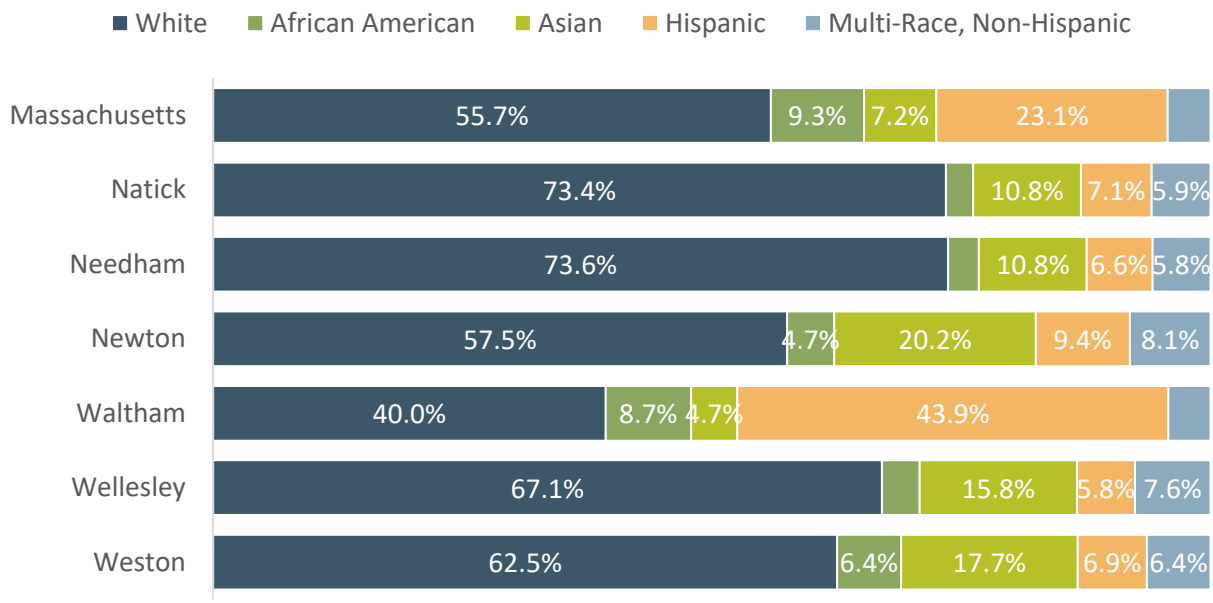
In 2021-2022, 60.0% of Waltham School District students identified as members of racial/ethnic minority groups, reflecting greater racial/ethnic diversity than public school districts across Massachusetts (44.3%) (**Figure 5**). The Waltham School District had approximately double the proportion of Hispanic (43.9%) students enrolled than the state (23.1%), and a similar proportion of Black students (8.7%) as

[10] Center for Governmental Research. 2022. "Newton Community Needs Assessment." https://www.newtonma.gov/government/health-human-services/social-services/community-needs-assessment

Massachusetts (9.3%). Except for Waltham (4.7%), the cities/towns in the NWH service area had a higher proportion of Asian students than the state (7.2%), with Newton (20.2%) and Weston (17.7%) having the highest percent of Asian students. Compared to the state overall (4.3%), apart from Waltham (4.3%), cities/towns across the NWH service area had a higher proportion of students who identified as multi-racial.

Racism was repeatedly discussed in the focus groups as impacting youth of color. Several participants described a communal expression of fear towards young men of color; one stated, "my son who was 13 at the time, had someone who was afraid of him because he is Black," another stated, "they [young men of color] are watched…when they [White community members] see young boys come they try to give them a hard time." Participants also shed light on the ways racism presents itself in the school system: one student described their peers' behavior and stated, "people are very vocal, and they are not afraid to say a racist slur" while other students expressed frustration with disproportionate mistreatment and targeting of students of color by school staff.

Figure 5. Racial Composition of Public School District Student Enrollment by State and City/Town, 2020-2021

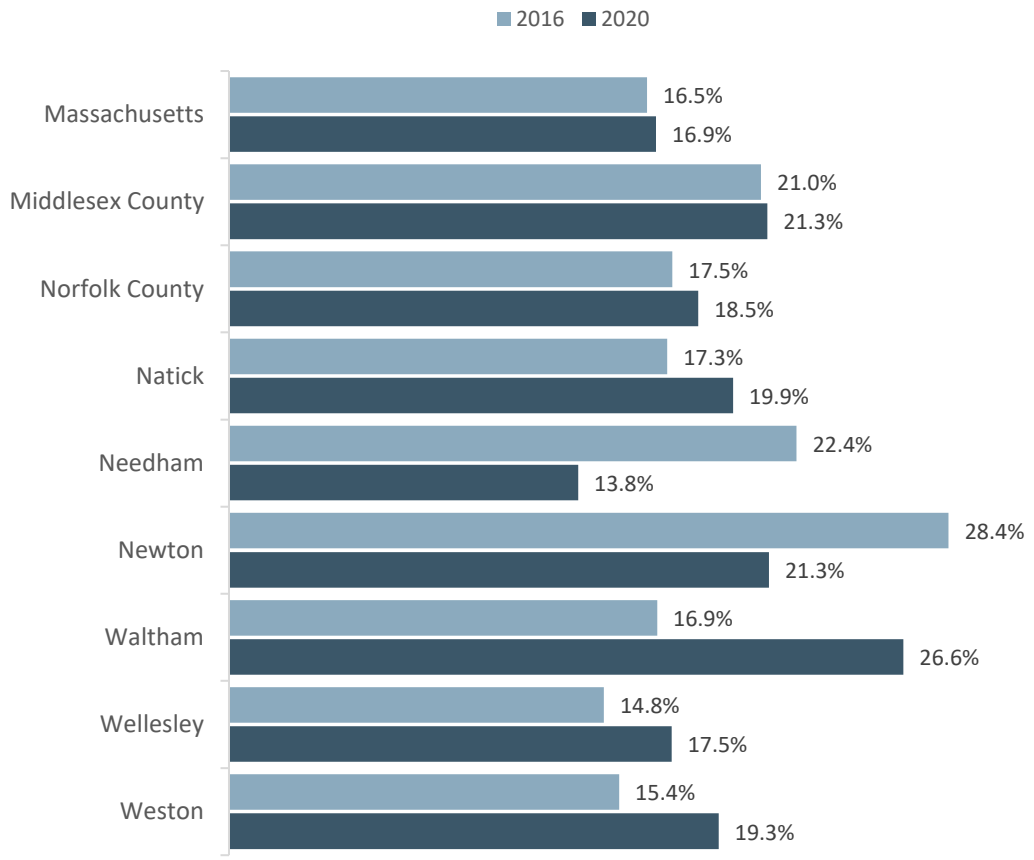


NOTE: Values <4.5% not presented. Students of Native American or Native Hawaiian/ Pacific Islander descent not presented, <4.5%
DATA SOURCE: School and District Profiles, Massachusetts Department of Elementary and Secondary Education, 2020-2021

As illustrated in **Figure 6**, from 2012-2016 to 2016-2020, most of the CHNA focus communities experienced an increase in the proportion of residents born outside of the United States. The exceptions to this growth were Needham and Newton. In 2016-2020, all the towns in the NWH service area, except for Needham (13.8%), had a higher percent of residents born outside of the U.S. than in the state overall (16.9%), while in 2012-2016 Wellesley (14.8%) and Weston (15.4%) had a lower percent of immigrant residents than the state (16.5%).

Similar to the discussions around race/ethnicity, focus group participants also discussed diversity as it relates to the foreign-born population. These conversations centered around the cultivation of community-based care networks; organizations founded for and by folks involved in various diasporas are working at the grassroots level to assess and meet the needs of their communities through providing peer-led educational, legal, social, and health related programming. Interviewees and focus group participants highlighted a disconnect from foreign-born populations that emerges within the service sector, one interviewee said, "It's hard to reach out to those communities [foreign-born/immigrant], partly because I am not a part of that culture. I don't know the best way to reach out to them." A key concept that emerged from these discussions is the need for intentional engagement with these communities to better understand how to best support them and bolster the work they are already doing to support one another.

Figure 6. Percent of the Population Age 5 and Over Born Outside of the US by State, County, and City/Town, 2012-2016 and 2016-2020



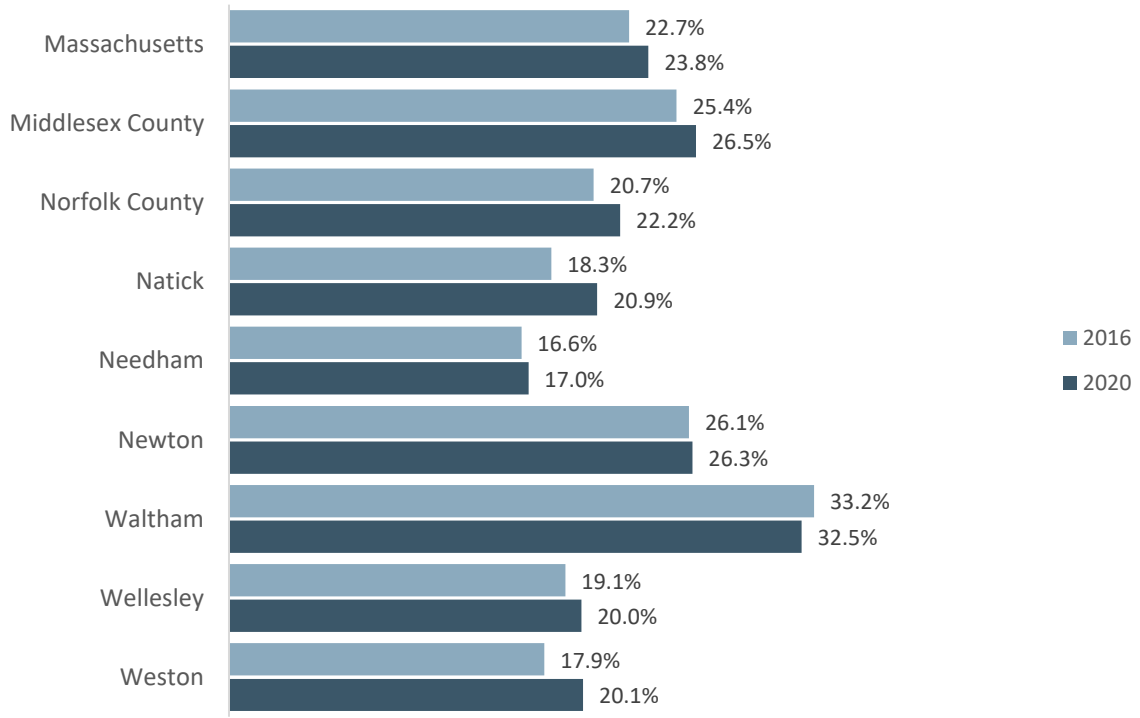
DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2012-2016, 2016-2020

In 2016-2020, over one-quarter (26.3%) of Newton residents over age 5, and almost one-third (32.5%) of Waltham residents spoke a language other than English at home, exceeding that for the state (23.8%). (**Figure 7**). All cities/towns in the service area had over 15% of residents speaking a language other than English at home. From 2012-2016 to 2016-2020, with the exception of Waltham, cities/towns across the

NWH service area experienced a slight increase in the percent of residents who spoke a language other than English at home, similar to patterns across Massachusetts and for Middlesex and Norfolk Counties.

According to the Newton Food Pantry Need's Assessment, linguistic barriers were identified as a major factor affecting immigrants and non-English speaking residents seeking social services in Newton. For agencies without linguistic or translation services, many immigrant clients were reluctant or unable to receive services there.[11] Focus group participants echoed this finding. Additionally, participants expressed a desire to learn English, however they highlighted several barriers that make it difficult to successfully engage with English learning programs offered in their communities. One participant stated, "It can be hard to learn the language; we need learning resources, there are some, but it is hard for us to get there." Another participant added to this sentiment when they explained, "The schools offer learning courses for English, but we are working multiple jobs. Especially on the weekends, we are busy working."

Figure 7. Percent of Population Age 5 and Over Who Were Non-English Speaking by State, County, and City/Town, 2012-2016 and 2016-2020



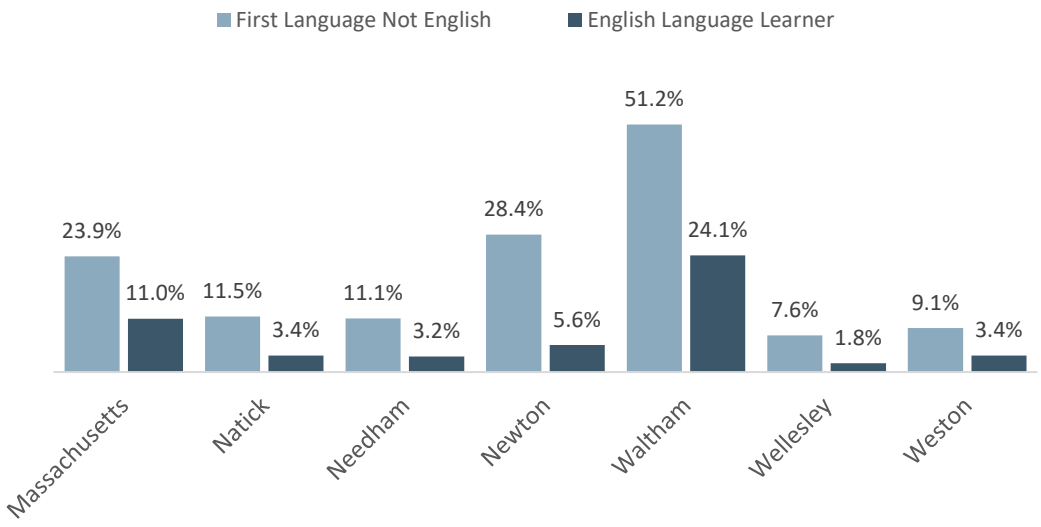
DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2012-2016, 2016-2020

During the 2021-2022 academic year, the Waltham public school district had more than double the percent of students whose first language was not English or who were considered English language learners (51.2% and 24.1%, respectively) compared to the state (23.9% and 11.0%) (**Figure 8**). English

[11] Newton Food Pantry. 2020. "Newton Food Pantry 2020 Needs Assessment Report."

was not the first language for slightly more than one-quarter (28.4%) of Newton public school district students.

Figure 8. Percent of Public School District Students whose First Language is Not English and who are English Language Learners by State and City/Town, 2021-2022



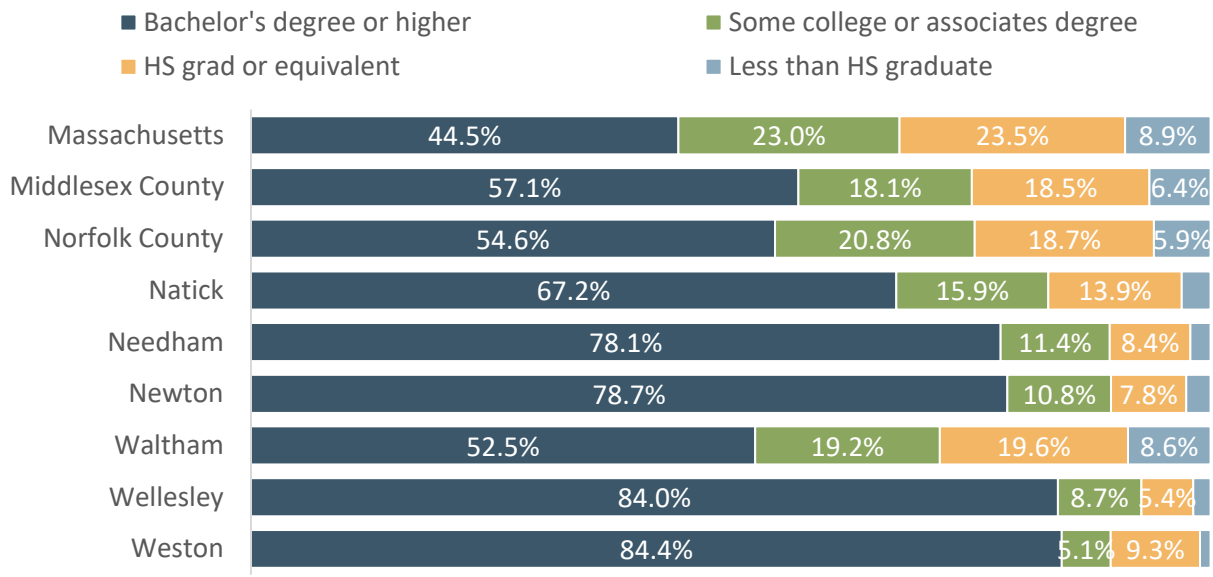
DATA SOURCE: School and District Profiles, Massachusetts Department of Elementary and Secondary Education, 2021-2022

Community Social and Economic Environment

Education

The six cities/towns in the NWH service area have high levels of education (**Figure 9**). Discussions surrounding education in the community focus groups suggest that these high levels of educational attainment are coupled with an overall positive perception of the public-school systems in the NWH service area. Participants described the school system as "one of the better school systems in the United States" and "very good." Compared to the state, higher proportions of adults aged 25 and older have earned a bachelor's degree or higher in all six assessment communities. Weston (84.4%) and Wellesley (84.0%) had the highest percentage of residents who have earned a bachelor's degree or higher. Waltham (8.6%) had the highest percent of residents who had less than a high school diploma.

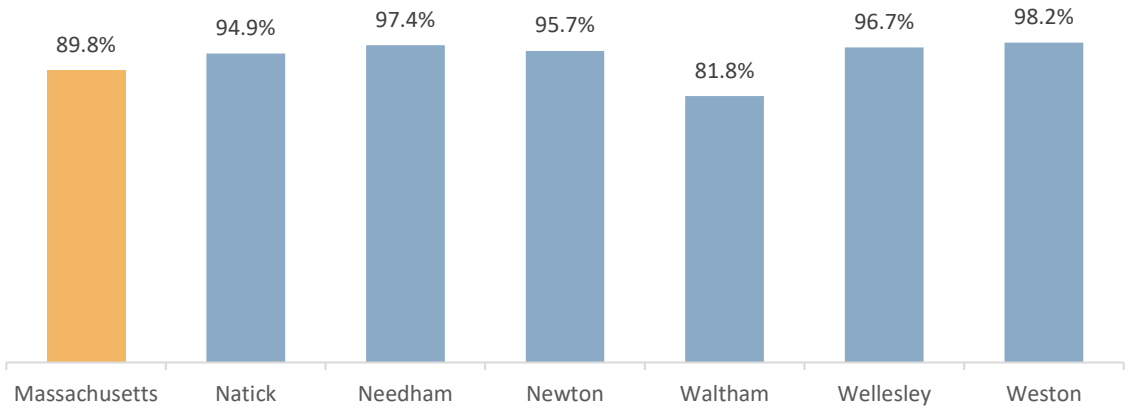
Figure 9. Educational Attainment of Adults Aged 25 years and older by State, County, and City/Town, 2016-2020



NOTE: Values <5% not presented.
DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020

In 2021, Waltham (81.8%) had the lowest percent of students who graduated from high school within four years, below the state average (89.8%) (**Figure 10**). Among the other five towns in the NWH service area, at least 95% of public high school students graduated within four years.

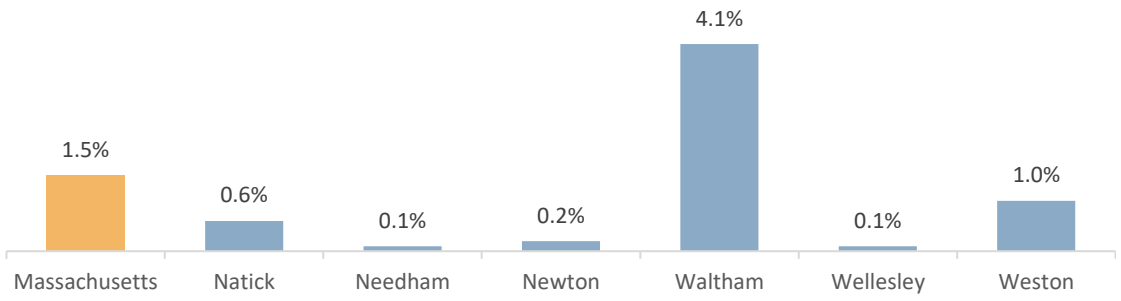
Figure 10. Percent of Public School District High School Students Who Graduate in Four Years by State and City/Town, 2021



DATA SOURCE: School and District Profiles, Massachusetts Department of Elementary and Secondary Education, 2021

As shown in **Figure 11**, the proportion of Waltham public school district students who dropped out of high school (4.1%) was more than double that of the state (1.5%) in 2021.

Figure 11. Percent of Public School District High School Students Who Dropped Out by State and City/Town, 2020-2021



DATA SOURCE: School and District Profiles, Massachusetts Department of Elementary and Secondary Education, 2020-2021

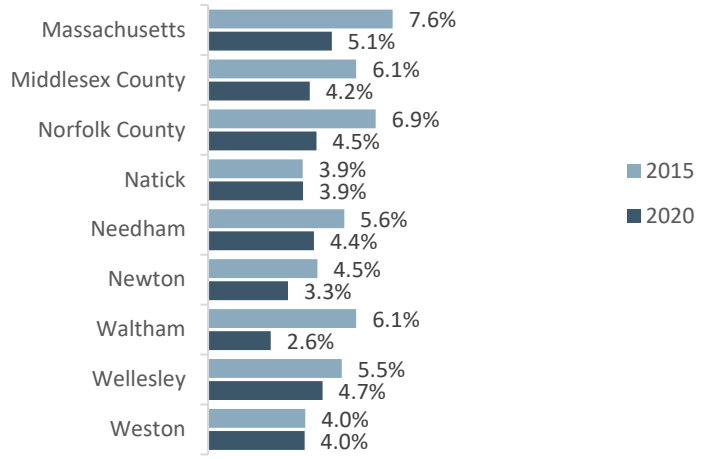
Employment and Workforce

As illustrated in **Figure 12**, from 2011-2015 to 2016-2020 trends suggest all cities/towns in the NWH service area except Natick and Weston experienced a decrease in unemployment. While there was no change in the percentage of unemployed residents in Natick and Weston (3.9% to 3.9% and 4.0% to 4.0% respectively), Waltham (6.1% to 2.6%) exhibited a reduction similar to that of Massachusetts (7.6% to 5.1%), Middlesex County (6.1% to 4.2%), and Norfolk County (6.9% to 4.5%). Note that these data do not fully capture the changes in employment status caused by the COVID-19 pandemic.

The pandemic was recognized by focus group participants as having had an impact on employment availability; one participant said, "even here in Newton, with the pandemic, there were people that couldn't work." Focus group participants and interviewees described how challenges with employment and economic opportunities uniquely impact specific populations throughout the NWH service area. For example, participants discussed the impact of unemployment on individuals living with disabilities. One interviewee stated, "it's very difficult to get a job if you have a disability." Respondents of the Newton community needs assessment discussed several challenges related to jobs and employment including: many jobs requiring credentials that they do not have or are difficult to get due to time and financial constraints as well as difficulty with finding well-paying jobs with health and dental benefits.[12]

[12] Center for Governmental Research. 2022. "Newton Community Needs Assessment." https://www.newtonma.gov/government/health-human-services/social-services/community-needs-assessment

Figure 12. Unemployment by State, County, and City/Town, 2011-2015 and 2016-2020



DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2011-2015, 2016-2020

Shown in **Figure 13** is the percentage of residents who are unemployed in each age group across each of the NWH service area communities. In 2016-2020, Needham had the highest unemployment rates relative to other cities/towns in the service area for residents 16-19 years old (18.8%) and 60-64 years old; Natick had the highest rate among 20-24 year-olds (16.0%) and residents 75 and older; Weston had the highest rate among 30-34 year-olds and 45-54 year-olds; and Wellesley had the highest rate among 35-44 year-olds and 65-74 year-olds.

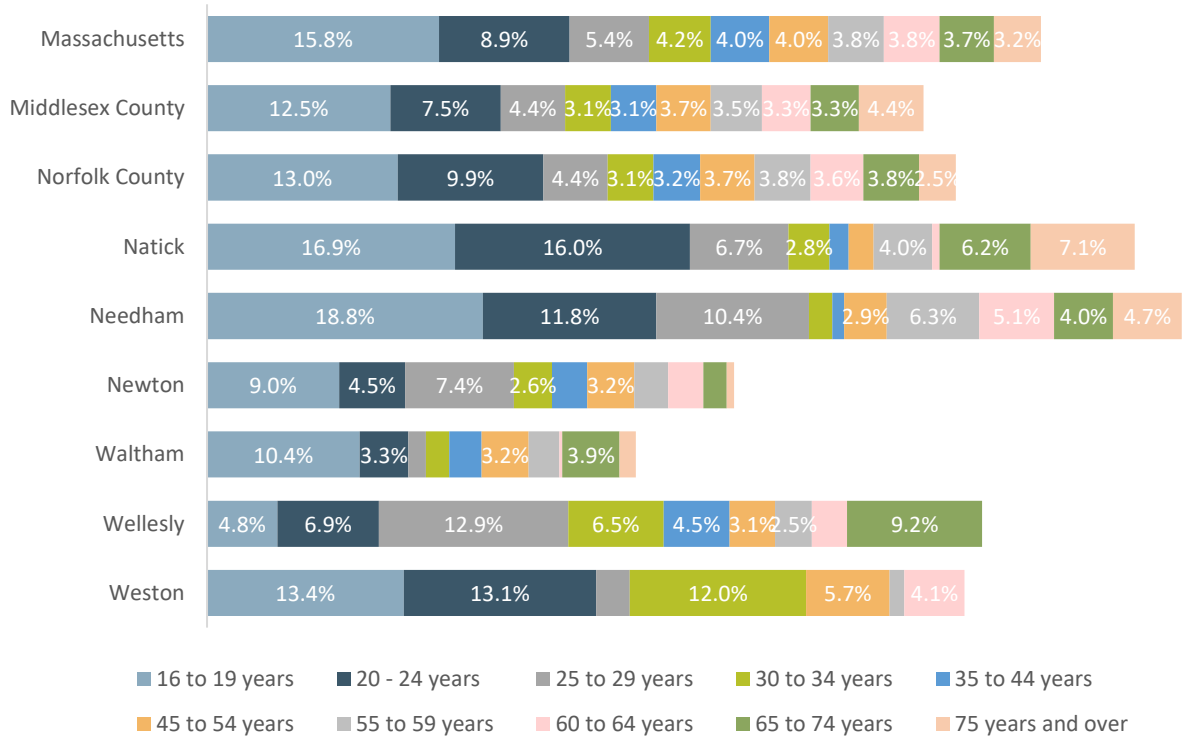
In discussing employment and economic opportunity, focus group participants and interviewees depicted challenges and barriers that manifest for specific age groups. In regard to the senior population, in particular the sub-set of seniors that have low socioeconomic status, participants named a need to continue working beyond retirement age; one participant stated, “I am 66 years old- but I can’t retire yet.” Participants and interviewees explained the necessity for these seniors to maintain their employment because, “they need to be able to afford their apartment, or pay for food, or their medical bills.” This sentiment was recurring across several focus groups and interviews, additionally highlighting the rising costs for elder care – an expense that was described by participants as not always being covered by retirement benefits. In addition to the need for continued employment, participants touched on the challenges of pursuing employment at an older age, with one participant naming “ageism” as a major barrier. The *Report on the Waltham Healthy Aging Summit* delve deeper into specific employment related barriers experienced by the senior population, as participating seniors noted that they would like help in accessing online job advertisements and applications and their interest in learning new trades.[13]

In addition to the senior population, focus group participants highlighted young adults as a key population that is impacted by employment-related challenges. Participants named competing priorities and life circumstances of young adults as a challenge in maintaining the level of employment necessary to afford the cost of living in the NWH service area; one participant stated, “I am going to school full

[13] Waltham Connections for Healthy Aging. 2022. "Report on the Waltham Healthy Aging Summit."

time and I don't have the opportunity to work more than 15 hours a week" and further elaborated, "single, young adults are going to feel the downfall of being a single person and not being able to work."

Figure 13. Percent of Unemployment by Age, by State, County, and City/Town, 2016-2020

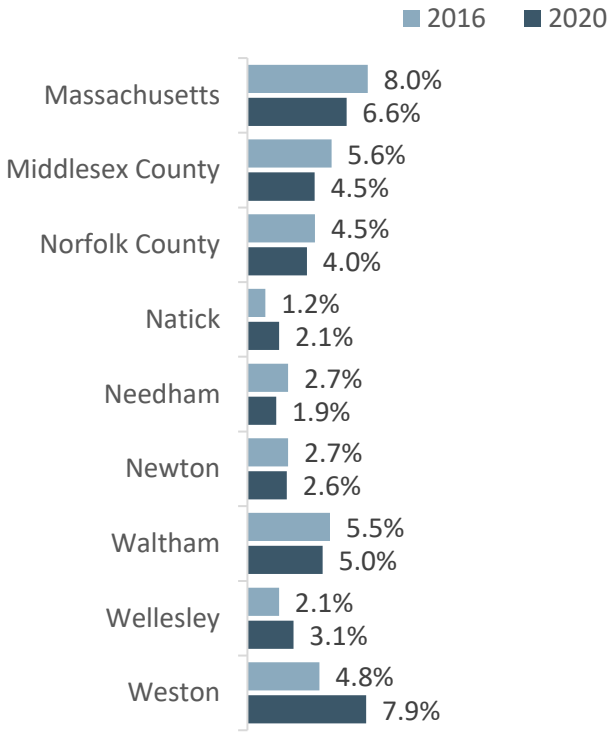


NOTE: Values <2.5% not presented.
DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2011-2015, 2016-2020

Income and Financial Security

Figure 14 shows the percent of families living below the federal poverty line in the cities and towns of the NWH service area. Because of possible methodological differences in how data were collected, comparisons should not be made between towns or regions. While the data show a poverty rate of 7.8% in Weston in 2020, this is likely inaccurate, possibly reflecting the small population of Weston with a larger proportion of older adults who may have assets, but with no employment income, thus skewing the data.

Figure 14. Percent of Families whose Income in the Past 12 Months is Below Poverty Level by State, County, and City/Town, 2012-2016 and 2016-2020



DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2012-2016, 2016-2020. NOTE: Estimates should not be compared across cities/towns due to methodology differences that may exist between different data sources.

While the quantitative data points to lower rates of families living below the poverty line in the NWH service area, focus group participants continuously raised concern around the perceptions of these towns as solely wealthy. One participant expressed this thought when they said, "they [towns in the NWH service area] may not be the most impoverished part of the state, but what we've seen is that just because a community is wealthier or has more access to resources, it does not mean that everyone in that community has that same access" and elevated this concern through stating that low-income folks in these communities tend to "fall through the cracks" and in turn are "disadvantaged in multiple ways." Another participant described this reality: "Newton is perceived as very wealthy, and there's a great portion of the city that is definitely in that category, but there is also a low-income portion of the community."

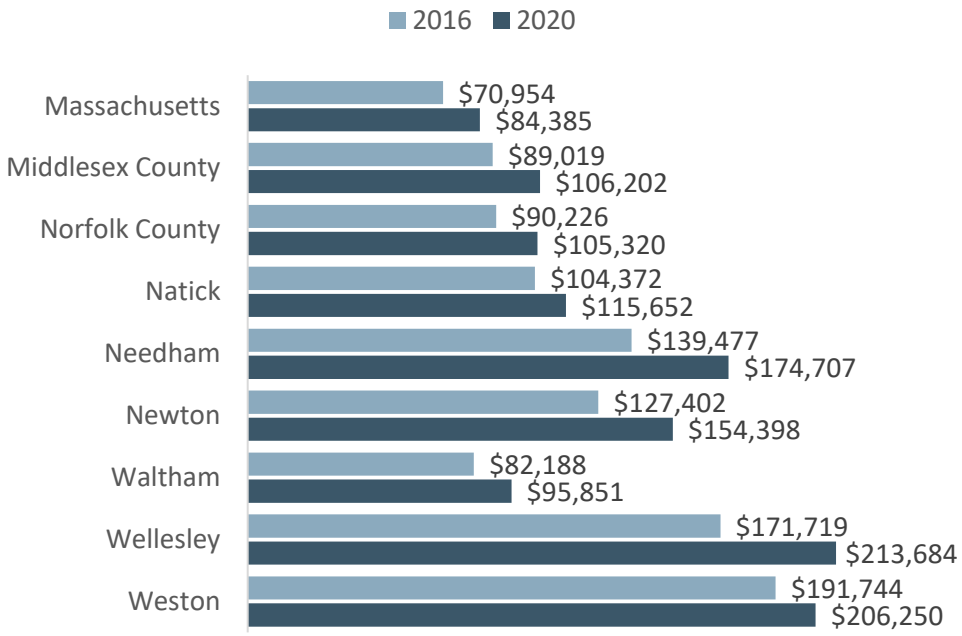
In a 2022 community needs assessment of residents of Newton, the ability to pay bills and the loss of a job or decrease in hours that negatively impact income was consistently ranked as the first or second personal challenge due to COVID.[14] This sentiment was most pronounced among residents with incomes

[14] Center for Governmental Research. 2022. "Newton Community Needs Assessment." https://www.newtonma.gov/government/health-human-services/social-services/community-needs-assessment

below $50,000, those with incomes below $30,000, speakers of a language other than English, those who utilize social services, and Black/African American and Hispanic/Latino residents.

Across the NWH service area towns, the median household income was lowest in Waltham in 2012-2016 ($82,118) and 2016-2020 ($95,851) (**Figure 15**). The median household income increased across all six assessment communities from 2012-2016 to 2015-2019. The towns of Wellesley (+$41,965), Needham (+$35,230), and Newton (+$26,996) experienced the greatest increase in median household income over this period, and it was approximately double the household income increase seen across Massachusetts (+$13,431) and close to double patterns across Middlesex (+$17,183) and Norfolk (+$15,094) counties during the same period. Weston (+$14,506), Waltham (+$13,663), and Natick (+$11,280) were closer to state and county trends for median household income.

Figure 15. Median Household Income by State, County, and City/Town, 2012-2016 and 2016-2020



DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2012-2016, 2016-2020 (inflation-adjusted $)

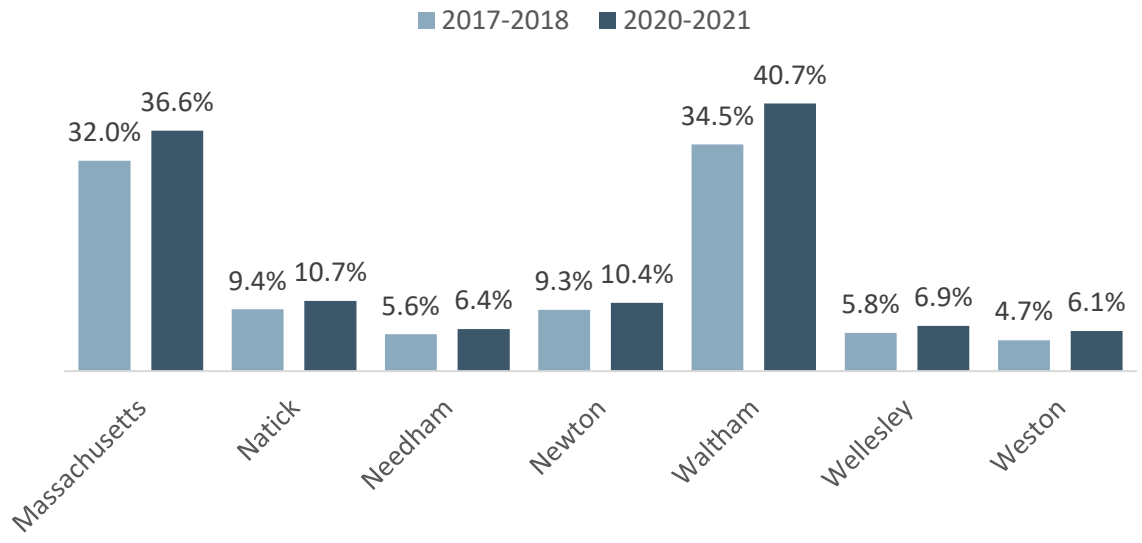
According to the Economic Policy Institute, income inequality is a major issue in the Boston-Cambridge-Newton metro area, where the top 1% of income earners make 32.2 times more than the bottom 99%, ranking the area 29th in income inequality out of 916 U.S. metro areas assessed. In 2015, the average annual income of the top 1% of earners was $2.3 million, compared to $71,000 for the bottom 99%.[15] Middlesex and Norfolk Counties both ranked in the top 75 U.S. counties for income inequality, out of over 3,000 counties assessed. In Norfolk County in 2015, the top 1% of income earners made an average of $3.2 million annually, compared to an average of $84,000 among the bottom 99%. In

[15] Economic Policy Institute: The New Gilded Age: Income Inequality in the U.S. by State, Metropolitan Area, and County; July 2018.

Middlesex County, the top 1% of income earners made an average of $3.5 million annually, compared to an average of $79,000 among the bottom 99%.[16]

Economic disadvantage among public school students is assessed by whether a student participates in at least one of the following programs: Supplemental Nutrition Assistance Program (SNAP), Transitional Assistance for Families with Dependent Children (TAFDC); Department of Children and Families' (DCF) foster care program; and/or MassHealth (Medicaid). All the NWH service areas and towns reported an increase in public school students who are economically disadvantaged from the 2017-2018 to 2020-2021 school year. The percentage of economically disadvantaged students increased from 34.5% in 2017-2018 to 40.7% in the 2020-2021 school year in Waltham, which exceeded that for the state (32.0% to 36.6%) (**Figure 16**). Among the other communities in NWH's primary service area, the percentage ranged from 6.1% in Weston to 10.7% in Natick during the same period. These increases likely reflect the economic reverberations of the COVID-19 pandemic.

Figure 16. Percent of Public School District Students who are Economically Disadvantaged by State and City/Town, 2017-2018 and 2020-2021



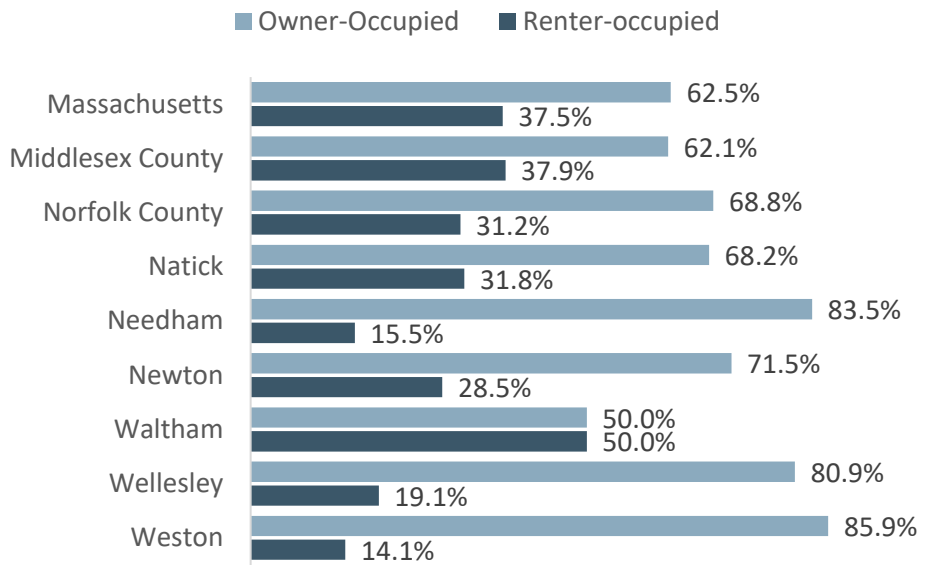
DATA SOURCE: School and District Profiles, Massachusetts Department of Elementary and Secondary Education, 2017-2018, 2020-2021

Housing

Similar to patterns in the 2018 CHNA, with the exception of Waltham (50.0%), towns across the NWH service area had a higher percentage of owner-occupied housing units than the state overall (62.5%) in 2016-2020 (**Figure 17**). Half (50.0%) of Waltham housing units were renter-occupied, compared to approximately one-third of Massachusetts units (37.5%). The towns of Weston (85.9%), Needham (83.5%), and Wellesley (80.9%) had the highest percentage of owner-occupied housing units.

[16] Economic Policy Institute: The New Gilded Age: Income Inequality in the U.S. by State, Metropolitan Area, and County; July 2018.

Figure 17. Percent of Households That Own or Rent Homes by State, County, and City/Town, 2016-2020



DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020

In 2016-2020, of the six NWH service area towns, median monthly housing costs for owner-occupied units were lowest in Waltham ($2,572), though these housing costs exceeded the average across Massachusetts ($2,268) (**Figure 18**). The towns of Natick ($1,625) and Needham ($1,604) had the lowest renter-occupied housing costs across the assessment communities, yet these costs were higher than the state average ($1,336). Monthly housing costs for renter-occupied units were highest in Wellesley ($2,177) and Newton ($1,897). Monthly mortgage costs were highest in Wellesley (>$4,000) and Weston (>$4,000). Because the service area is within the Boston suburbs, the median monthly housing costs in each of the six assessment communities exceeded those for the state overall for both owner-occupied and renter-occupied units.

Housing affordability in the NWH service area was a common topic of discussion throughout the focus groups and interviews. Focus group participants and interviewees described an "insufficient supply of housing" that is affordable and available to folks of low socioeconomic status. Several participants recognized an investment in housing construction that is catering to wealthier community members stating, "you have these developers coming in and buying out housing before the normal people can even go look at the house. They're tearing them down then building mansions, or luxury apartments." Another participant similarly called attention to the conflicting intentions of developers when they stated, "developers are not going to focus on affordability." This sentiment and the impacts of this reality on low-income community members was further expressed when a participant said, "Two family housing is disappearing. A lot of families that used to be able to afford housing are no longer able to. The city has allowed developers to make those homes into fancy condos for wealthier subgroups."

In addition to the lack of affordable housing, focus group participants brought up challenges in applying for and accessing the affordable housing options that are available to community members. Several participants specifically referenced the ways these application processes are further complicated for immigrants and folks that do not speak, read, and/or write in English. Stakeholders in the Newton Food

Pantry Assessment noted that applying for subsidized housing was challenging and that the wait time can be long, around 5-10 *years*. Additionally, they reported that even if a family is able to get housing, the cost to remain in their housing can be just as challenging as finding affordable housing and many households are cost burdened.[17] While some focus group participants that currently live in subsidized housing expressed satisfaction with their housing, they explained that maintaining eligibility for certain housing assistance programs can be a challenge, however they cannot afford to live in their community outside of subsidized housing. One participant explained, "I'm capping out and have to move. You make good enough money [to pay your rent in subsidized housing] but then at the same time I cannot afford $3,000 in rent." Another participant described the impacts of losing eligibility for subsidized housing stating "I'm facing having to uproot my son from Newton, it's like 'now you're over income, bye.'"

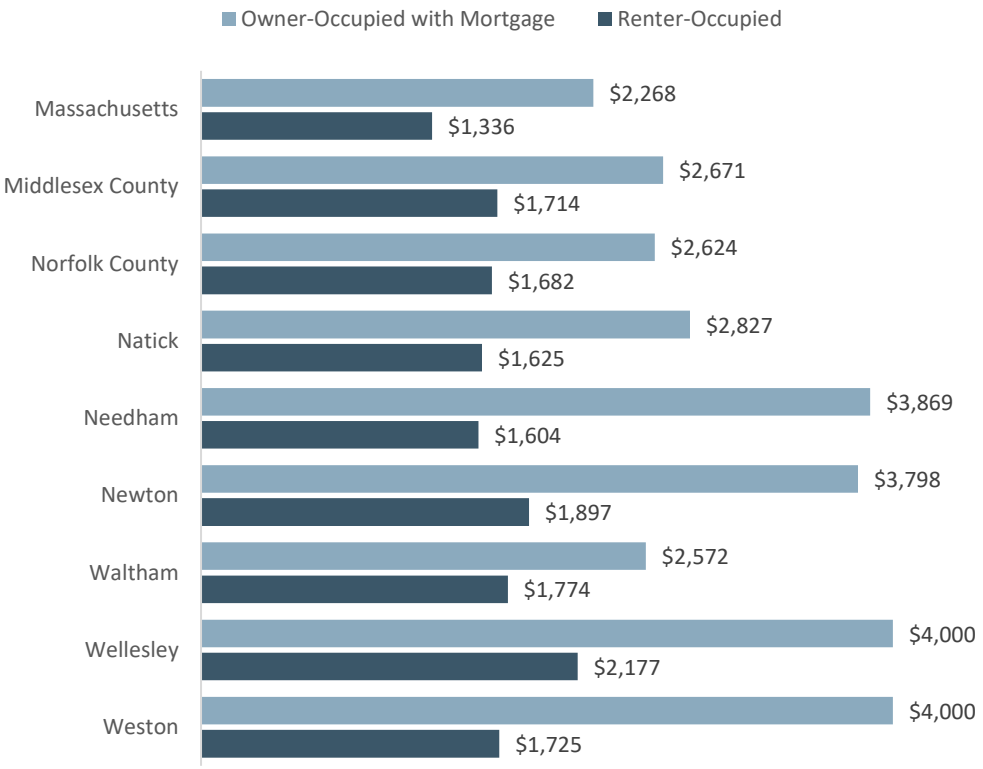
In focus groups and interviews, seniors were highlighted as a population that is particularly impacted by challenges relating to housing affordability. One participant depicted the precarity of senior housing when they said, "A lot of elderly people that still live in their own homes would like to move but want to stay in Newton, but when I talk to people they say there is nowhere to go." The lack of housing options for seniors were described in the focus groups as a result of high costs associated with senior living facilities and a lack of affordable, quality senior living options. This sentiment was echoed by seniors who participated in the Waltham Healthy Aging Summit. They mentioned the importance of more affordable senior housing and better management of senior housing as something that Waltham could do better.[18]

In addition to the direct impacts of challenges related to housing affordability, seniors and individuals living with disabilities are adjacently impacted by rising costs of living in the NWH service area and a resulting shortage in home health aides and caregivers. Focus group participants drew a connection between high costs of living and low wages for these workers and the shortage of employees in this sector. Focus group participants described this paradigm when they stated, "What is the encouragement for people to go into the field [health aide] when expenses are so high? It is hard to get health aids." Another participant said, "I find that home health aides don't get paid for mileage. Many of them are coming from Boston and Dorchester, Roxbury, Mattapan. To come out here and not get paid for mileage is tough," illuminating the ways cost of living in the NWH service area impact the greater economy and systems of care.

[17] Newton Food Pantry. 2020. "Newton Food Pantry 2020 Needs Assessment Report."

[18] Waltham Connections for Healthy Aging. 2022. "Report on the Waltham Healthy Aging Summit."

Figure 18. Median Monthly Housing Costs by Tenure and State, County, and City/Town, 2016-2020



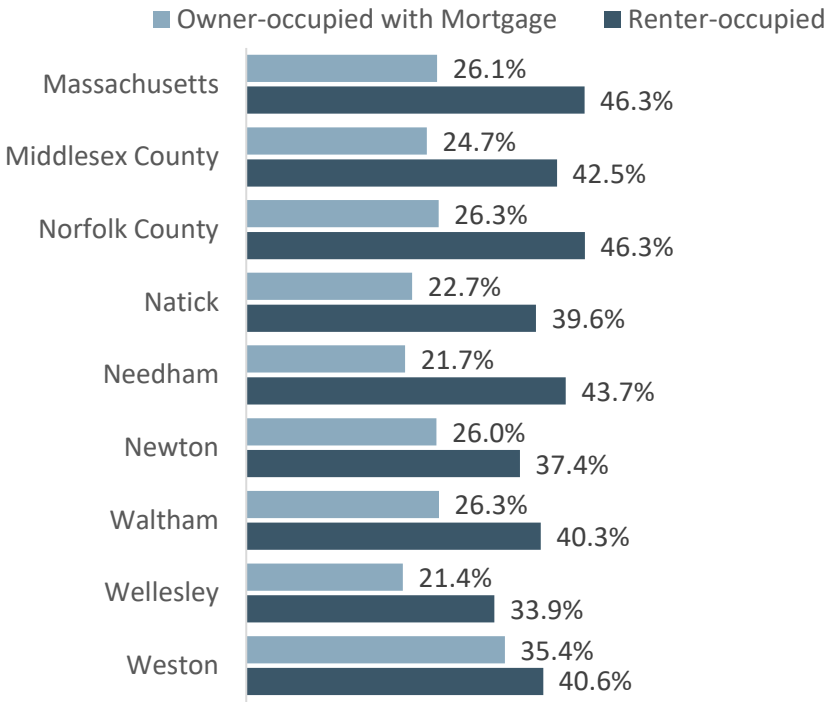
DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020
NOTE: Monthly housing costs for owner occupied units with a mortgage is defined as the sum of payments for mortgages, deeds of trust, contracts to purchase, similar debts on the property; real estate taxes; fire, hazard, or flood insurance; utilities; and fuels. Monthly housing costs for renter-occupied units is defined as the average monthly cost of the contract rent and utilities.

A household is considered by the Department of Housing and Urban Development to be "housing cost burdened" if more than 30% of monthly income is dedicated to housing costs (e.g., rent, mortgage, utilities). The housing cost burden was highest for renter-occupied units in Needham (43.7%) and owner-occupied units in Weston (35.4%). The percentage of renter-occupied units with housing costs of 30% or more across the six assessment communities were lower than that for the state (46.3%). As illustrated in **Figure 19**, in each of the six assessment communities a higher percentage of renter-occupied housing units were burdened compared to owner-occupied housing units. While Weston (35.4%) and Waltham (26.3%) had a high housing cost burden, the percentage of residents of owner-occupied units who are housing cost burdened was lower than the state average for the remaining four towns in the NWH service area.

Housing and rental costs were also named in the Newton community needs assessment among those with incomes less than $50,000 and $30,000 as a top issue, with residents stating, "It's hard to afford

housing here unless you're making six figures" and "It feels like they're trying to push the lower-income people out of Newton."[19]

Figure 19. Percent of Residents Whose Housing Costs are 30% or More of Household Income by State, County, and City/Town, 2016-2020

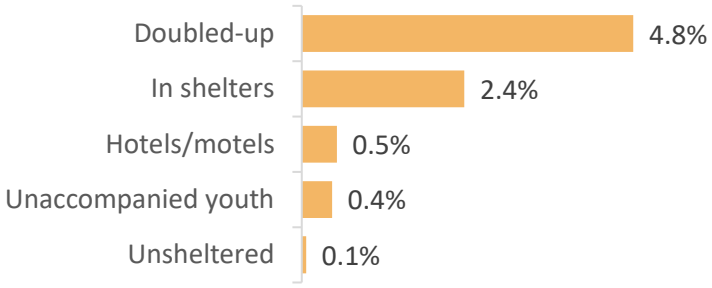


DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020

In Massachusetts overall in 2018-2019, there were 26,180 homeless students in public schools. As illustrated in **Figure 20**, a higher proportion of youth (<18 years of age) who were experiencing homelessness reported "doubling up" (e.g., sharing a room) (4.8%) or shelters (2.4%) as their primary nighttime residence in 2018-2019. Compared to 2016-2017, the percentage of youth reporting being doubled up increased from 0.7% to 4.7% and students in shelters increased from 0.5 to 2.4%. While homelessness rates are reported statewide, we expect similar rates in the towns of Natick and Waltham as they have a comparable socioeconomic and housing affordability profile as the overall State of Massachusetts.

[1919] Center for Governmental Research. 2022. "Newton Community Needs Assessment." https://www.newtonma.gov/government/health-human-services/social-services/community-needs-assessment

Figure 20. Percent of Homeless Youth by Primary Nighttime Residence in Massachusetts, 2018-2019



DATA SOURCE: Massachusetts Coalition for the Homeless
NOTE: Denominator of Massachusetts statewide population under age 18 in 2016 (Source: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2012-2016)

Transportation

Public transportation to Boston is available and many residents from the NWH service area travel into the city. However, some public housing developments are not within walking distance from public transportation, creating challenges for lower income residents. Local transportation options are less available, making travel from town to town difficult for those without private vehicles. The RIDE program, for seniors and those with disabilities who cannot independently use public transportation is available but has some limitations.[20]

Discussions in the focus groups pertaining to transportation similarly highlighted challenges maneuvering transportation systems for seniors. For example, one participant exemplified the limitations of the existing senior transportation infrastructure when they said, "The city has transportation for seniors but it's primarily within Newton, luckily Newton-Wellesley is in Newton but anyone who's going to a hospital in Boston has to find a different type of transportation." Participants further reflected, "transportation [for seniors] has been difficult with the lack of taxis. They feel less comfortable in *Ubers* and *Lyfts*." Transportation was also an issue mentioned by seniors at the Waltham Healthy Aging Summit who noted a need for transportation to grocery stores, community events, the library, and to medical appointments.[21]

Reflecting patterns across Massachusetts, the majority of workers in each assessment community drove to work in 2016-2020. Even though the quantitative data point to a majority of residents utilizing cars as their mode of transportation to work, focus group participants explained that in many cases, their communities are not accessible for folks who do not own or drive a car. On participant said, "It is hard to get around – I don't have a car" and another said, "It [transportation] is not good for community members without a car," these sentiments were echoed repeatedly throughout discussions pertaining to transportation. One participant discussed the challenges faced by folks without a car when they said, "the burden of accessing quality healthcare is greatest for people of limited means, for example if they don't have a car, it's a big trouble to get to their appointments...our society is centered around cars and that's an inequity." Newton (12.9%), Needham (12.8%), and Natick (10.1%) had a higher percentage of residents who commuted to work via public transportation compared to the state (9.5%) (**Figure 21**).

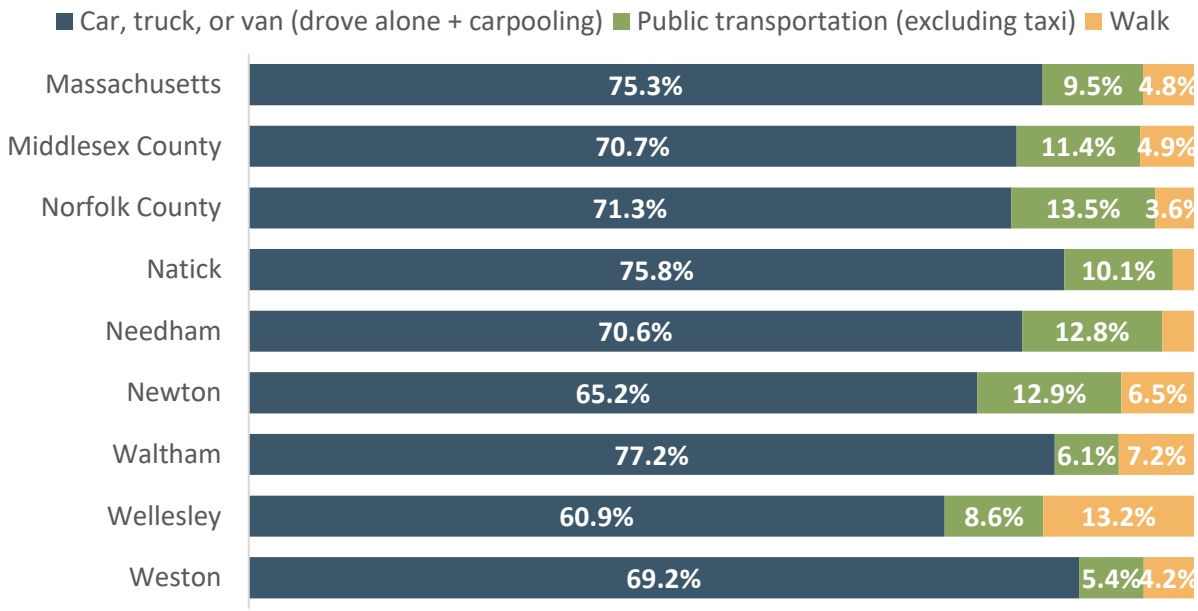
[20] Massachusetts Bay Transportation Authority. 2022. *The RIDE.* https://www.mbta.com/accessibility/the-ride.

[21] Waltham Connections for Healthy Aging. 2022. "Report on the Waltham Healthy Aging Summit."

Across the six assessment communities, Weston (5.4%) had the lowest percent of public transportation commuting. A higher percentage of residents walked to work in Wellesley (13.2%) than the other towns in the assessment area and the state overall (4.8%).

Overall, focus group participants expressed the sentiment that "transportation is tough" and the lack of accessible transportation creates barriers in accessing food and healthcare. Newton residents noted in the Newton community needs assessment that transportation "is expensive and unreliable" and that "the RIDE works, but it is notoriously difficult to access and is not a particularly pleasant experience."[22]

Figure 21. Mode of Transportation to Work for Workers Aged 16+ Years by State, County, and City/Town, 2016-2020



DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020
NOTE: Car, truck, or van includes both driving alone and carpooling; public transportation does not include taxi; other includes other means and working from home. Values <3.5% not presented.

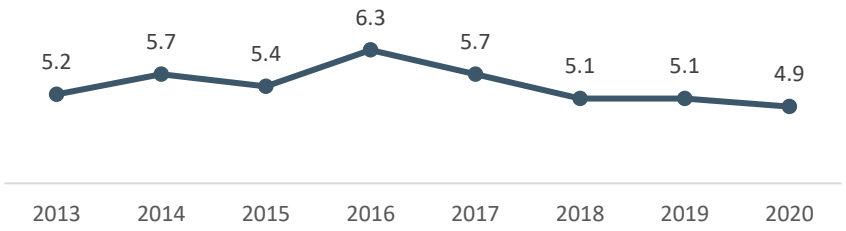
Injury, Crime, Violence, and Bullying

In 2020 across the state of Massachusetts, the age-adjusted mortality rate due to motor vehicle accidents was 4.9 deaths per 100,000 population (

Figure 22). Trends across Massachusetts suggest that the motor vehicle-related mortality rate has remained relatively stable from 2013 to 2020. Data were not available specific to the cities and towns that are the subject of this report.

[22] Center for Governmental Research. 2022. "Newton Community Needs Assessment." https://www.newtonma.gov/government/health-human-services/social-services/community-needs-assessment

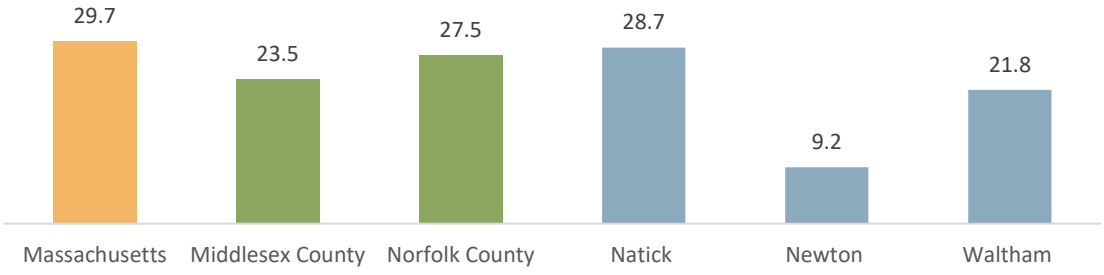
Figure 22. Age-Adjusted Motor Vehicle-Related Death Rate per 100,000 Population in the State of Massachusetts, 2013-2020



DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2016-2017, Policy Map, 2018-2020

As shown in **Figure 23**, Natick had the highest rate of work-related injury (28.7 per 100,000 employed residents). Across all towns reported, they had a lower rate of work-related injury hospitalizations than across Massachusetts (29.7 per 100,000 employed residents).

Figure 23. Rate of Inpatient Hospitalizations per 100,000 Employed Residents for Work-Related Injury among Employed Residents by State, County, and City/Town, 2016-2019

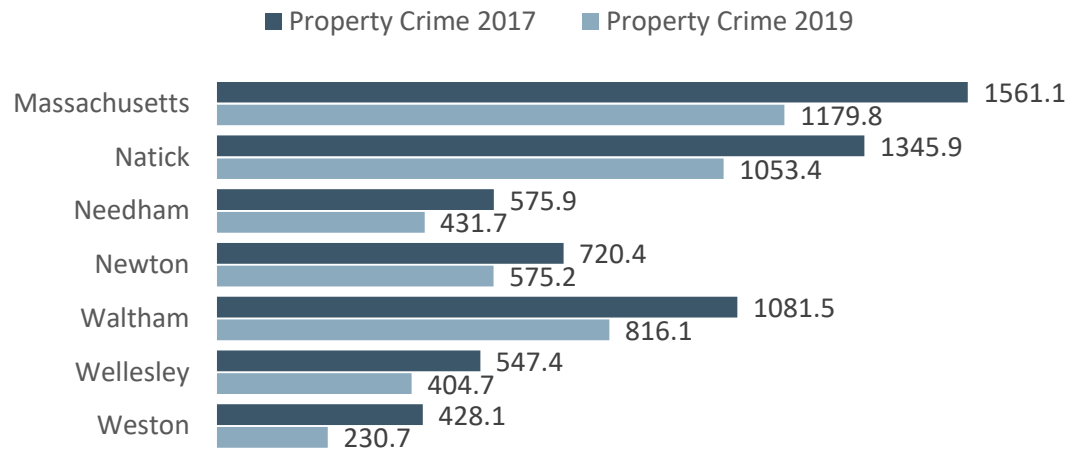


DATA SOURCE: Inpatient Hospital Discharge data from CHIA (Center for Health Information and Analysis), Restricted to subset of patients who experienced at least 1 work injury between calendar year 2016-2019 and are MA residents. Data not available for Needham, Wellesley, and Weston.

As shown in **Figure 24**, among the NWH service area, the property crime rate was highest in Natick and Waltham in both 2017 (1,345.9 and 1,081.5 crimes per 100,000 population, respectively) and 2019 (1,053.4 and 816.1 crimes per 100,000 population, respectively). In 2019, the property crime rate was lower than the state average (1,179.8 crimes per 100,000 population) for all six assessment

communities. From 2017 to 2019, following state patterns, the property crime rate declined across all six assessment communities.

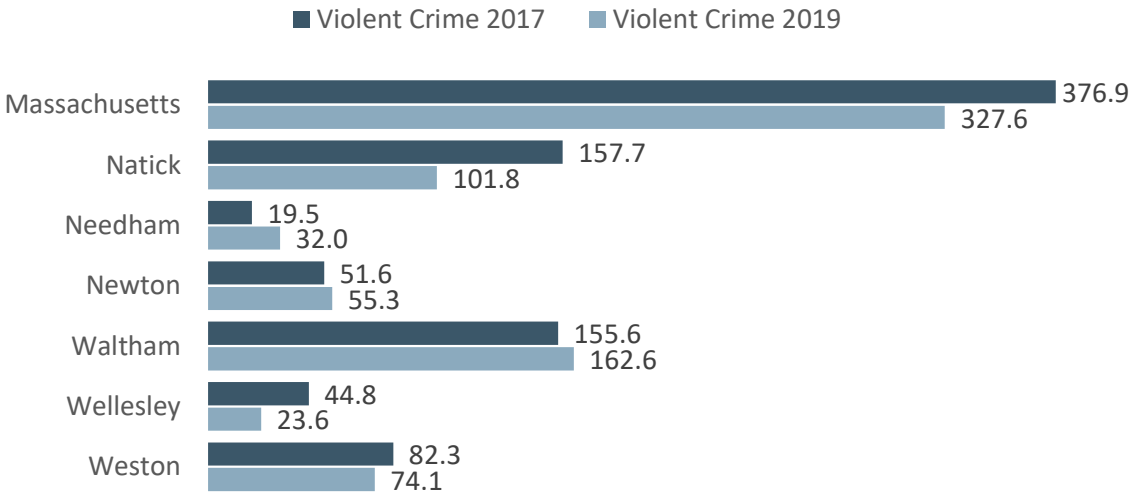
Figure 24. Property Crime Rate per 100,000 Population, by State and City/Town, 2017 and 2019



DATA SOURCE: Federal Bureau of Investigation, Offenses Known to Law Enforcement, 2017
NOTE: Property crime includes burglary, larceny-theft, and motor vehicle theft

In 2017 and 2019, the violent crime rate was highest in Waltham (155.6 and 162.6 crimes per 100,000 population, respectively) and Natick (157.7 and 101.8 crimes per 100,000 population, respectively) (**Figure 25**). During this same period, the violent crime rate was lowest in Needham (19.5 crimes and 32.0 crimes per 100,000 population, respectively) but crime percentage grew by 39%. The violent crime rate across all six assessment communities was lower than that for Massachusetts overall in both 2017 and 2019. Mirroring state patterns, from 2017 to 2019 the violent crime rate declined in Natick, Wellesley, and Weston, while the violent crime rate increased in Needham, Newton, and Waltham.

Figure 25. Violent Crime Rate per 100,000 Population by State and City/Town, 2017 and 2019



DATA SOURCE: Federal Bureau of Investigation, Offenses Known to Law Enforcement, 2017
NOTE: Violent crime includes murder and nonnegligent manslaughter, rape, robbery, and aggravated assault

From 2016 to 2019, Natick and Waltham were the only towns across the six assessment communities that had deaths attributed to firearms (**Table 2**).

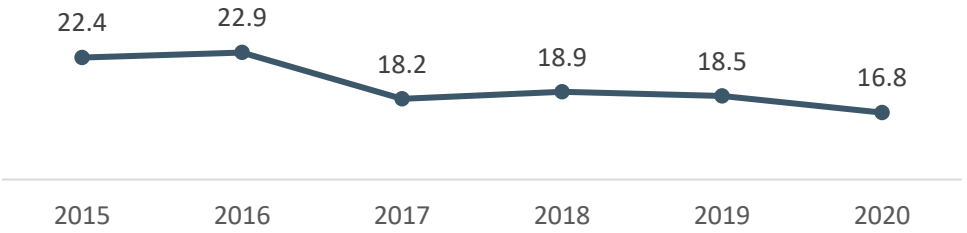
Table 2. Firearm Death Counts by State and City/Town, 2016-2019

	2016	2017	2018	2019
Massachusetts	245	270	250	234
Natick	2	0	1	1
Needham	0	0	0	0
Newton	0	0	0	0
Waltham	2	0	1	0
Wellesley	0	0	0	0
Weston	0	0	0	0

Data Source: Massachusetts Department of Public Health, Massachusetts Violent Death Reporting System, Injury Surveillance Program 2016-2019

Data about reported child maltreatment are only available for the state of Massachusetts as a whole. As shown in **Figure 26**, the rate of child maltreatment victimization decreased from 22.4 cases per 1,000 children in 2015 to 16.8 cases of victimization per 1,000 children in 2020.

Figure 26. Rate of Child Maltreatment Victimization per 1,000 Children in the State of Massachusetts, 2015-2020



DATA SOURCE: U.S. Department of Health and Human Services, Administration for Children & Families and Administration on Children, Youth and Families, Children's Bureau, Child Maltreatment, 2015-2020

From 2010 to 2019, the number of child maltreatment fatalities across Massachusetts ranged from 8 deaths in 2016 to 23 deaths in 2011 (**Table 3**).

Table 3. Count of Child Maltreatment Fatalities in the State of Massachusetts, 2010-2019

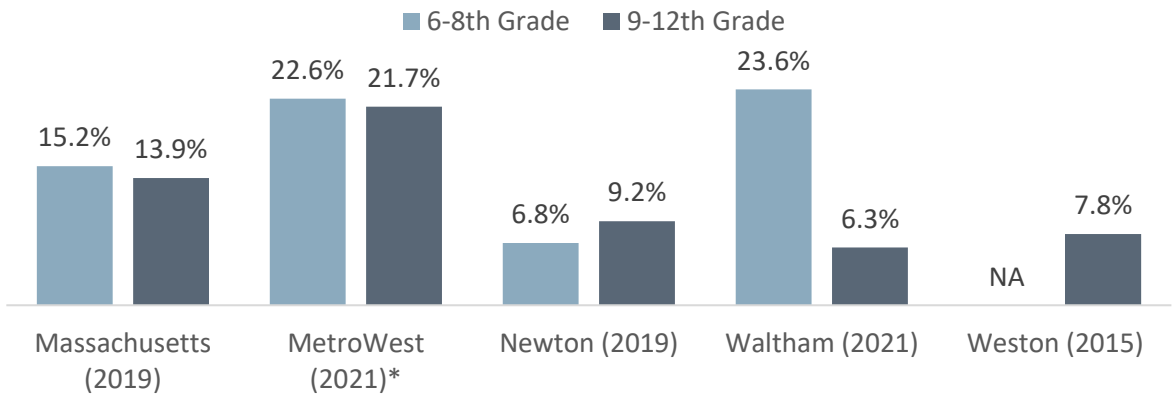
Year	Count
2010	17
2011	23
2012	20
2015	14
2016	8
2017	14
2018	14
2019	13

DATA SOURCE: U.S. Department of Health and Human Services, Administration for Children & Families and Administration on Children, Youth and Families, Children's Bureau, Child Maltreatment, 2010-2019

In the focus groups and interviews, the NWH service area was described by many as generally safe, however during conversations around safety in schools, participants highlighted bullying and school-based violence as a concern. One young adult student stated "I don't feel safe at school. I don't feel safe one bit. At all." Several participants referenced recent national accounts of school shootings as a point of fear and didn't believe the public-school systems' security teams were "doing anything" to keep them safe.

In 2015-2021, youth experiences of electronic bullying varied across the NWH assessment communities (**Figure 27**). Waltham had a lower prevalence of electronic bullying amongst high school students (6.3%) compared to Newton (9.2%), Weston (7.8%, 2015 data), and the state overall (13.9%). The proportion of middle school (22.6%) and high school (21.7%) students experience electronic bullying in the MetroWest region overall were higher compared to the state and the focal communities.

Figure 27. Percent of Students Bullied Electronically by State and City/Town, 2015-2021

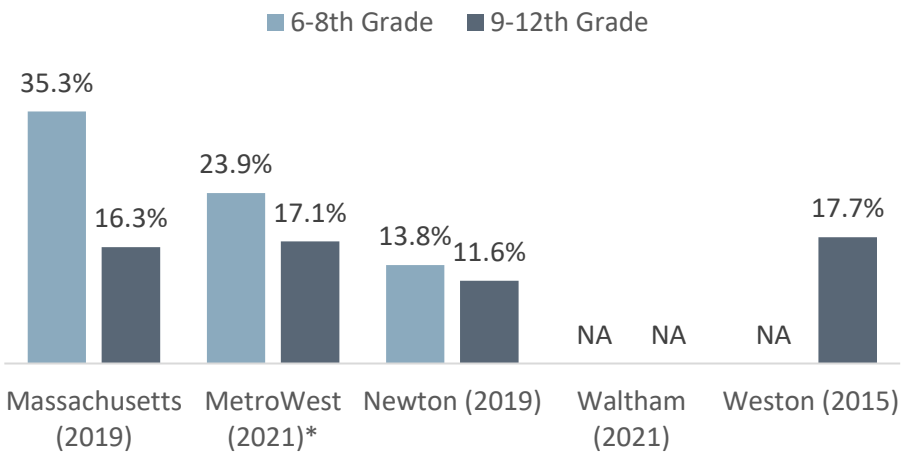


DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Health Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015

NOTE: * includes students in grades 7-8. Data for the other assessment communities were not available. MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley

As shown in **Figure 28**, approximately one-third (35.3%) of Massachusetts middle school students reported being bullied on school property in 2019. That proportion decreases by more than half for high school students (16.3%) in the same time period. In 2021, approximately a quarter (23.9%) of middle school students in the MetroWest region reported being bullied on school property, compared to 17.1% of high school students. Compared to MetroWest, Waltham (16.8%) and Weston (17.7%) had similar proportions of high schoolers reported being bullied on school property, while the proportion of Newton was lower (11.6%).

Figure 28. Percent of Students (Grades 6-8 & 9-12) Bullied on School Property by State and City/Town, 2015-2021



DATA SOURCE: Massachusetts Youth Health Risk Report, 2017; MetroWest Health Foundation, Health Data Search, 2018; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2019; Weston Youth Health Assessment, 2015
NOTE: * includes students in grades 7-8. Data for the other assessment communities were not available. MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley

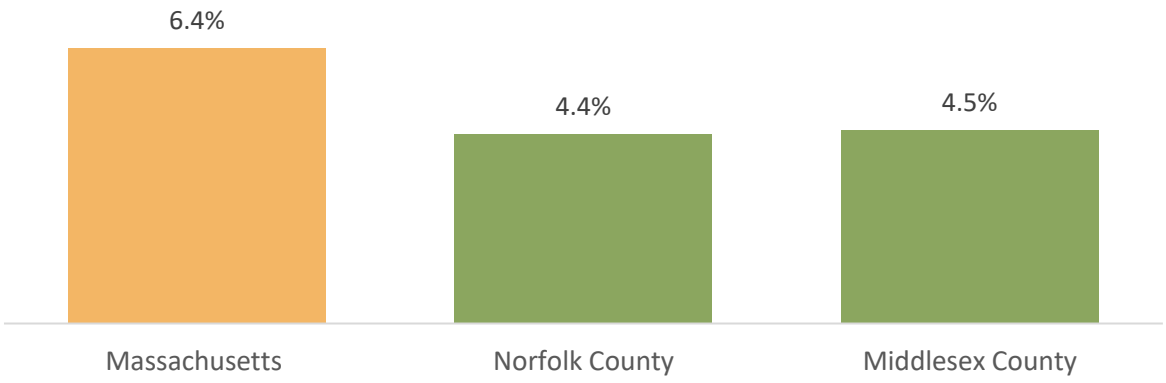
Bullying was a topic that presented itself in focus groups, mainly as it pertains to the youth and young adult population. Some participants who were parents of children in the NWH service area provided examples of scenarios in which their children were being bullied at school and a discontent in the transparency between school officials and parents. One participant explained, “Sometimes there is discrimination or bullying and we don’t find out about it until later. So especially for those of us that work long hours, if teachers could relay that to us, so that we are not constantly worried about how they are doing.” Another shared, “I have a nephew who was being bullied and the teacher did not do anything about it. So we need to make sure teachers are providing a safe place for our children to learn.” Young adult focus group participants described bullying as an issue that is not addressed thoroughly enough by school officials and that it particularly impacts POC students and students in the LGBTQ community; one student said, “A lot of LGBTQ people also don’t feel safe in Waltham. They’re getting hate crimed in school. They get verbal and physical abuse and it’s really bad. They get pushed around, they get made fun of. They tell the principals and associate principals, but they don’t do anything about it. POC also have this issue, the perpetrators will get suspended for a day, but then they get to come back.” Another student echoed the existence of this targeted bullying: “There are people in the schools that pick on the LGBTQ+ and POC communities for fun.”

Food Insecurity

Food access is directly associated with mortality from obesity, hypertension, diabetes, and heart disease. As shown in **Figure 29**, in 2019 6.4% of low-income Massachusetts residents did not live close to a grocery store, an increase from 4.0% in 2015. The percentage of low-income residents that do not live close to a grocery store also increased in Norfolk (4.4%) and Middlesex (4.5%) counties between 2015 and 2019.

Access to a supermarket was an issue expressed by focus group participants, which was further exacerbated by the pandemic; one participant explained their reliance on food delivery services, noting: "I've been using Instacart, and you pay a fee to use it." Supermarket access is a pronounced issue for senior or aging populations 65 years and older, especially if they have issues with transportation. For example, 62.8% of seniors in Weston, 45.6% of seniors in Wellesley, and 39.9% of seniors in Natick reported poor supermarket access, which is much higher than the state average of 29.3% of seniors. [23]

Figure 29. Percent of Population Who are Low-Income and Do Not Live Close to a Grocery Store, by State and County, 2019



NOTE: Not close to a supermarket defined as beyond 1 mile for urban areas or 10 miles for rural areas
DATA SOURCE: U.S. Department of Agriculture, Food Access Research Atlas, 2019

In 2020, Massachusetts had similar rates of overall food insecurity (7.2%) compared to Middlesex (7.2%) and Norfolk (7.0%) Counties (**Table 4**). The rate of child food insecurity was also higher in the state overall (8.8%) compared to Middlesex (6.9%) and Norfolk (6.7%) counties. While Middlesex and Norfolk counties had lower rates of food insecurity, both counties had higher average costs per meal[24] compared to the state overall. Higher food costs can contribute to an overall higher cost of living for individuals and families.

[23] Massachusetts Healthy Aging Collaborative. 2018. "Community Profiles." https://mahealthyagingcollaborative.org/data-report/explore-the-profiles/community-profiles/

[24] Average cost per meal is "*the average weekly dollar amount food-secure individuals report spending on food…divided by 21 (assuming three meals a day, seven days a week).*" Feeding America, Map the Meal Gap, 2021

Table 4. Food Insecurity Rate and Number and Cost Per Meal, by State and County, 2020

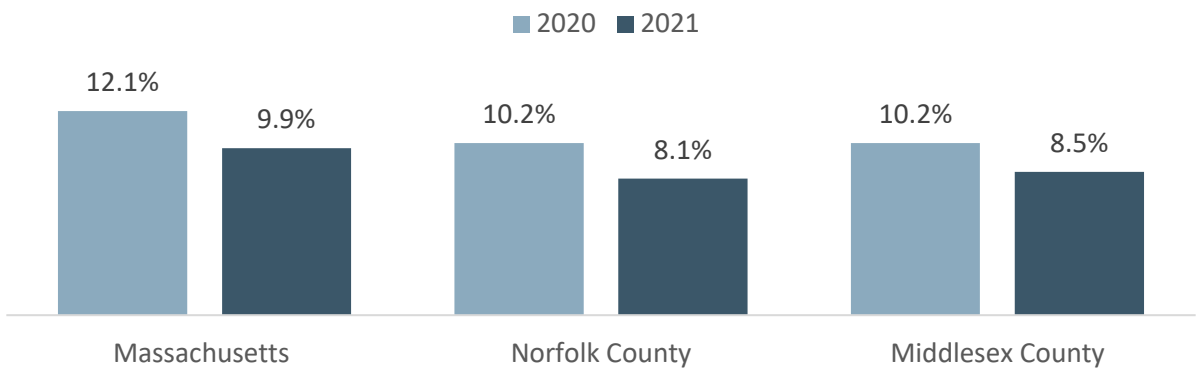
	Overall Food Insecurity Rate		Child Food Insecurity Rate		Cost Per Meal	
	2017	2020	2017	2020	2017	2020
Massachusetts	9.0%	7.2%	11.7%	8.8%	$3.55	$3.81
Middlesex County	7.5%	7.2%	9.3%	6.9%	$3.96	$4.33
Norfolk County	7.2%	7.0%	9.0%	6.7%	$3.79	$4.24

DATA SOURCE: Map the Meal Gap, 2017 and 2020

In addition to high costs, another driver of food insecurity among Newton residents as identified in the Newton Food Pantry Needs Assessment is the lack of transportation to food assistance. Another barrier is time constraints as many food assistance services are only open during working hours and families may be unable to access services in that time because they are working. Finally, families may be reluctant to access services due to stigma.[25] This stigma was also discussed by various participants throughout the focus groups, which mainly stemmed from misinformation surrounding food pantries; one participant expressed this when they said, "I thought you had to be so poor that you were on the streets," another participant explained their hesitancy in utilizing food resources: "you don't consider yourself poor or that you can ask for help"

Feeding America projects a slight decrease in food insecurity from 2020-2021 but rates of food insecurity are still high, see **Figure 30**.

Figure 30. Overall Projected Food Insecurity Rate by State and County, 2020-2021



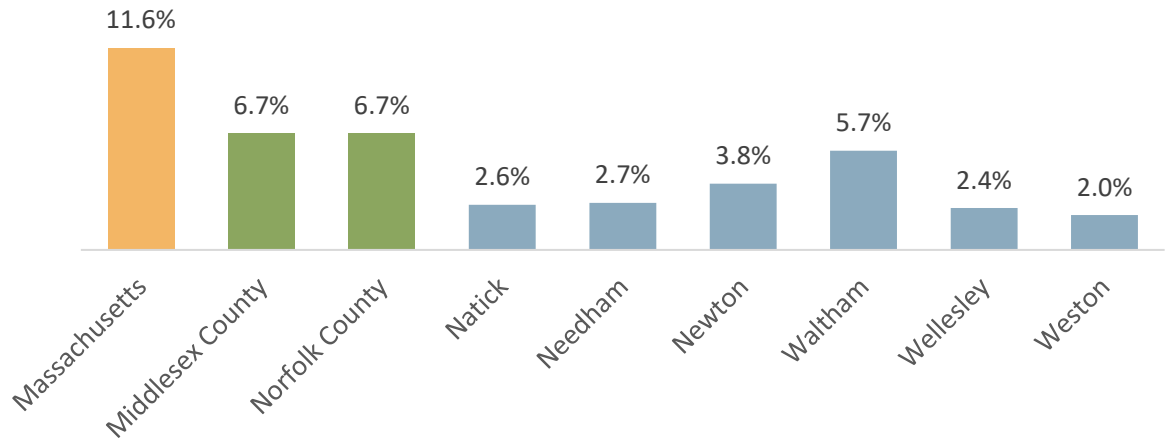
DATA SOURCE: Feeding America, The Impact of Coronavirus on Food Insecurity, 2020-2021

In 2016-2020, Waltham (5.7%) and Newton (3.8%) had the highest percentage of families receiving food stamps/SNAP, though this was below that for the state (11.6%) and Middlesex (6.7%) and Norfolk (6.7%) counties. Weston (2.0%) and Wellesley (2.4%) had the lowest percentage of families receiving food stamps/SNAP, which was around half of the percentage of families in Waltham (**Figure 31**). When discussing food insecurity in the focus groups, participants acknowledged a need for increased funding

[25] Newton Food Pantry. 2020. "Newton Food Pantry 2020 Needs Assessment Report."

for food related benefits, as they were still relying on food pantries and other community food resources to supplement what they could afford with food stamps. Participants expressed concern around the rising food prices and the stagnant amount of food stamp benefits; one participant expressed this when they said, “A lot of folks who are low income were getting SNAP benefits through COVID. With inflation, I worry about what they are going to do once that runs out.”

Figure 31. Percent Households Receiving Food Stamps/SNAP by State, County, and City/Town 2016-2020

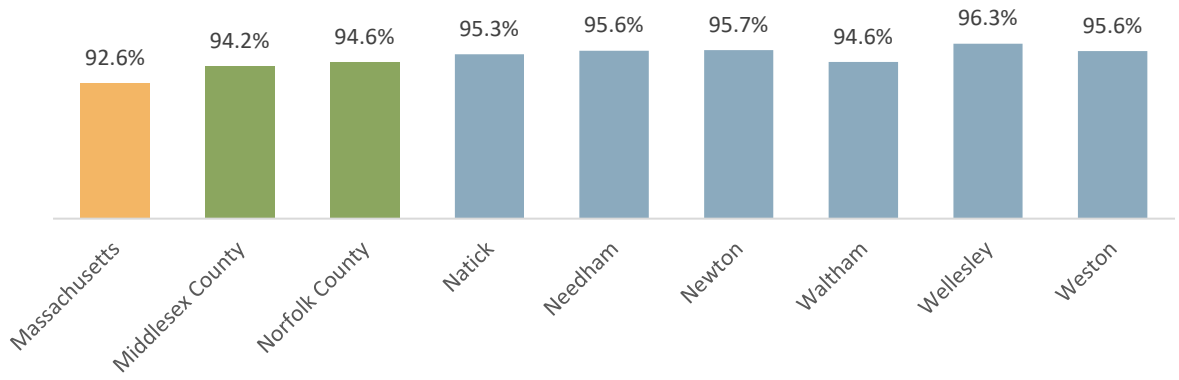


DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020

Technology

As shown in **Figure 32**, Waltham (94.6%) had the lowest percentage of households with any type of computer. Among all six towns in the NWH service area, they all had a higher percentage of households with any type of computer compared to the state (92.6%).

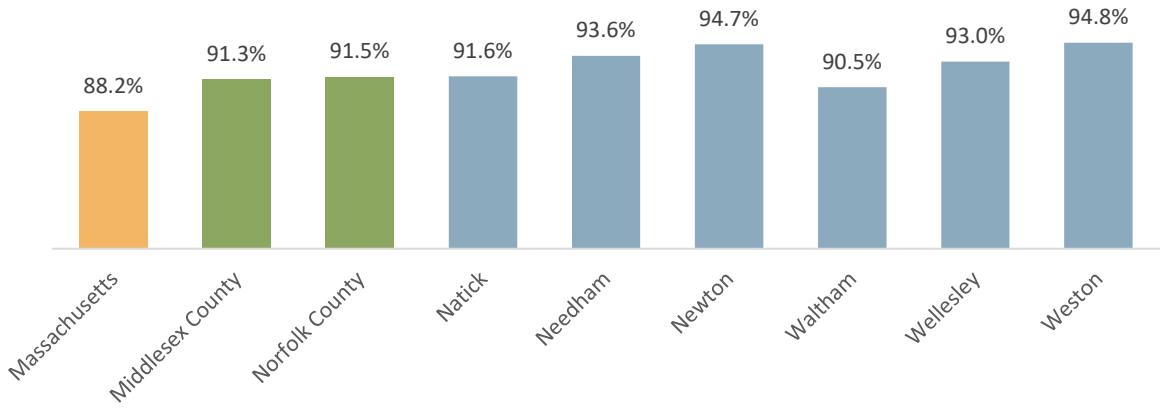
Figure 32. Estimated Percent of Households with Any Type of Computer by State, County, and City/Town, 2016-2020



DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020

As shown in **Figure 33**, Waltham (90.5%) had the lowest percentage of households with a subscription to broadband internet. Among all six towns in the NWH service area, they all had a higher percentage of households with a subscription to broadband internet compared to the state (88.2%).

Figure 33. Estimated Percent of Households with a Subscription to Any Type of Broadband Internet by State, County and City/Town, 2016-2020



DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020

Community Health Issues

Overall Mortality

As shown in **Table 5**, similar to the prior CHNAs, the leading causes of death in the NWH service area in 2017 were heart disease and cancer. These patterns were consistent with those for Massachusetts in 2017. In 2017, stroke emerged as the third leading cause of death for Needham, Newton, and Weston. In 2017, as with Massachusetts, chronic lower respiratory disease (CLRD) was the third leading cause of death in Natick, Waltham, and Wellesley. Of note, in the 2015 CHNA patterns for total cancer and lung cancer were presented separately, limiting further comparisons of leading causes of death across the prior CHNAs.

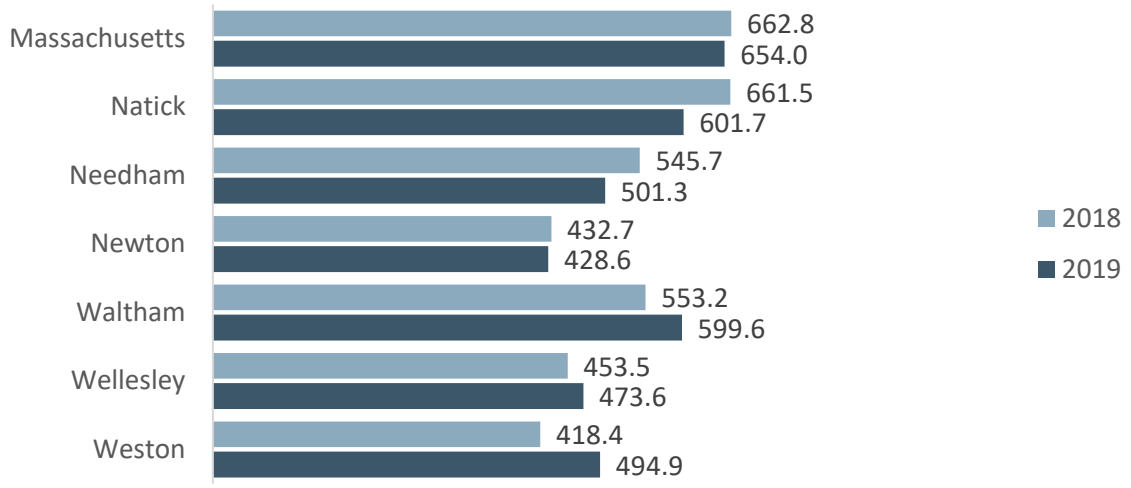
Table 5. Leading Causes of Death, by State and City/Town, 2017

Rank	Massachusetts	Natick	Needham	Newton	Waltham	Wellesley	Weston
1	All-Site Cancer	Heart Disease	Heart Disease	All-Site Cancer	All-Site Cancer	Heart Disease	Heart Disease
2	Heart Disease	All-Site Cancer	All-Site Cancer	Heart Disease	Heart Disease	All-Site Cancer	All-Site Cancer
3	Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease	Stroke	Stroke	Chronic Lower Respiratory Disease	Chronic Lower Respiratory Disease	Stroke

DATA SOURCE: Massachusetts Department of Public Health, Massachusetts Deaths, 2017

In 2018 and 2019, across the six assessment communities the age-adjusted mortality rate was lower than that of the state; however, rates varied by town (**Figure 34**). In 2019, Natick had the highest mortality rate (601.7 deaths per 100,000). In contrast, Newton had the lowest mortality rate in 2019 (428.6 deaths per 100,000). Waltham had the second highest mortality rate (599.6 deaths per 100,000 population) in 2019. From 2016-2017, Natick, Needham, Newton, saw a decrease in mortality rate.

Figure 34. Age-Adjusted Mortality Rate per 100,000 Population by State and City/Town, 2018-2019

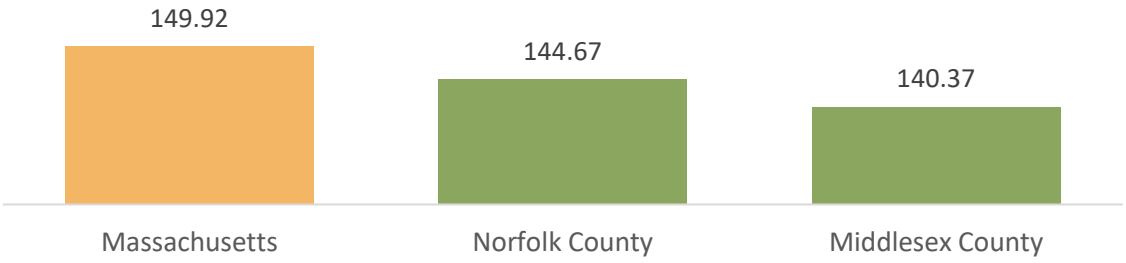


DATA SOURCE: MA Department of Public Health, Registry of Vital Records and Statistics, 2018-2019.

Chronic Diseases and Related Risk Factors

Cancer was a top three leading cause of death across Massachusetts and in the six towns in 2017 (Table 6). Norfolk County had a higher age-adjusted cancer mortality rate (144.67 per 100,000) due to all cancers, compared to Middlesex County (140.37 per 100,000) (**Figure 35**).

Figure 35. Age-Adjusted Cancer Mortality Rates per 100,000 by State and County, 2014-2018



DATA SOURCE: Massachusetts Cancer Registry, Cancer Mortality, 2014-2018

When examined by cancer type, as shown in **Table 6**, from 2014-2018, breast cancer mortality (10.3 deaths per 100,000 population) in Norfolk County exceeded the average for Massachusetts.

Table 6. Age-Adjusted Mortality due to Cancer by Type per 100,000 Population, by State and County, 2014-2018

Geography	Breast	Cervical	Colorectal	Lung	Prostate
Massachusetts	9.8	1.1	11.6	37.1	18.3
Middlesex County	9.1	1.1	11.3	33.3	16.7
Norfolk County	10.3	1.2	11.1	36.1	17.7

DATA SOURCE: Massachusetts Cancer Registry, Cancer Mortality, 2014-2018

The breast cancer incidence rate in Middlesex (101.5 cases per 100,000 population) and Norfolk (106.5 cases per 100,000 population) Counties exceeded the breast cancer incidence rate for Massachusetts overall (94.8 cases per 100,000 population) (**Table 7**). When compared to the state and Middlesex County, Norfolk County had higher incidence rates for colorectal (36.2 per 100,000) and prostate cancers (113.7 per 100,000). Both Middlesex and Norfolk counties had lower incidence rates of cervical cancer (4.7 per 100,000 and 4.2 per 100,000, respectively) compared to Massachusetts (5.5 per 100,000).

Table 7. Age-Adjusted Cancer Incidence Rate by Type per 100,000, by State and County, 2014-2018

Age-Adjusted Cancer Incidence Rate by Type per 100,000, by State and County, 2014-2018

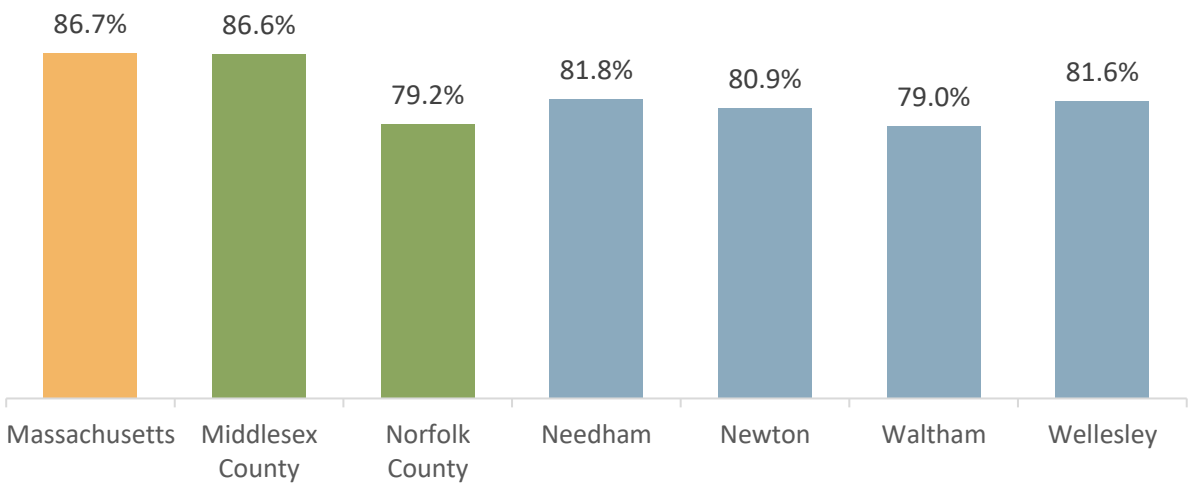
Geography	Breast	Cervical	Colorectal	Lung	Prostate
Massachusetts	94.8	5.5	36	61.4	108.8
Middlesex County	101.5	4.7	35.4	54.9	106.5
Norfolk County	106.2	4.2	36.2	60.4	113.7

DATA SOURCE: Massachusetts Cancer Registry, All Cancer Incidence, 2014-2018

In 2018, the proportion of female residents 50 to 74 years of age that reported receiving a mammogram in the past two years was lower in all four NWH service towns with data available (Needham: 81.8%, Newton: 80.9%, Waltham: 79.0%, and Wellesley: 81.6%) than breast cancer screening across Massachusetts (86.7%) than breast cancer screening across Massachusetts (86.7%) (**Figure 36**) In senior populations in all of the towns/cities in the NWH service, they had higher percentages of women with breast cancer compared to the state. In Massachusetts, 10.9% of women 65 years and older have breast cancer while 11.0% of Waltham, 12.7% of Natick, 12.8% of Weston, 13.2% of Newton, 13.5% of Needham, and 15.4% of Wellesley populations have breast cancer.[26]

[26] Massachusetts Healthy Aging Collaborative. 2018. "Community Profiles." https://mahealthyagingcollaborative.org/data-report/explore-the-profiles/community-profiles/

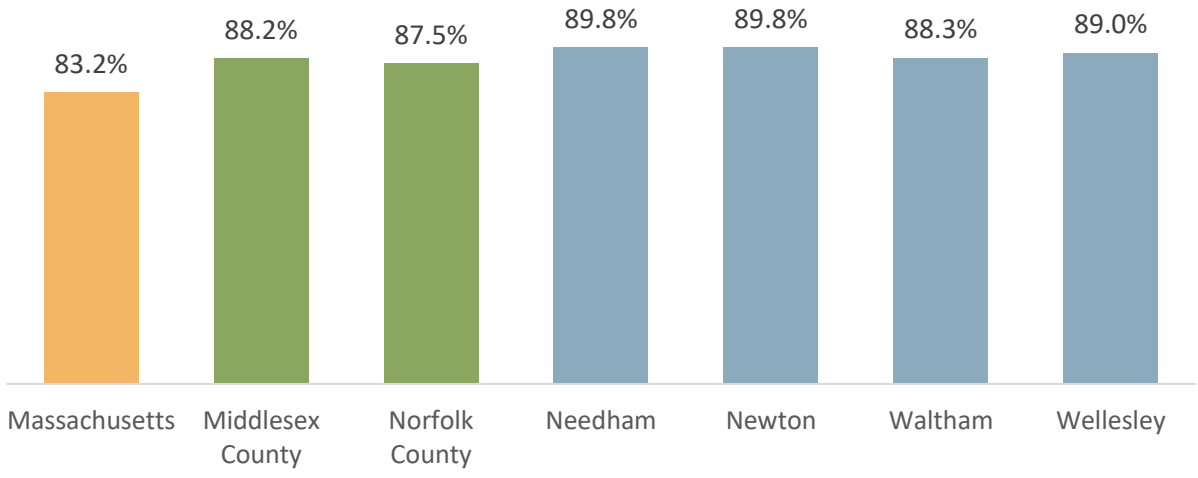
Figure 36. Percent of Female Adults (50-74 Years) who Reported Receiving a Mammogram within the Past 2 Years, by State, County, and City/Town, 2018



DATA SOURCE: Massachusetts Department of Public Health, Office of Data Management and Outcomes Assessment, A Profile of Health among Massachusetts Adults, 2018; Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018; County and City/Town data from Centers for Disease Control and Prevention, PLACES: Local Data for Better Health, 2018
NOTE: Data not available on PLACES for Natick and Weston; data are age-adjusted

In 2018, nearly nine in ten female residents 21 to 65 years of age in each of the NWH service towns reported receiving a pap test within the past three years, higher than the state overall (83.2%) (**Figure 37**).

Figure 37. Percent of Female Adults (21-65 years) who Reported Cervical Cancer Screening, by State, County, and City/Town, 2018

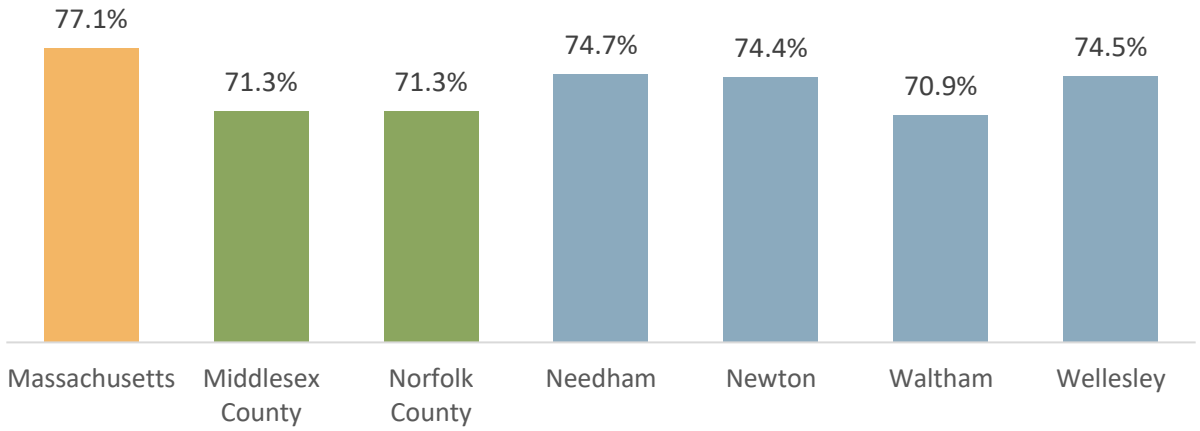


DATA SOURCE: Massachusetts Department of Public Health, Office of Data Management and Outcomes Assessment, A Profile of Health among Massachusetts Adults, 2018; Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance

System, 2018; County and City/Town data from Centers for Disease Control and Prevention, PLACES: Local Data for Better Health, 2018
NOTE: Data not available on PLACES for Natick and Weston; data are age-adjusted

In 2018, fewer than three-quarters of residents 50-75 years of age from regions served by NWH reported receipt of colon cancer screening within the time frames recommended by the US Preventive Services Task Force (**Figure 38**). In contrast, more than three-quarters (81.1%) of Massachusetts residents reported colon cancer screening within the recommended schedule in 2020.

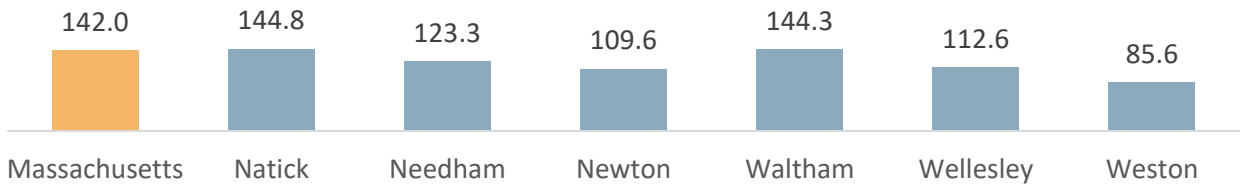
Figure 38. Percent of Adults (50-75 years) who Reported FOBT within Past Year, Sigmoidoscopy within Past 5 Years and FOBT within Past 3 Years, or Colonoscopy within Past 10 Years, by State, County, and City/Town, 2018



DATA SOURCE: Massachusetts Department of Public Health, Office of Data Management and Outcomes Assessment, A Profile of Health among Massachusetts Adults, 2018; Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018; County and City/Town data from Centers for Disease Control and Prevention, PLACES: Local Data for Better Health, 2018
NOTE: Data not available on PLACES for Natick and Weston; data are age-adjusted

In 2014, the age-adjusted heart disease mortality rate in Natick (144.8 deaths per 100,000 population) and Waltham (144.3 deaths per 100,000 population) was greater than the state average (142.0 deaths per 100,000 population). Weston (85.6 deaths per 100,000 population) had the lowest heart disease mortality rate in the NWH service area (**Figure 39**).

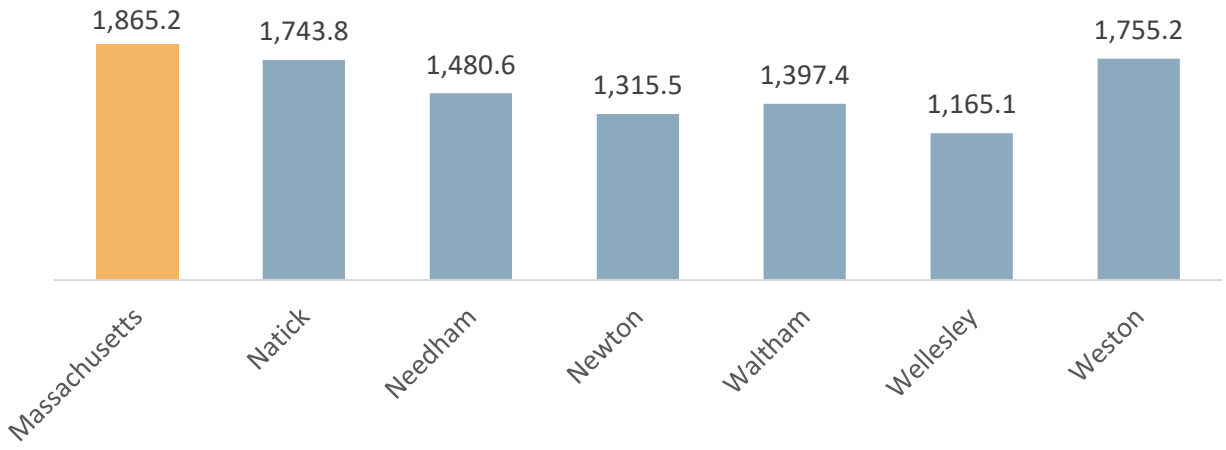
Figure 39. Age-Adjusted Mortality due to Heart Disease per 100,000 Population by State and City/Town, 2014



DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, 2014

In 2014, Weston (1,755.2 hospitalizations per 100,000 population) and Natick (1,743.8 hospitalizations per 100,000 population) had the highest cardiovascular disease hospitalization rate across the six assessment communities (**Figure 40**). The cardiovascular disease hospitalization rate was lowest in Wellesley (1,165.1 hospitalizations per 100,000 population) and Newton (1,315.5 hospitalizations per 100,000 population).

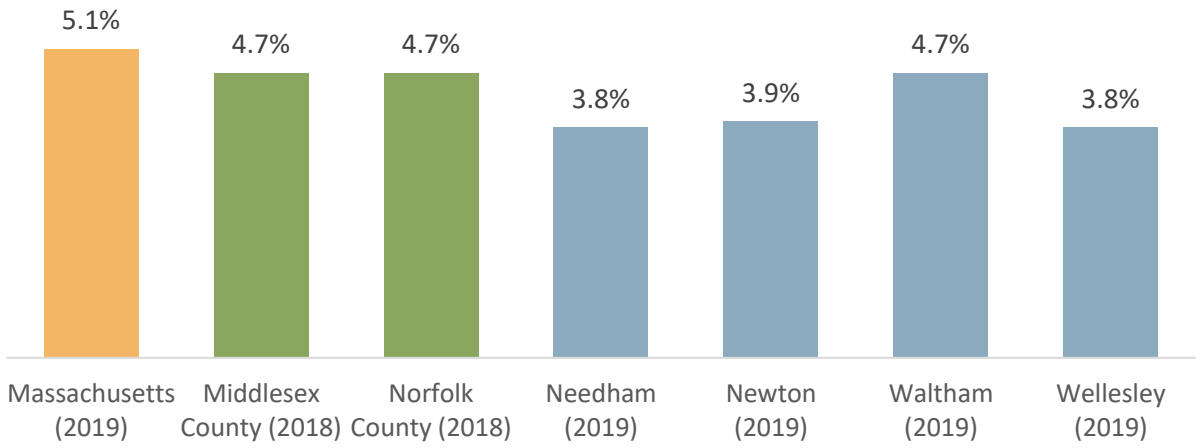
Figure 40. Cardiovascular Disease Hospitalization Rates per 100,000 population, by State and City/Town, 2014



DATA SOURCE: Center for Health Information and Analysis (CHIA), as cited by Massachusetts Department of Public Health, 2014

While local data on heart disease prevalence among adults are not available for all communities, in 2019 5.1% of Massachusetts adults reported a coronary heart disease diagnosis (**Figure 41**). In Middlesex and Norfolk Counties in 2018, the rate increased slightly to 4.7% with similar or slightly lower rates in Needham, Newton, Waltham, and Wellesley in 2019.

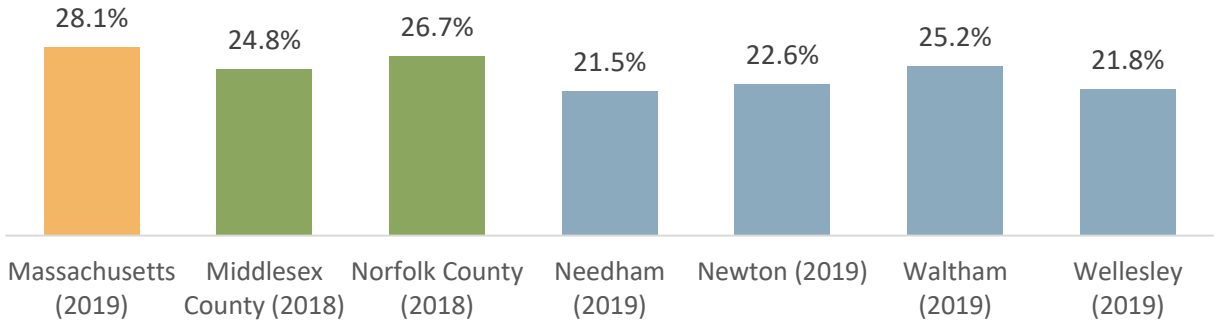
Figure 41. Percent of Adults (35 years and older) who Reported Coronary Heart Disease Diagnosis, by State, County, and City/Town, 2018 and 2019



DATA SOURCE: Massachusetts Department of Public Health, Office of Data Management and Outcomes Assessment, A Profile of Health among Massachusetts Adults, 2019; Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018, 2019; County and City/Town data from Centers for Disease Control and Prevention, PLACES: Local Data for Better Health, 2018, 2019
NOTE: Data not available on PLACES for Natick and Weston; data are age-adjusted

As shown in **Figure 42**, over one quarter of Massachusetts adults reported a high blood pressure diagnosis in 2019 (28.1%). In 2019, a slightly lower proportion of Needham, Newton, Waltham, and Wellesley adults reported being told by a health care provider that they had high blood pressure compared to the state.

Figure 42. Percent of Adults Ever Reported High Blood Pressure, by State, County, and City/Town, 2018 and 2019

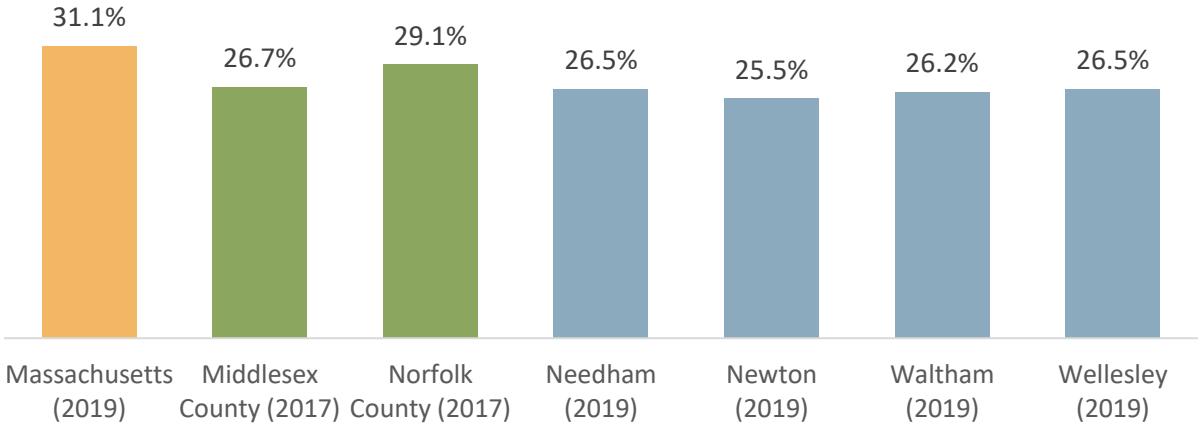


DATA SOURCE: Massachusetts Department of Public Health, Office of Data Management and Outcomes Assessment, A Profile of Health among Massachusetts Adults, 2019; Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018, 2019; County and City/Town data from Centers for Disease Control and Prevention, PLACES: Local Data for Better Health, 2018, 2019
NOTE: Data not available on PLACES for Natick and Weston; data are age-adjusted

In 2015, nearly one-third of Massachusetts adults reported a high cholesterol diagnosis (30.1%, data not shown). Four years later, the state prevalence of high cholesterol diagnoses increased to 31.1% (**Figure**

43). At the town level, the prevalence of high cholesterol among adults was slightly lower than the Massachusetts average in 2019.

Figure 43. Percent of Adults with High Cholesterol among Those Screened in the Past 5 Years, by State, County, and City/Town, 2017 and 2019



DATA SOURCE: Massachusetts Department of Public Health, Office of Data Management and Outcomes Assessment, A Profile of Health among Massachusetts Adults, 2019; Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018, 2019; County and City/Town data from Centers for Disease Control and Prevention, PLACES: Local Data for Better Health, 2018, 2019
NOTE: Data not available on PLACES for Natick and Weston; data are age-adjusted

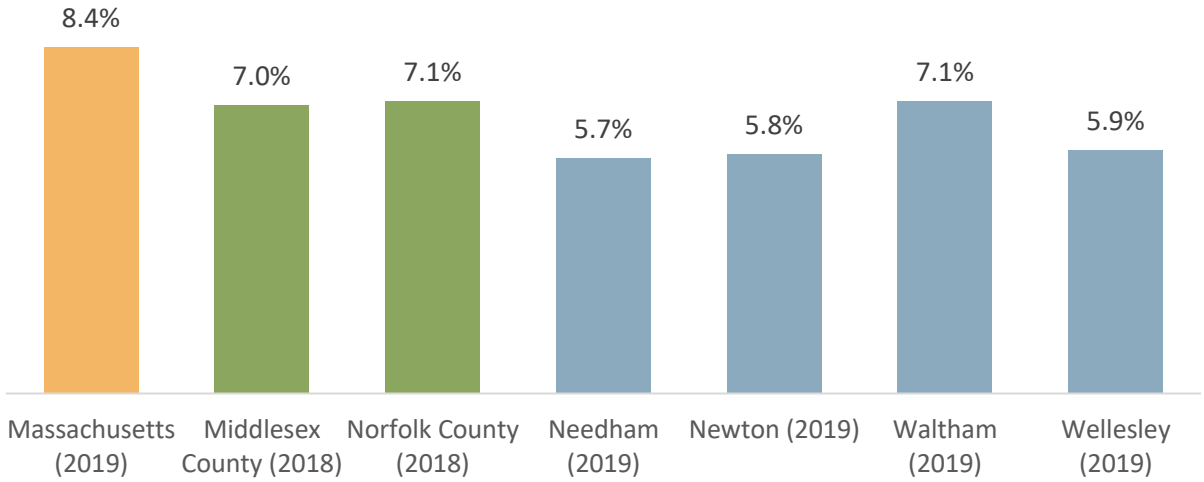
High blood pressure is a significant issue in senior populations 65 years and older. According to the Massachusetts Healthy Aging Collaborative, in Waltham, 75.4% of senior residents had high blood pressure and in Natick, 74.1% of senior residents had high blood pressure.[27]

In 2018, 7.7% of adults across Massachusetts reported being diagnosed with diabetes (data not shown). Prevalence of diabetes in 2019 increased slightly (8.4%) at the state level, with Middlesex County (7.0%), Norfolk County (7.1%) in 2018, and service towns falling below state levels in 2019 (**Figure 44**).

According to the Massachusetts Healthy Aging Collaborative, diabetes is a significant issue in senior populations 65 years and older with around a quarter to a third of senior populations having diabetes, which is much higher than the average adult population. In Natick and Needham, the percentage of seniors with diabetes is as high as 31.6%.[28]

[27] Massachusetts Healthy Aging Collaborative. 2018. "Community Profiles." https://mahealthyagingcollaborative.org/data-report/explore-the-profiles/community-profiles/
[28] Massachusetts Healthy Aging Collaborative. 2018. "Community Profiles." https://mahealthyagingcollaborative.org/data-report/explore-the-profiles/community-profiles/

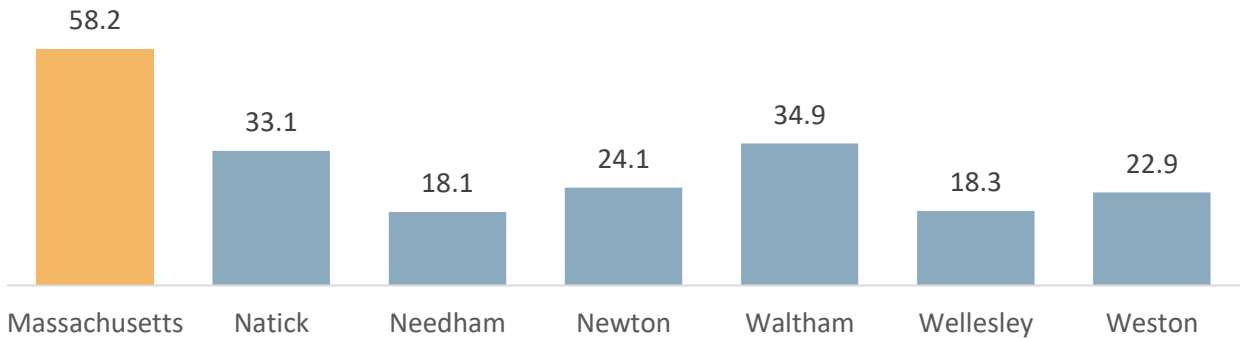
Figure 44. Percent of Adults Aged 18+ Years with Diagnosed Diabetes by State, County, and City/Town, 2018 and 2019



DATA SOURCE: Massachusetts Department of Public Health, Office of Data Management and Outcomes Assessment, A Profile of Health among Massachusetts Adults, 2019; Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018, 2019; County and City/Town data from Centers for Disease Control and Prevention, PLACES: Local Data for Better Health, 2018, 2019
NOTE: Data not available on PLACES for Natick and Weston; data are age-adjusted

In 2017, the asthma emergency department visit rate was greatest for Waltham (34.9 ED visits per 100,000 population) and Natick residents (33.1 ED visits per 100,000 population; **Figure 45**). However, the asthma emergency department visit rate was lower across towns served by NWH than Massachusetts (58.2 ED visits per 100,000).

Figure 45. Asthma Emergency Department (ED) Visit Rates per 100,000 Population, by State and City/Town, 2017

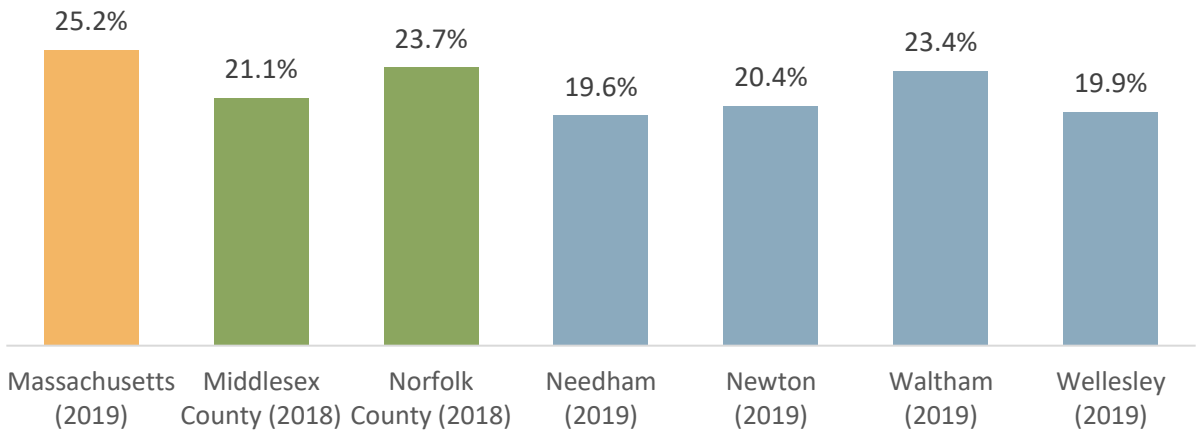


DATA SOURCE: Massachusetts Department of Public Health, Population Health Information Tool (PHIT), 2017

The prevalence of obesity among adults 18 years of age and older was slightly lower in Middlesex (21.1%) and Norfolk (23.7%) counties in 2018, compared to Massachusetts overall (25.2%) in 2019

(**Figure 46**). Newton had a slightly lower prevalence of adult obesity (19.6%) compared to Needham, Waltham, and Wellesley in 2019.

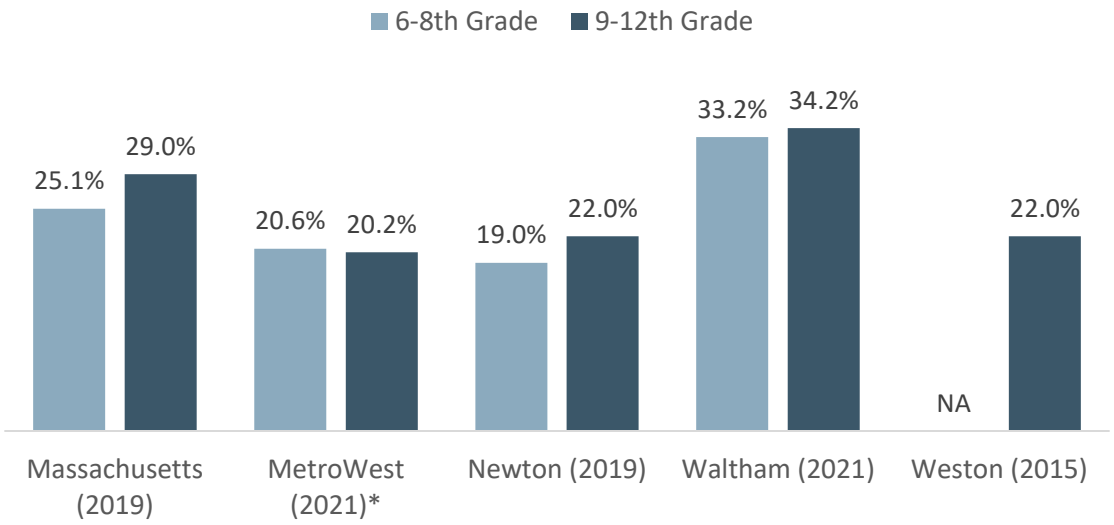
Figure 46. Percent of Adults 18+ who Are Obese, by State, County, and City/Town, 2018 and 2019



DATA SOURCE: Massachusetts Department of Public Health, Office of Data Management and Outcomes Assessment, A Profile of Health among Massachusetts Adults, 2019; Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018, 2019; County and City/Town data from Centers for Disease Control and Prevention, PLACES: Local Data for Better Health, 2018, 2019
NOTE: Data not available on PLACES for Natick and Weston; data are age-adjusted

In 2019, approximately a quarter of 6 – 8th graders (25.1%) and 9 – 12th graders (29.0%) in Massachusetts were identified as being overweight or obese. In 2019, the prevalence of overweight or obese 6 – 8th and 9 – 12th graders in Waltham (41.3% and 34.8%, respectively) was higher compared to the same age groups in Newton (19.0% and 22.0%, respectively) (**Figure 47**).

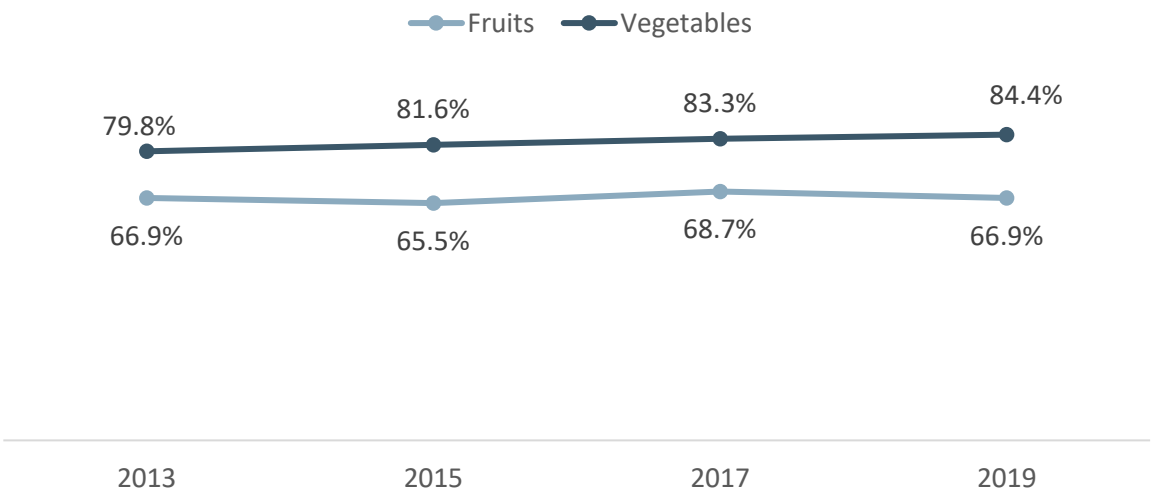
Figure 47. Percent of Students (Grades 6-8 & 9-12) who are Overweight or Obese, by State and Select City/Town, 2015-2021



DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Health Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015
NOTE: *All communities included middle school students in grades 6-8, except for MetroWest, which only includes students in grades 7-8. Data for the other assessment communities were not available. MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley.

In 2019, 84.4% of Massachusetts adults reported consuming vegetables at least once daily (Figure 40), an approximately 5% increase from 2013 (**Figure 48**). Compared to vegetable consumption, the proportion of adults who reported eating fruit at least once a day was lower (66.9%) in 2019. This proportion has remained relatively consistent between 2013 and 2019.

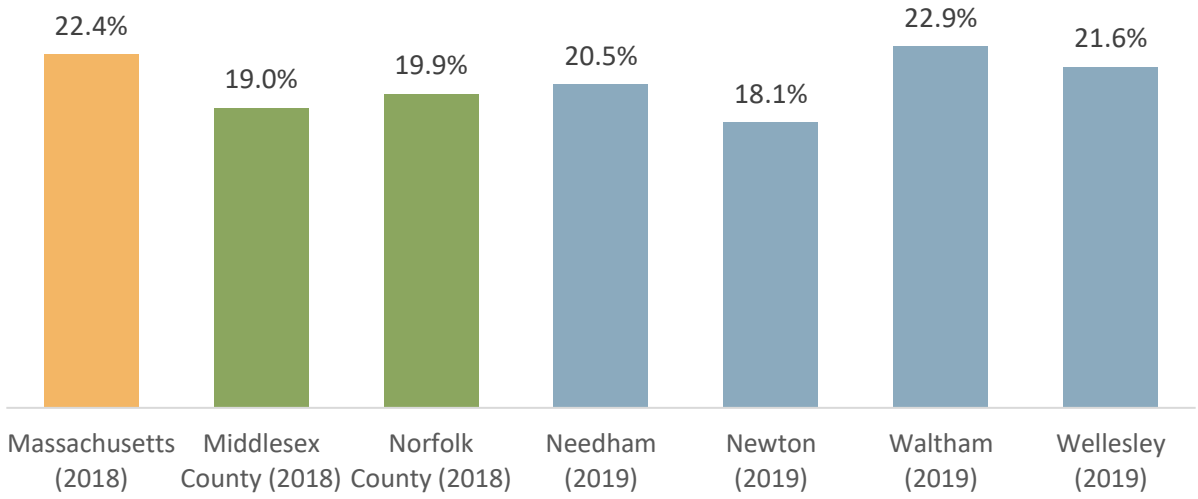
Figure 48. Percent of Adult Population Consuming Fruits and Vegetables At least One Time per Day in the State of Massachusetts, 2013-2019



DATA SOURCE: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2013-2019
NOTE: Age-adjusted

As shown in **Figure 49**, approximately one-in-five adults in Middlesex (19.0%) and Norfolk Counties (19.9%) reported no leisure time physical activity in 2018. Newton (18.1%) had the lowest reported leisure time physical activity among the towns served by NWH.

Figure 49. Percent of Adult Population Over 18 Years Reported No Leisure Time Physical Activity, by State, County, and City/Town, 2018 and 2019

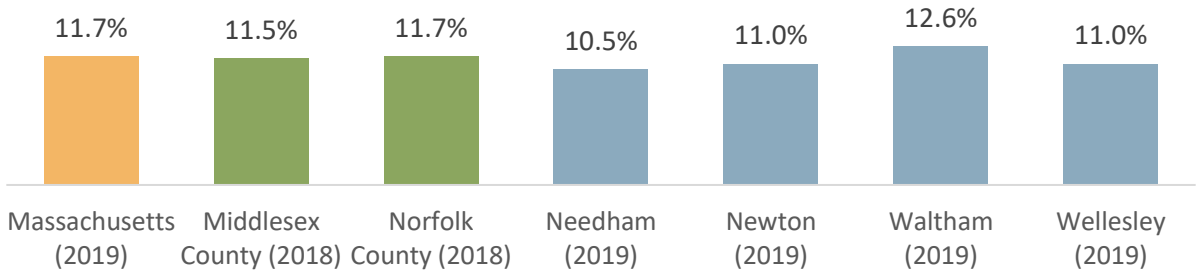


DATA SOURCE: Massachusetts Department of Public Health, Office of Data Management and Outcomes Assessment, A Profile of Health among Massachusetts Adults, 2018; Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018, 2019; County and City/Town data from Centers for Disease Control and Prevention, PLACES: Local Data for Better Health, 2018, 2019
NOTE: Data not available on PLACES for Natick and Weston; data are age-adjusted

Mental Health

To assess mental health status among adults, the Behavioral Risk Factor Surveillance System survey asks respondents whether they experienced poor mental health, or feelings of sadness and depression for at least 15 days in the past month. As shown in **Figure 50**, Middlesex (11.5%) and Norfolk (11.7%) County adults were similarly likely to report experiencing poor mental health in 2018 as residents statewide (11.7%) in 2019. Among the towns with available data, Waltham had the highest percentage of adults with poor mental health, at 12.6% compared to about 10.5% of adults in Needham.

Figure 50. Percent of Adults Reporting 15 or More Days of Poor Mental Health per Month, by State, County, and City/Town, 2018 and 2019



DATA SOURCE: Massachusetts Department of Public Health, Office of Data Management and Outcomes Assessment, A Profile of Health among Massachusetts Adults, 2019; Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018, 2019; County and City/Town data from Centers for Disease Control and Prevention, PLACES: Local Data for Better Health, 2018, 2019
NOTE: Data not available on PLACES for Natick and Weston; data are age-adjusted

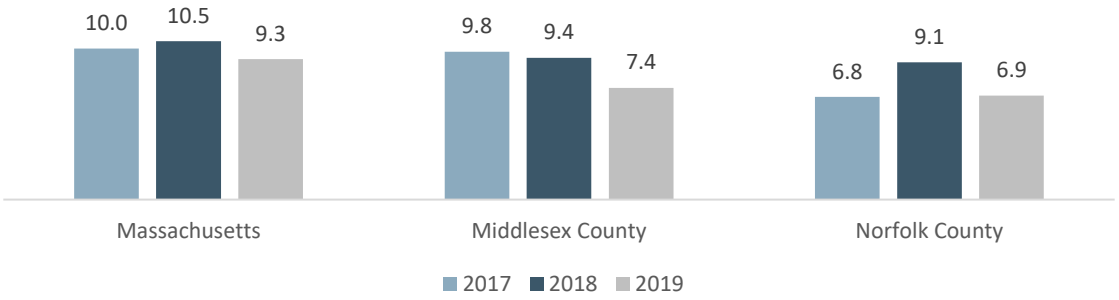
Mental health was a topic that came up across all of the focus groups and interviews and was repeatedly identified by participants as a priority area for community improvement efforts. Participants discussed the broad impact of a lack of providers for and affordable mental health services, and stigma and silence around mental health in general; one participant stated, “Mental wellness is not talked about as much, and I think in general, people don’t see it as being important.” This stigma was described as further permeating specific communities with different customs and traditions surrounding mental health; a participant illustrated this when they said, “One of the things we discovered is that parents – especially immigrant parents – don’t believe in mental health,” then continued on to say “stereotypes exist about men needing to be in touch and people get isolated and don’t reach out.” Another participant described this stigma: “The mental health stigma in immigrant families is so real. They think it is a White person problem...They think that POC can’t have as many mental health issues as White people." This stigma was further discussed as an issue that affects the children of immigrant parents; a participant stated, “they [immigrant parents] are not educated on mental health, and they shut us down when we do open up about mental health with them.”

In addition to the stereotypes and stigma surrounding mental health, focus group participants highlighted youth and young adults and seniors as key populations that are particularly impacted by mental health-related challenges. One participant described mental health challenges within the youth and young adult population as a result of environmental factors: “Teens and young adults or even children are really struggling. Wars and rumors of wars...Young people are having a hard time dealing with that and thinking about their future. Everything from climate issues to police brutality and all the different social issues throughout America.” Students that participated in a focus group similarly highlighted mental health as one of the main issues facing youth and young adults in their communities. Participants acknowledged the existence of mental health resources in their communities, however they discussed a need for more prevention and educational programming to make others aware of the available resources; a participant said “I think we could teach students more coping mechanisms if stress leads to vaping, and really try to get the resources out there to help with stress,” another stated, “we should try and connect students to use those [mental health] services.”

When discussing mental health within the senior population, focus group participants explain how challenges faced by the general population are further exacerbated within this particularly marginalized subgroup. One participant explains, “untreated mental health issues lead to a lot of barriers to all kinds of services and can lead to issues with seniors living in housing, possibly leading to eviction,” another participant highlighted that “some providers only do telehealth,” which is not always accessible, particularly for the senior population that struggles with computer literacy.

As shown in **Figure 51**, from 2017 to 2019, the suicide rate in Massachusetts ranged from 10.0 to 9.3 deaths per 100,000 population, the suicide rate in Middlesex County ranged from 9.8 to 7.4, and the suicide rate in Norfolk County ranged from 6.8 to 6.9.

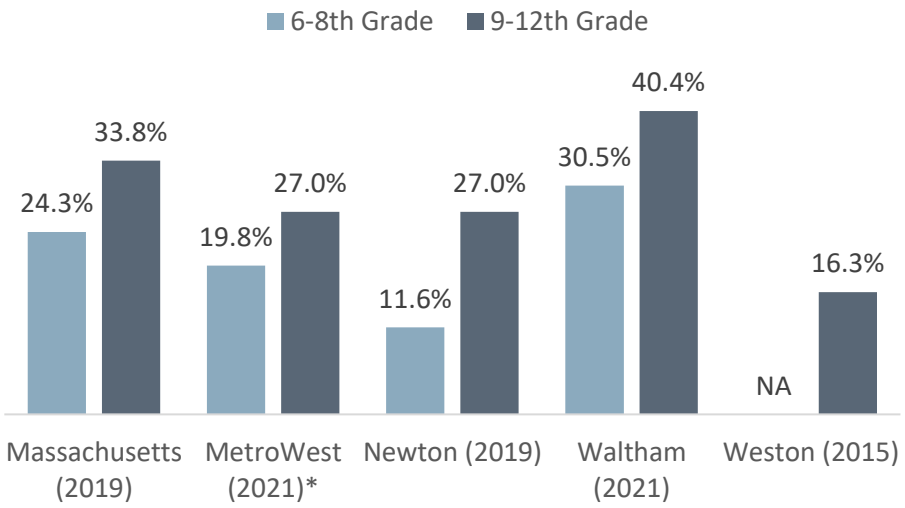
Figure 51. Suicide Mortality per 100,000 Population by State and County, 2017-2019



DATA SOURCE: Massachusetts Department of Public Health, Massachusetts Violent Death Reporting System, Injury Surveillance Program

In 2015 - 2021, the percent of high school students reporting symptoms of depression was higher in Waltham (40.4%) compared to Newton (27.0%), Weston (16.3%), and the MetroWest region (27.0%) and Massachusetts (33.8%) overall (**Figure 52**). Nearly one-fourth of middle school youth (24.3%) across Massachusetts reported symptoms of depression in 2019, slightly higher when compared with the assessment communities and the MetroWest region (19.8%) overall.

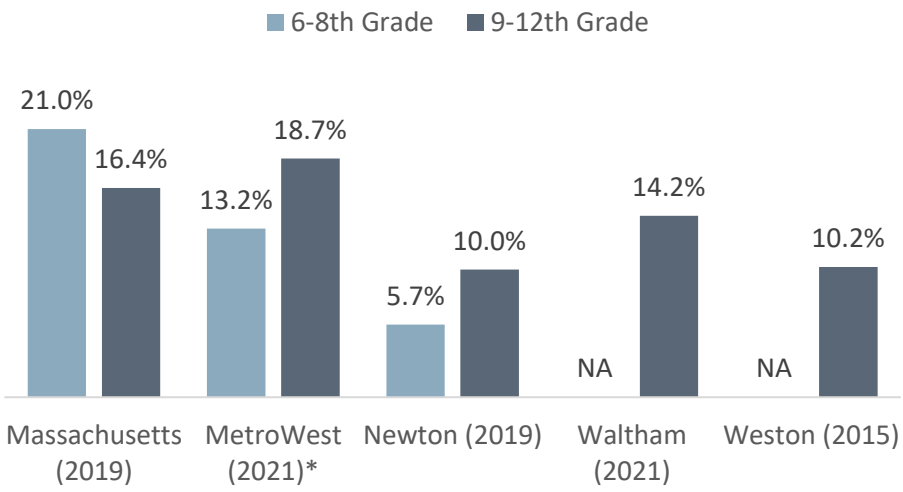
Figure 52. Percent of Students (Grades 6-8 & 9-12) with Symptoms of Depression by State and City/Town, 2015-2021



DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Health Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015
NOTE: * includes students in grades 7-8. Data for the other assessment communities were not available. MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley

In 2015-2021, high school youth in Waltham (14.2%) had the highest prevalence of reported self-harm compared to the other assessment communities for which data were available (**Figure 53**). However, compared to their peers statewide (16.4%), there was a lower percentage of high school youth indicating self-harm for each of the assessment communities for which data were available. Newton was the only assessment community where data pertaining to self-harm was reported by middle school students. The prevalence of self-harm among Newton middle school youth (5.7%) was lower compared to MetroWest (13.2%) and Massachusetts (21.0%) overall.

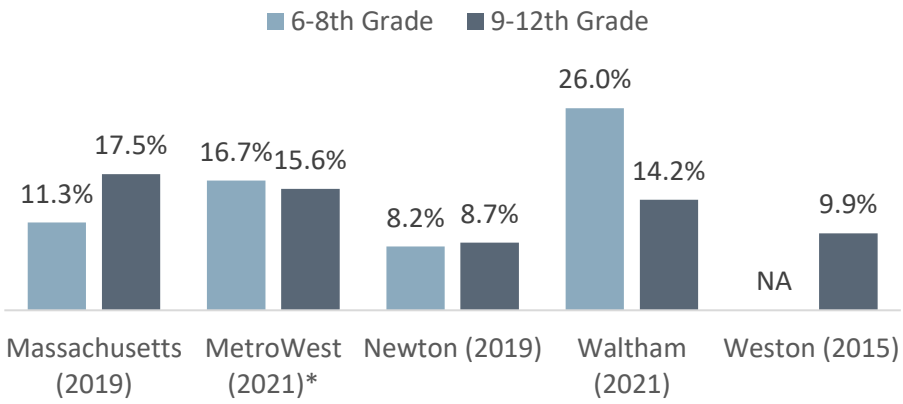
Figure 53. Percent of Students (Grades 6-8 & 9-12) Reporting Self Harm, by State and City/Town, 2015-2021



DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Health Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015
NOTE: * includes students in grades 7-8. Data for the other assessment communities were not available. MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley

As shown in **Figure 54**, more than one-fourth of middle school students (26.0%) in Waltham reported suicide ideation in 2021, an increase from the previous CHNA (12.7%). This percentage was also considerably higher compared to Newton (8.2%), the MetroWest region (16.7%), and Massachusetts overall (11.3%). The percentage of high school students reporting suicide ideation in Waltham (14.2%) was comparable to both the MetroWest region (15.6%) and the state (17.5%), though higher when compared to Newton (8.7%) and Weston (9.9%).

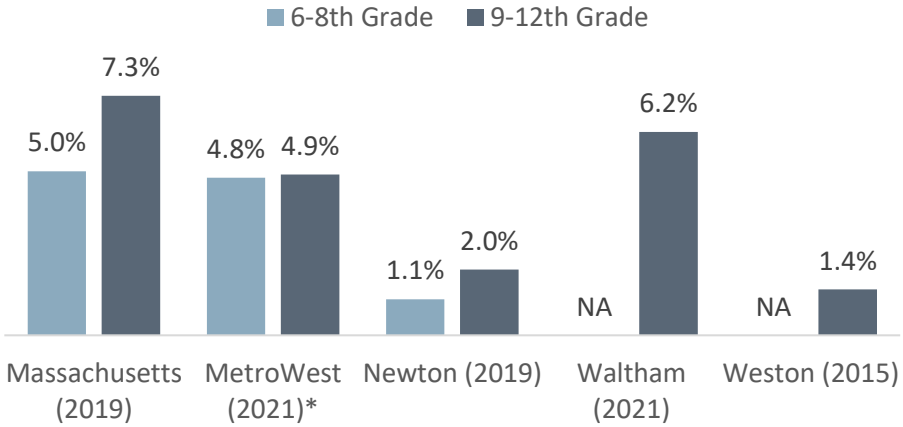
Figure 54. Percent of Students (Grades 6-8 & 9-12) Reporting Suicide Ideation, by State and City/Town, 2015-2021



DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Health Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015
NOTE: * includes students in grades 7-8. Data for the other assessment communities were not available. MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley

In 2015-2021, middle school student reports of a past suicide attempt were similar in the MetroWest region (4.8%) compared to the state (5.0%). For high school youth, the prevalence of suicide attempts was highest in Waltham (6.2%) and lowest in Weston (1.4%) and was below the state average (7.3%) for all the assessment communities (**Figure 55**).

Figure 55. Percent of Students Reporting Suicide Attempt, by State and City/Town, 2015-2021



DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Health Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015
NOTE: * includes students in grades 7-8. Data for the other assessment communities were not available. MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley.

Substance Use

Both quantitative and qualitative data suggest that substance use is a challenge for the communities in the NWH service area. Focus group participants identified stigma as a major barrier to accessing treatment and recovery services. One said, "Stigma is alive and well. Stigma continues to be the number one block in solving this issue." Participants explained that "through education we can reduce the stigma" and further expressed a need for a more open dialogue around the topics of substance use and substance use disorder. One participant stated their hope for an environment where, "a kid can come forward to a teacher, parent, or friend and say that I have a problem with drugs and does not feel afraid or ashamed." Young adult focus group participants similarly expressed a desire for more educational programming around the risks associated with substance use. Discussions about substance use in the focus groups focused primarily on challenges accessing quality treatment. Similar to challenges accessing general mental health services, focus group participants highlighted a lack of availability for beds in treatment facilities. Participants also highlighted the challenges of accessing treatment when holding intersecting marginalized identities; one participant said, "Substance abuse SUD treatment is not very accessible to the deaf and hard of hearing population. There are no specific substance abuse treatment centers that are really in ASL or geared towards the deaf and hard of hearing community. So that makes the deaf and hard of hearing people not willing to go for treatment because they know they're not going to have communication access."

Table 8 shows the rates of admissions to Bureau of Substance Abuse Services (BSAS)-funded and licensed treatment programs. In FY 2017, the number of total admissions was highest for residents of Waltham (431 admissions) and Newton (227 admissions). Admissions where alcohol was the primary substance of use were most common in the assessment focus areas, whereas heroin was the most common primary substance in admissions in Massachusetts overall. Of the assessment communities, Newton had the highest proportion of admissions where heroin was the primary substance (41.0% of all admissions), followed by Waltham (39.9%) and Wellesley (34.1%).

Table 8. Total Admissions to DPH Funded Treatment Programs and Percent Admissions by Primary Substance of Use, by State and City/Town, FY 2017

		Percent Admissions by Primary Substance of Use				
	Total Admissions to BSAS Funded/Licensed Treatment Programs	**Alcohol**	**Heroin**	**Marijuana**	**Crack/ Cocaine**	**Other Opioids**
Massachusetts	98,944	32.8%	52.8%	3.5%	4.1%	4.6%
Natick	211	51.7%	34.1%	5.2%	3.3%	3.3%
Needham	0-100	50.8%	30.5%	*	*	*
Newton	227	44.5%	41.0%	4.8%	2.6%	4.4%
Waltham	431	48.5%	39.9%	3.2%	1.6%	5.8%
Wellesley	0-100	50.0%	34.1%	*	*	*
Weston	0-100	70.0%	*	*	*	*

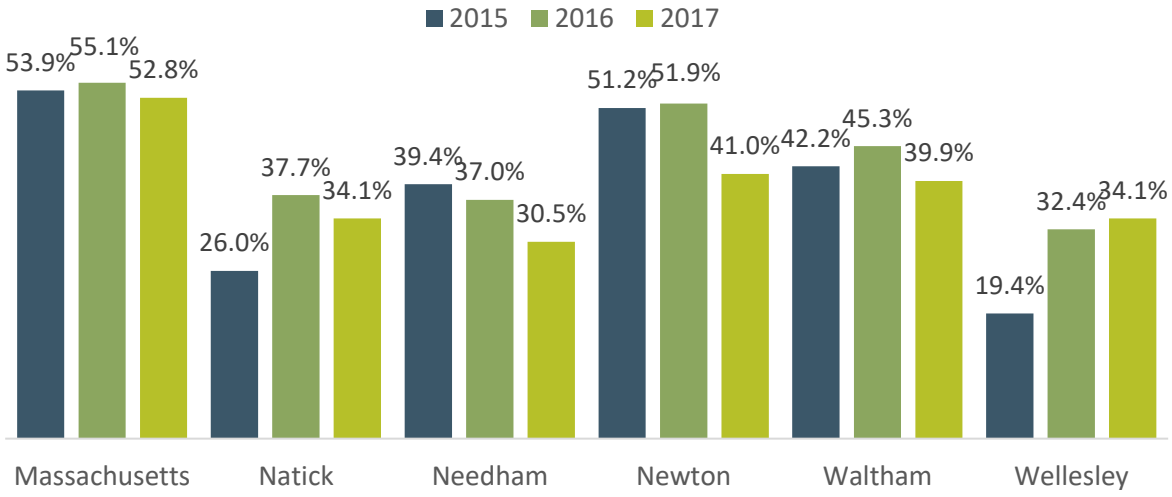
DATA SOURCE: Massachusetts Department of Public Health, Bureau of Substance Abuse Services, Geographic Fact Sheets Report, FY 2017

Note: * Number of total admissions missing/unknown values for primary drug

In 2017, among patients admitted for substance use treatment, Newton (41.0%) and Waltham (39.9%) had the highest percent of patients admitted where heroin was the primary substance of use (**Figure**

56). From 2015 to 2017, the prevalence of heroin-related treatment decreased in four of the five NWH assessment communities. Patients seeking treatment for heroin use increased in Wellesley from 32.4% in 2016 to 34.1% in 2017.

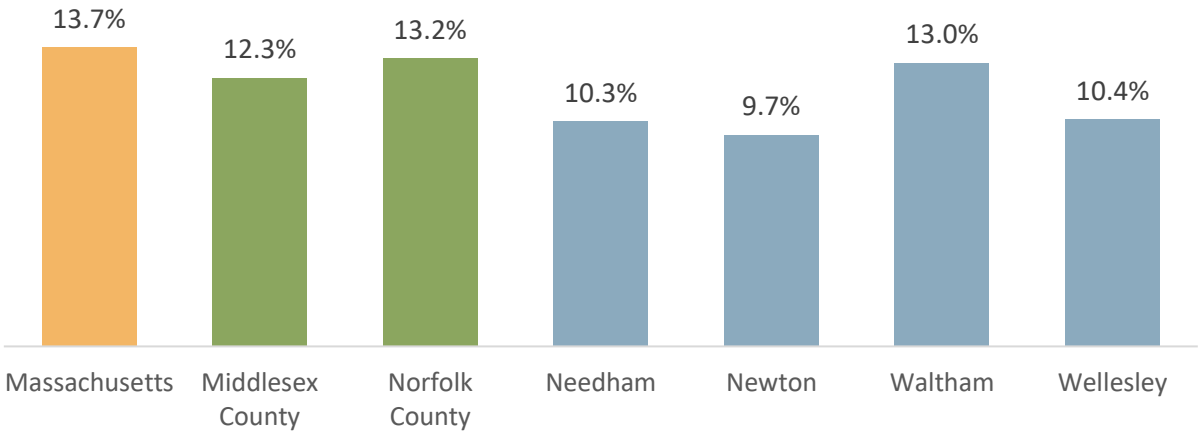
Figure 56. Percent of Patients in Treatment Listing Heroin as Their Primary Substance of Use, by State and City/Town, 2015-2017



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Substance Abuse Services, Geographic Fact Sheets Report FY 2017, 2015-2017
NOTE: Data not available for Weston

In 2018, approximately one in ten adults in Middlesex (12.3%) and Norfolk (13.2%) Counties reported that they currently smoked, a prevalence similar to Massachusetts overall (13.7%) (**Figure 57**). this is consistent with the prevalence reported in the previous CHNA. Of the focal communities, Waltham had the highest percentage of adults that reported smoking (13.0%), followed by Wellesley (10.4%), Needham (10.3%), and Newton (9.7%).

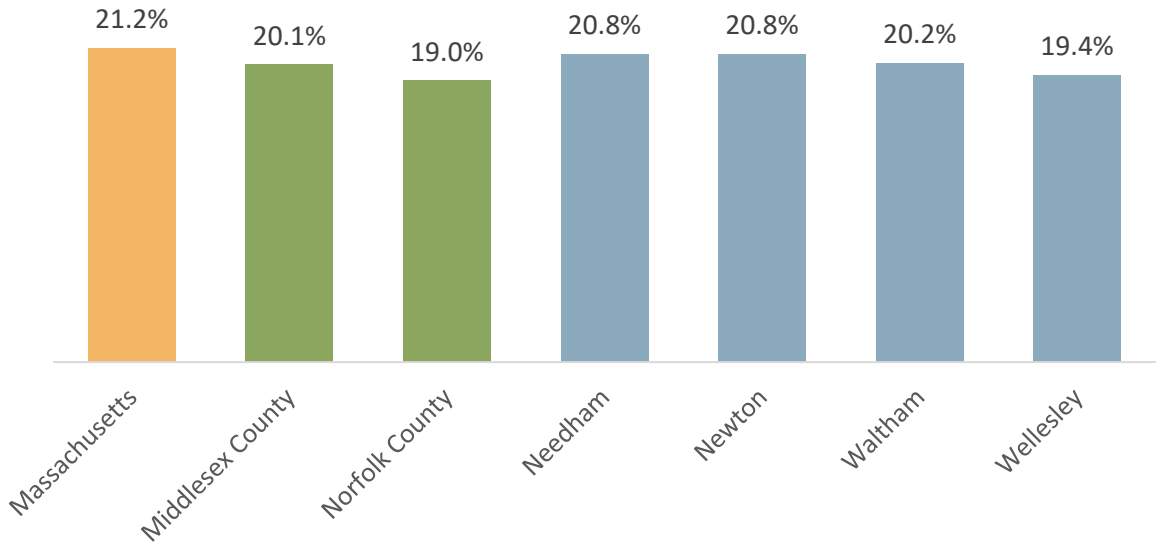
Figure 57. Percent of Adults Who Report Current Smoking, by State, County, and City/Town, 2018



DATA SOURCE: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018; County and City/Town data from Centers for Disease Control and Prevention, PLACES: Local Data for Better Health, 2018
NOTE: Data not available on PLACES for Natick and Weston; data are age-adjusted

In 2018, approximately one-fifth of adults in Middlesex and Norfolk Counties reported excessive/binge drinking (20.1% and 19.0%, respectively) (**Figure 58**). This was comparable to proportion in the focus communities and Massachusetts overall.

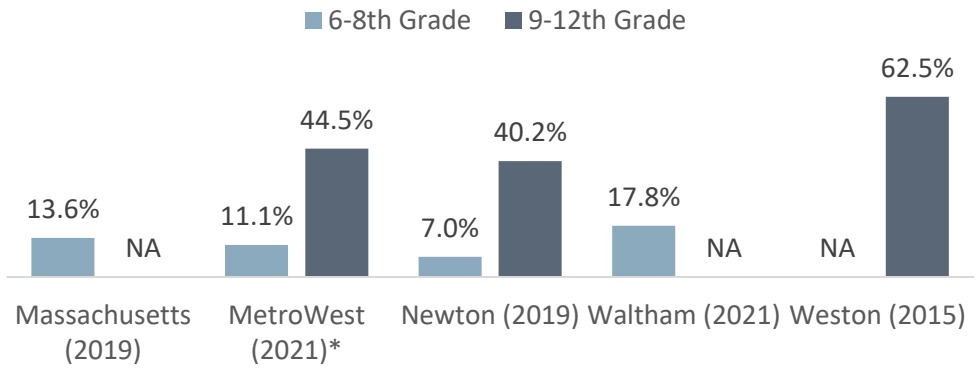
Figure 58. Percent of Adults Who Report Binge Drinking, by State, County, and City/Town, 2018



DATA SOURCE: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2018; County and City/Town data from Centers for Disease Control and Prevention, PLACES: Local Data for Better Health, 2018
NOTE: Data not available on PLACES for Natick and Weston; data are age-adjusted

Among middle school youth, lifetime alcohol use was highest in Waltham (17.8%), followed by MetroWest (11.1%) and Newton (7.0%) (**Figure 59**). Of the four NWH service area cities/towns, only Waltham had a prevalence among middle school students that exceeded the state (13.6%). Among high school students, less than five in ten high school students in the MetroWest region (44.5%) and Newton (40.2%) reported alcohol use in their lifetime in 2019-2021. Prevalence of lifetime alcohol use was highest among 9-12th grade youth in Weston (62.5%).

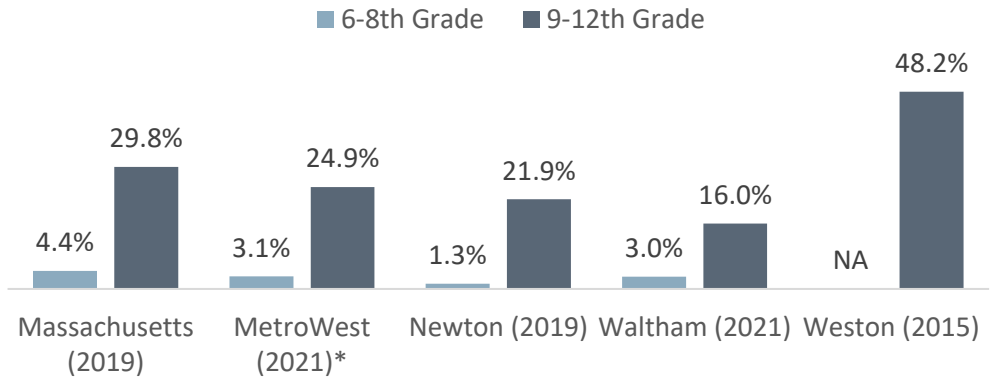
Figure 59. Percent of Students Reporting Lifetime Alcohol Use, by State and City/Town, 2015-2021



DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Health Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015
NOTE: * includes students in grades 7-8. Data for the other assessment communities were not available. MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley

During the 2015 to 2021 period, current alcohol use among middle school youth was below the state average (4.4%) (**Figure 60**). The prevalence of current alcohol use among high school students ranged from less than one-quarter in Waltham (20.7%) to approximately half of students in Weston (48.2%) during the 2015 to 2019 period. Weston was the only assessment community where current alcohol use among high school youth exceeded the prevalence for Massachusetts youth overall (31.4%).

Figure 60. Percent of Students Reporting Current Alcohol Use, by State and City/Town, 2015-2021

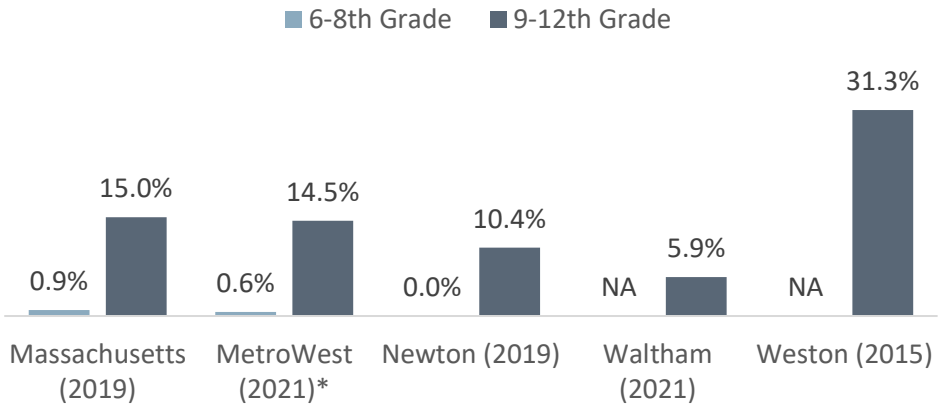


DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Health Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015
NOTE: * includes students in grades 7-8. Data for the other assessment communities were not available. MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley

Following patterns for lifetime and current alcohol use, in 2015-2021 nearly one-third (31.3%) of high school students in Weston reported binge drinking, a prevalence that was double that for Massachusetts overall (15.0%) and exceeded the prevalence across the other NWH service area cities/towns for which data were available (**Figure 61**). Among middle school students, reported binge

drinking among MetroWest (0.6%) was similar to patterns for Massachusetts overall (0.9%) during the 2019 to 2021 period. Since the 2015 CHNA and 2018 CHNA, binge drinking among middle school students declined slightly across Massachusetts (3.0% to 1.5% to 0.8%).

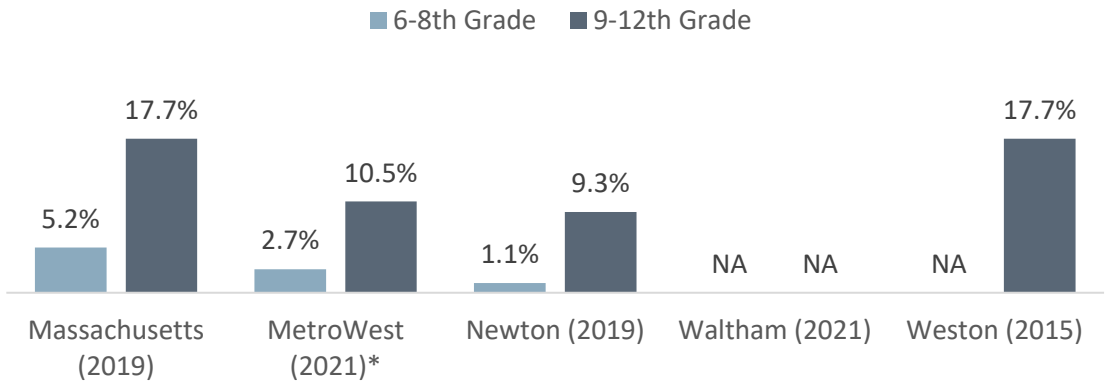
Figure 61. Percent of Students Reporting Current Binge Alcohol Use, by State and City/Town, 2015 – 2021



DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Health Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015
NOTE: MA Youth Health Risk Report defined binge drinking as: Having four or more drinks of alcohol in a row for female students or five or more drinks of alcohol in a row for male students, within a couple of hours, on at least 1 day during the 30 days before the survey
NOTE: * MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley

Over the 2019 to 2021 period, a lower percent of middle school youth in each of the five assessment communities for which data were available reported lifetime cigarette use compared to their peers statewide (5.2%) (**Figure 62**). Among middle school youth, the prevalence of lifetime cigarette use was highest in the MetroWest region (2.7%). The prevalence of lifetime cigarette use among high school youth was also either equal to or lower in each of the four assessment communities compared to Massachusetts overall (17.7%) during the 2015 to 2021 period. Lifetime cigarette use was highest for high school youth in Weston (17.7%) and the MetroWest region (10.5%) and lowest in Newton (9.3%).

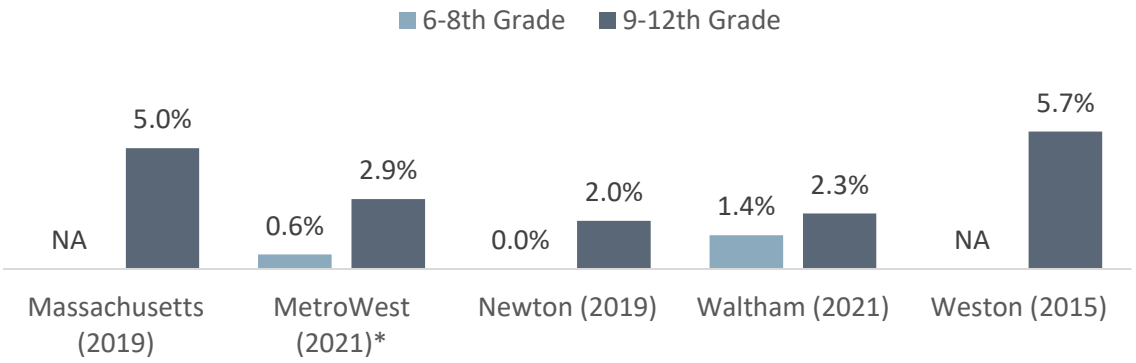
Figure 62. Percent of Students Reporting Lifetime Cigarette Use, by State and City/Town, 2015-2021



DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Health Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015
NOTE: * includes students in grades 7-8. Data for the other assessment communities were not available. MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley

As shown in **Figure 63**, during the 2015 to 2021 period, current cigarette use among middle school students in Waltham (1.4%) was the highest. In the four assessment communities for which data are available, except for Weston (5.7%), a lower percent of high school youth reported current cigarette use than their peers statewide (5.0%). Current cigarette use among high school students was highest in Weston (5.7%) and lowest in Newton (2.0%).

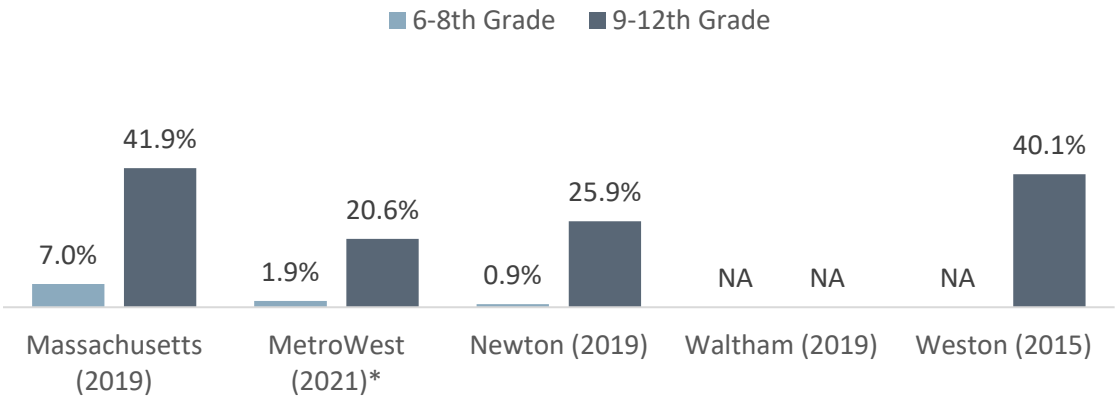
Figure 63. Percent of Students Reporting Current Cigarette Use, by State and City/Town, 2015-2021



DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Health Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015
NOTE: * includes students in grades 7-8. Data for the other assessment communities were not available. MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley

As shown in **Figure 64**, among middle school students, lifetime marijuana use was highest in the MetroWest region (1.9%), followed by Newton (0.9%), and did not exceed the state (7.0%) for any of the cities/towns in the assessment region. Among high school students in all the NWH service area cities/towns the prevalence of lifetime marijuana use was lower than Massachusetts overall (41.9%). In the assessment region, lifetime marijuana use was lowest in Newton (25.9%).

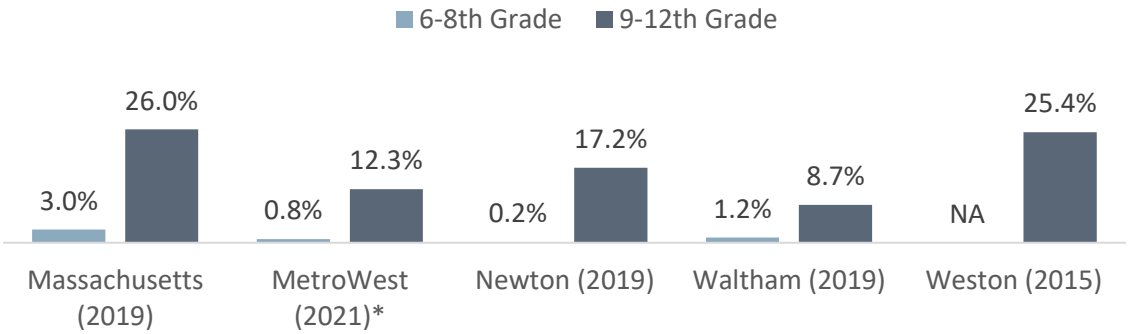
Figure 64. Percent of Students Reporting Lifetime Marijuana Use, by State and City/Town, 2015-2021



DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Youth Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015
NOTE: * includes students in grades 7-8. Data for the other assessment communities were not available. MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley

Shown in **Figure 65**, current marijuana use among middle school students in the cities/towns in the assessment region was lower than the state (3.0%). During the 2015 to 2019, period, one-quarter of Weston (25.4%) high school students reported current marijuana use, similar to the statewide prevalence (26.0%).

Figure 65. Percent of Students Reporting Current Marijuana Use, by State and City/Town, 2015-2021



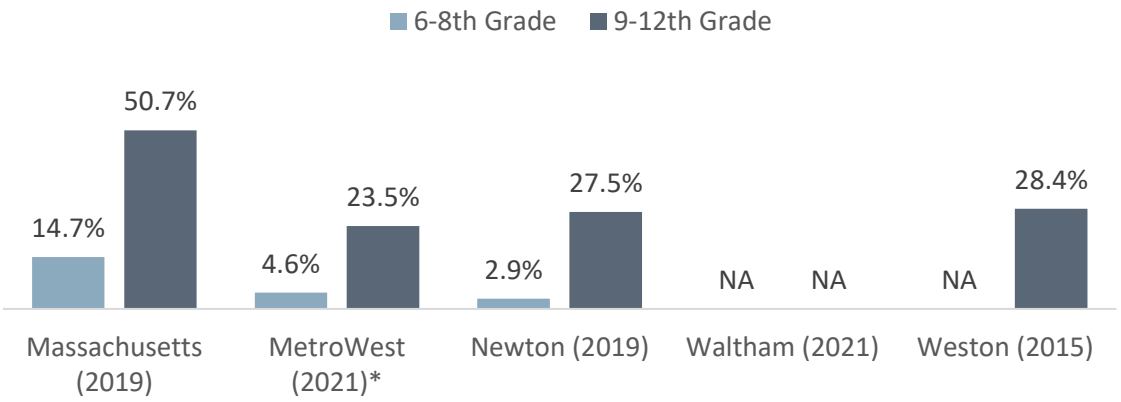
DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Youth Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015
NOTE: * includes students in grades 7-8. Data for the other assessment communities were not available. MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley

Schools in the NWH service area have also begun adopting the Screening, Brief Intervention, and Referral to Treatment (SBIRT) program to address substance use by middle and high school students.[29]

[29] Massachusetts Department of Public Health. 2022. *MASBIRT TTA.* https://www.masbirt.org/.

During the 2015 to 2021 period, lifetime electronic cigarette use ranged from a high of 50.7% at the overall state level, to a low of 23.5% in MetroWest region (**Figure 66**). Data regarding the prevalence of lifetime electronic cigarette use for middle school students were not available for most assessment communities, though estimates indicate that 4.6% and 2.9% of middle school students in the MetroWest region and Newton, respectively, reported electronic cigarette use in their lifetime.

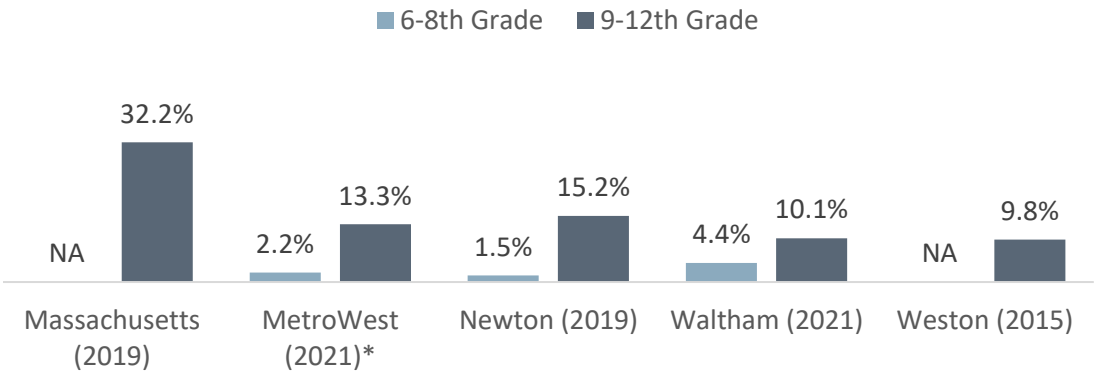
Figure 66. Percent of Students Reporting Lifetime Electronic Cigarette Use by State and City/Town, 2015-2021



DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Youth Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015
NOTE: * includes students in grades 7-8. Data for the other assessment communities were not available. MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley

As shown in **Figure 67**, during the 2015 to 2021 period current electronic cigarette use among middle school students was highest in the Waltham (4.4%). Among high school students, the prevalence of current electronic cigarette use in Newton (15.2%) was the highest but all of the cities/towns in the service area were still lower than the state (32.2%).

Figure 67. Percent of Students Reporting Current Electronic Cigarette Use by State and City/Town, 2015-2021

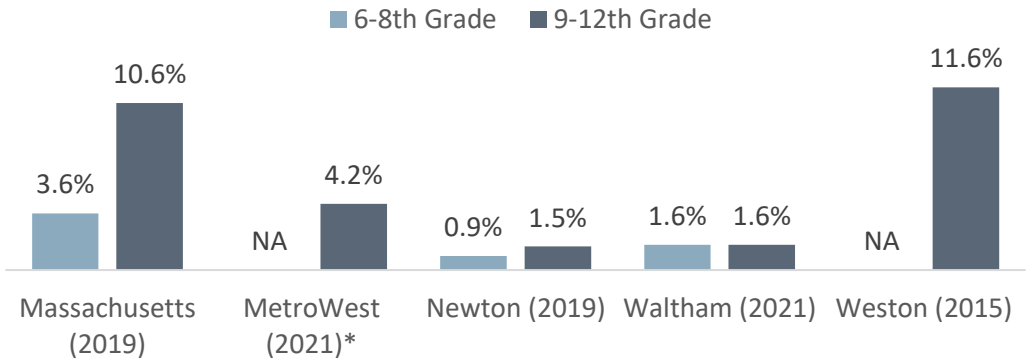


DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Youth Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015

NOTE: * includes students in grades 7-8. Data for the other assessment communities were not available. MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley

During the 2015-2021 period, lifetime prescription drug misuse reported by high school students exceeded the state average (10.6%) in Weston (11.6%) and was lowest in Newton (1.5%) and Waltham (1.6%) (**Figure 68**).

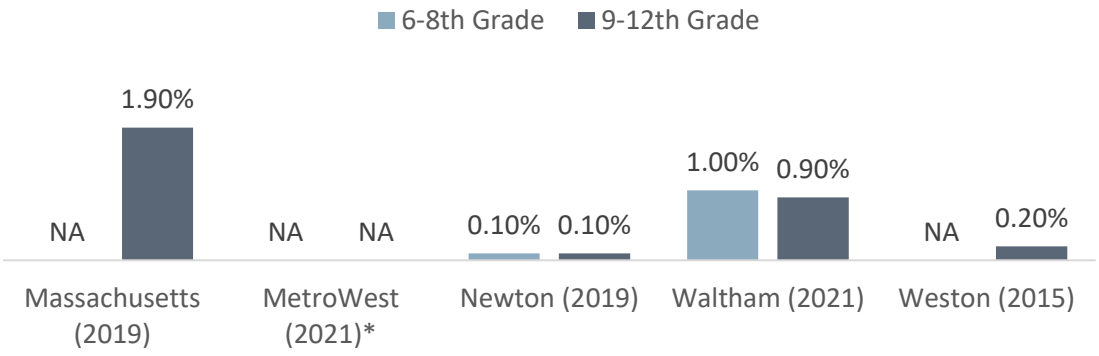
Figure 68. Percent of High School Students (Grades 9-12) Lifetime Misuse of Someone Else's Prescription, by State and City/Town, 2015-2021



DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Youth Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015
NOTE: * includes students in grades 7-8. Data for the other assessment communities were not available. MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley

Among high school students in the NWH service area cities/towns for which data were available, current opioid use was lower than Massachusetts overall (**Figure 69**).

Figure 69. Percent of Students Reporting Lifetime Heroin Use by State and City/Town, 2015-2021

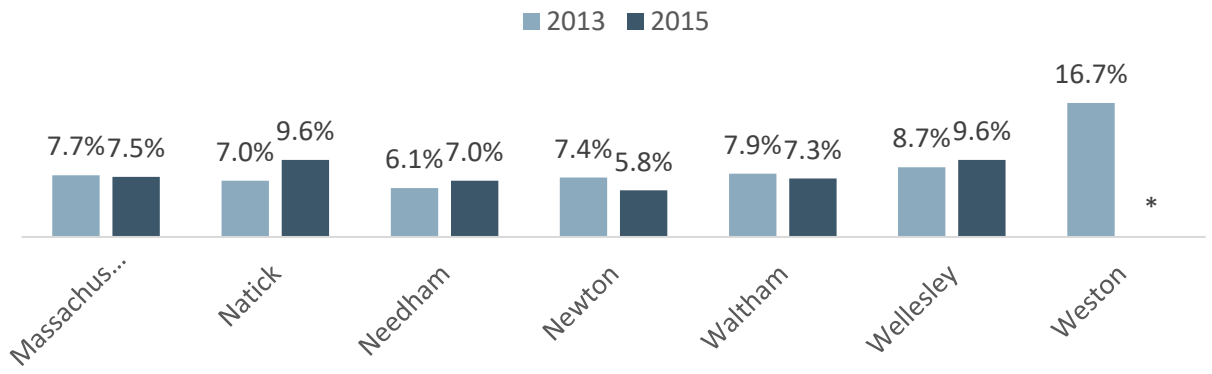


DATA SOURCE: Health and Use Risk Factors of Massachusetts Youth Survey, 2019; MetroWest Adolescent Youth Survey, 2021; Newton Youth Risk Behavior Survey, 2019; Waltham Public Schools Youth Risk Behavior Survey, 2021; Weston Youth Health Assessment, 2015
NOTE: * includes students in grades 7-8. Data for the other assessment communities were not available. MetroWest covers 25 cities/towns in the MetroWest Region including Natick, Needham, and Wellesley

Reproductive Health

In 2015, the proportion of low birthweights births was highest in Natick (9.6%) and Wellesley (9.6%), a prevalence that exceeded patterns across Massachusetts (7.5%) (**Figure 70**). In 2013, Weston (16.7%), Wellesley (8.7%), and Waltham (7.9%) had a prevalence of low birthweight that was higher than the state overall (7.7%). From 2013 to 2015, the percent of low birthweight births increased slightly in Natick (7.0% to 9.6%), Needham (6.1% to 7.0%), and Wellesley (8.7% to 9.6%), while this prevalence decreased for Newton (7.4% to 5.8%).

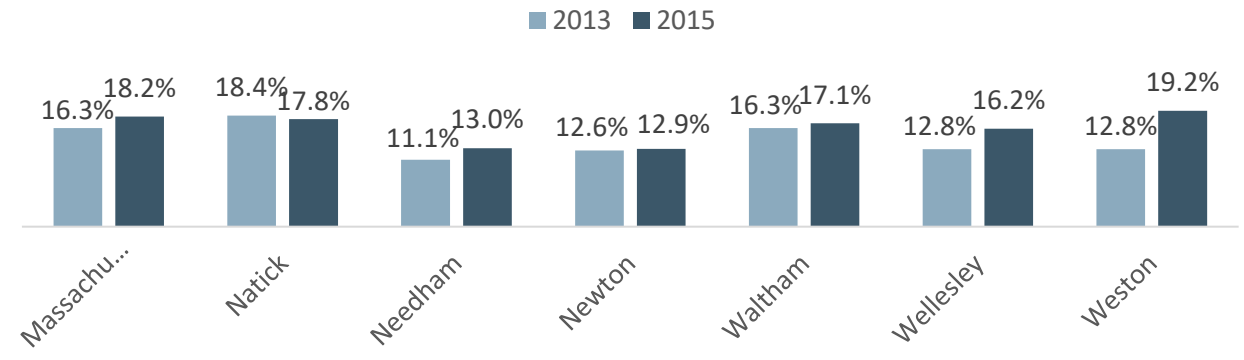
Figure 70. Percent of Low Birthweight Births by State and City/Town, 2013-2015



DATA SOURCE: Massachusetts Department of Public Health, Data Request, 2018
NOTE: * indicates data suppressed due to small numbers

Similar to patterns across Massachusetts, from 2013 to 2015, the percent of mothers with inadequate prenatal care increased slightly in Needham (11.1% to 13.0%), Wellesley (12.8% to 16.2%), and Weston (12.8% to 19.2%) (**Figure 71**). In 2015, the percent of mothers with inadequate prenatal care was highest in Weston (19.2%), a prevalence that exceeded the state average (18.2%). Natick (18.4%) and Waltham (16.3%) had the highest percent of mothers receiving inadequate prenatal care in 2013. From 2013 to 2015, inadequate prenatal care increased notably in Wellesley (12.8% to 16.2%) and Weston (12.8% to 19.2%).

Figure 71. Percent of Mothers with Inadequate Prenatal Care by State and City/Town, 2013-2015



DATA SOURCE: Massachusetts Department of Public Health, Data Request, 2018

As shown in **Table 9**, among the NWH service area cities/towns for which data were available, the rate of births to adolescent mothers was consistently below the state average between 2017-2019, except in Waltham in 2018 (7.5 births to adolescent mothers per 1,000) when the state average was (7.1 births to adolescent mothers per 1,000).

Table 9. Rate of Births to Adolescent Mothers per 1,000 by State and City/Town, 2017-2019

	2017	2018	2019
Massachusetts	8.1	7.1	7.1
Newton	-	-	3.8
Waltham	5.9	7.5	5.6

DATA SOURCE: Massachusetts Department of Public Health, Registry of Vital Records and Statistics, Birth Reports 2017-2019
NOTE: Data not available for other assessment communities

Communicable Disease and Sexual Health

Cases of Hepatitis A and tuberculosis are very rare in the NWH service area, and data are not presented, due to small values.

From 2013 to 2017, Waltham had the highest number of new HIV diagnoses among the focus communities, followed by Newton (**Table 10**). Trends suggest a slight decline in new HIV diagnoses in Waltham (12 cases in 2013 to 7 cases in 2017).

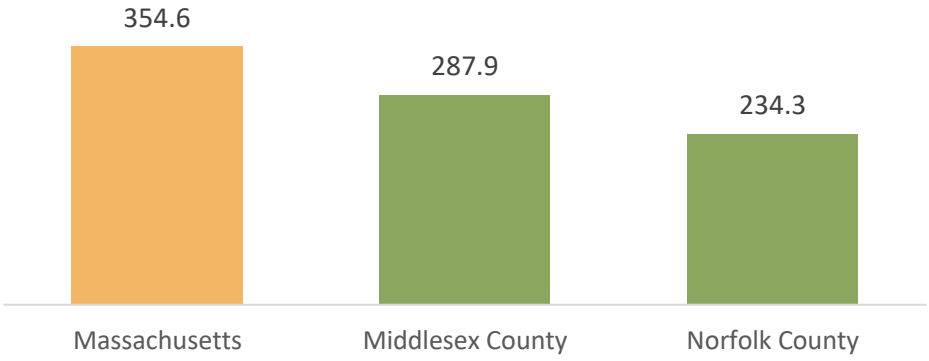
Table 10. Number of Individuals Diagnosed with HIV by State and City/Town, 2013-2017

Geography	2013	2014	2015	2016	2017
Massachusetts	696	653	605	641	611
Natick	<5	5	0	<5	0
Needham	0	<5	0	0	0
Newton	<5	<5	7	<5	<5
Waltham	12	12	7	7	7
Wellesley	0	0	0	0	<5
Weston	<5	0	0	0	0

DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, HIV/AIDS Surveillance Program, 2018, MA PHIT, 2017
NOTE: Does not include people incarcerated at the time of data collection

The rate of persons living with an HIV diagnosis who were 13 years of age or older was 18.8% below the rate for Massachusetts overall (354.6 cases per 100,000 population) for Middlesex County (287.9 cases per 100,000 population) and 33.9% below the state average for Norfolk County (234.3 cases per 100,000 population) (**Figure 72**).

Figure 72. Rate of Persons Aged 13+ Years Living with a Diagnosis of HIV per 100,000 Population by State and County, 2019



DATA SOURCE: Policy Map, HIV Cases/100,000 People, Massachusetts, 2019

From 2016-2020, the number of confirmed and probable cases of Hepatitis C were highest in Waltham, followed by Newton, then Natick, compared to the other assessment communities **Table 11**).

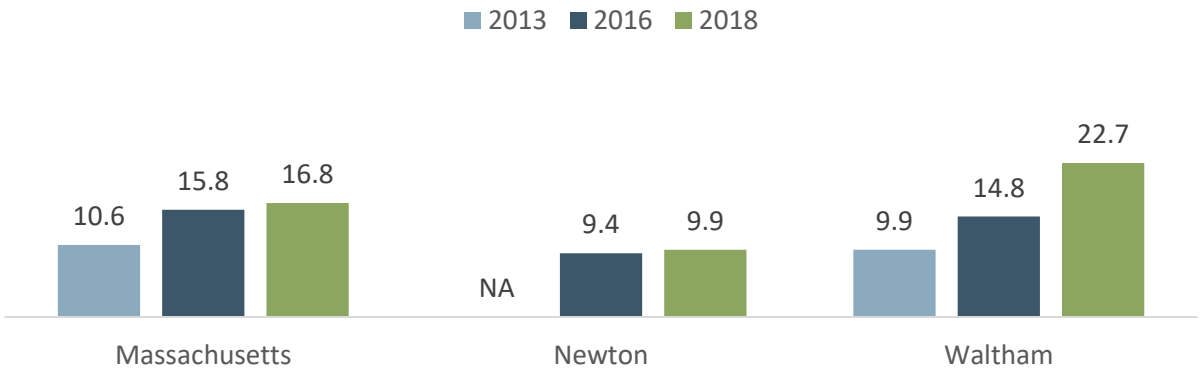
Table 11. Confirmed and Probable Cases of Hepatitis C by Select City/Towns, 2016-2020

Geography	2016	2017	2018	2019	2020
Natick	14	16	7	8	5
Needham	5	11	5	<5	<5
Newton	27	35	30	18	12
Waltham	37	39	33	27	16
Wellesley	<5	6	7	<5	<5
Weston	<5	<5	<5	0	0

DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, Count and Rate of Newly Reported Confirmed and Probable Hepatitis C Cases 2016-2020

Similar to state patterns, in Waltham the syphilis case rate increased from 9.9 cases per 100,000 residents in 2013 to 22.7 cases per 100,000 residents in 2018 (**Figure 73**). In 2018, the syphilis case rate in Newton (9.9 cases per 100,000 residents) was 41.0% below the rate for Massachusetts overall (16.8 cases per 100,000 residents).

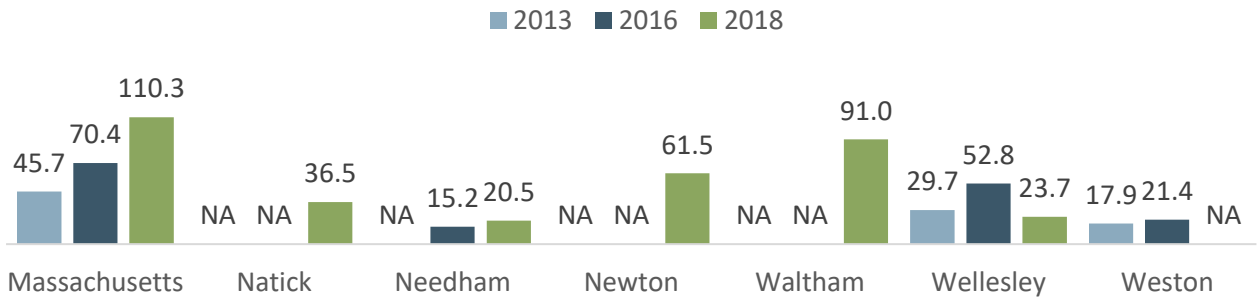
Figure 73. Syphilis Case Rate per 100,000 Population, by State and City/Town, 2013, 2016, and 2018



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, Division of STD Prevention, 2013 and 2016
NA indicates that rates were not calculated due to small number of cases, data for the other assessment communities are not reported

Among the cities/towns in the NWH service region for which data were available, the gonorrhea case rate was below the state rate in 2013, 2016, and 2018 (**Figure 74**). In 2018, the gonorrhea case rate was highest in Waltham (91.0 cases per 100,000 population) and Newton (61.5 cases per 100,000 population), and lowest in Needham (20.5 cases per 100,000 residents).

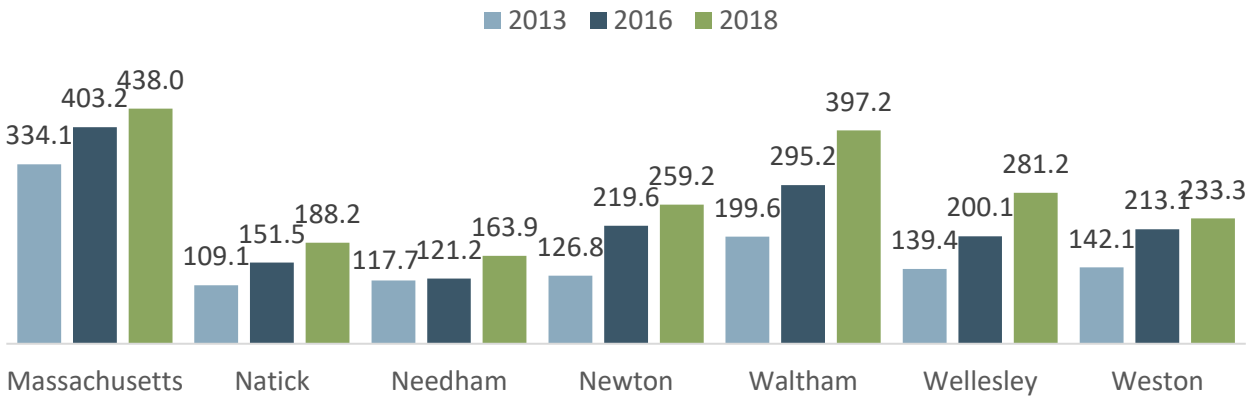
Figure 74. Gonorrhea Case Rate per 100,000 Population, by State and City/Town, 2013, 2016, and 2018



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, Division of STD Prevention, 2013 and 2016; MA PHIT, 2021
NA indicates that rates were not calculated due to small number of cases

As shown in **Figure 75**, the chlamydia case rate was below the rate for Massachusetts overall for all cities/towns in the NWH service area. However, following patterns across the state, the chlamydia case rate increased for all assessment communities from 2013 to 2018, with the greatest percent increase in Waltham, Wellesley, and Needham. In 2013, 2016, and 2018, the chlamydia case rate was highest in Waltham (199.6, 295.2, and 397.2 cases per 100,000 population, respectively). The chlamydia case rate was lowest in Needham (163.9 cases per 100,000 population) in 2018.

Figure 75. Chlamydia Case Rate per 100,000 Population, by State and City/Town, 2013, 2016, and 2018



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Infectious Disease and Laboratory Sciences, Division of STD Prevention, 2013 and 2016: MA PHIT, 2021

COVID-19

On February 1, 2020, the Massachusetts Department of Public Health (MDPH) experienced its first recorded case of the SARS-COV-2 virus in the Commonwealth of Massachusetts.[30] Public health officials and scientists determined the novel SARS-COV-2 virus could lead to a mild to severe respiratory syndrome, known as COVID-19, in infected individuals.[31] Shortly afterwards, Governor Charlie Baker declared a state of emergency on March 10, 2020, due to local transmission of the virus in Massachusetts and growing concern for transmission across areas of the US.[32] The following section reviews data on cases, deaths, and vaccinations in the NWH service area as of August 11, 2022 utilizing surveillance data from MDPH.

As shown in **Table 12**, COVID-19 case numbers varied across the NWH service area, but Newton and Waltham experienced the highest number of total cases amongst the towns in the NWH service area.

[30] Massachusetts Department of Public Health. 2020. "Man Returning from Wuhan, China is First Case of 2019 Novel Coronavirus Confirmed in Massachusetts." 02 01. https://www.mass.gov/news/man-returning-from-wuhan-china-is-first-case-of-2019-novel-coronavirus-confirmed-in-massachusetts.

[31] World Health Organization. 2021. *Coronavirus (COVID-19).* https://www.who.int/emergencies/diseases/novel-coronavirus-2019/question-and-answers-hub/q-a-detail/coronavirus-disease-covid-19.

[32] Office of Governor Charlie Baker and Lt. Governor Karyn Polito. 2021. *COVID-19 State of Emergency.* https://www.mass.gov/info-details/covid-19-state-of-emergency

Table 12. Total COVID-19 Cases by State, County, and Town through 8/11/22

	Total COVID-19 Case Count	2020 U.S. Census Bureau Population Estimate
Massachusetts	1,821,987	6,873,003
Middlesex County	393,200	1,605,899
Norfolk County	156,444	703,740
Natick	7,031	36,044
Needham	6,171	31,177
Newton	16,380	88,322
Waltham	15,590	62,597
Wellesley	5,464	28,747
Weston	2,023	12,103

DATA SOURCE: Massachusetts COVID-19 Dashboard COVID-19 Cases by State, County, and Town through 8/11/22; U.S. Census Bureau, American Community Survey 5-Year Estimates, 2015-2019

Public health officials and researchers determined that certain groups of people are more likely to become severely ill and possibly die from COVID-19 including older adults and certain people with disabilities who are more likely to live in congregate settings, have chronic health conditions, and face barriers to accessing healthcare.[33] As shown below (**Table 13**), Middlesex County had double the deaths compared to Norfolk County.

Table 13. Total Confirmed and Probable COVID-19 Deaths by State and County through 8/11/22

Geography	Total Confirmed and Probably COVID-19 Deaths
Massachusetts	19,978
Middlesex County	4,205
Norfolk County	2,000

DATA SOURCE: Massachusetts COVID-19 Dashboard COVID-19 Deaths by State, County, and Town through 8/11/22

When examining state-level COVID-19 mortality data in Massachusetts, those who identified as other race, Black, or Hispanic had the highest number of deaths (**Table 14**). Additionally, residents of color had a high cumulative death rate with Black residents having the highest death rate per 100,000 among people of color (279.70 deaths per 100,000) (**Figure 76**).

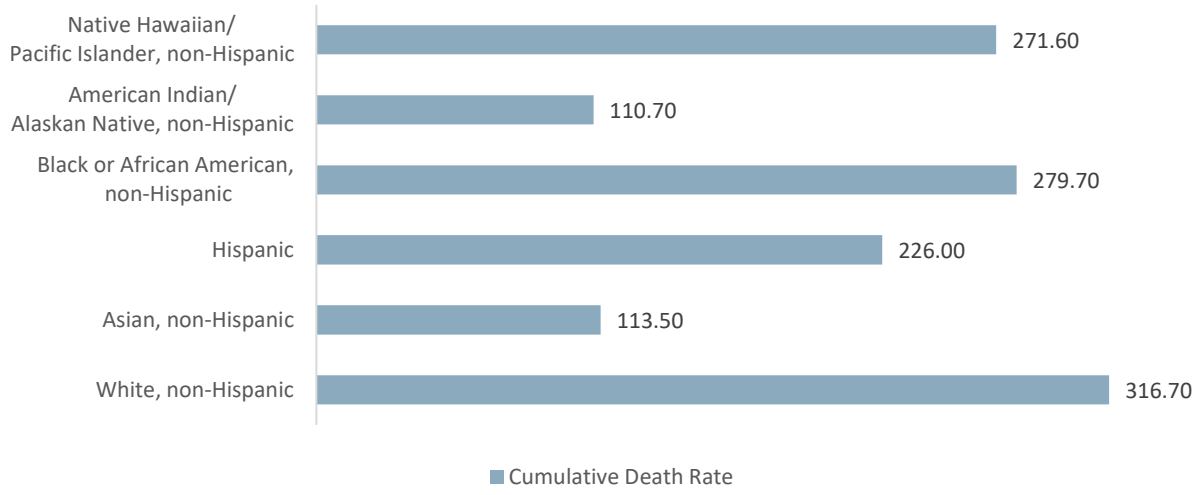
[33] Centers for Disease Control and Prevention. 2022. *People with Certain Medical Conditions.* https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

Table 14. COVID-19 Deaths in Massachusetts by Race/Ethnicity through 8/11/22

Race/Ethnicity	Deaths
Native Hawaiian/ Pacific Islander, non-Hispanic	5
American Indian/Alaskan Native, non-Hispanic	11
White, non-Hispanic	15,282
Black or African American, non-Hispanic	1,334
Hispanic	1,986
Asian, non-Hispanic	579
Other race, non-Hispanic	2,018
Unknown, missing, or refused	70

DATA SOURCE: Massachusetts COVID-19 Dashboard COVID-19 Deaths by State, County, and Town through 8/11/22

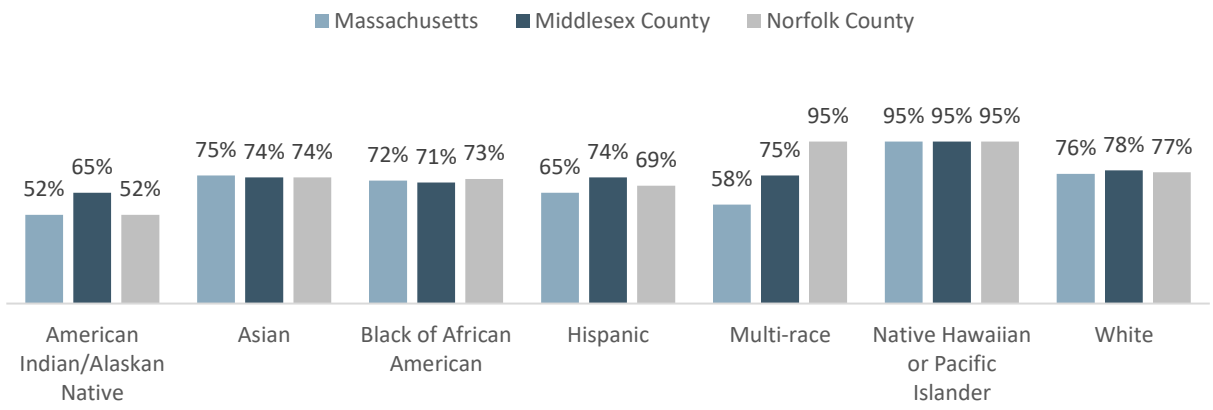
Figure 76. Cumulative COVID-19 Death Rate per 100,000 by Race and Ethnicity through 08/11/22



DATA SOURCE: Massachusetts COVID-19 Dashboard COVID-19 Deaths by State, County, and Town through 8/11/22

Overall, a similar percentage of the Asian, Black or African American, Native Hawaiian or Pacific Islander, and White populations have been fully vaccinated across Middlesex and Norfolk counties and the state. However, among American Indian/Alaskan Native, Hispanic, and Multi-race populations, there are notable differences in the percentage of people who are fully vaccinated between the geographic regions of interest (**Figure 77**).

Figure 77. Percentage of Individuals Fully Vaccinated by State/County and Race/Ethnicity through 8/1/22



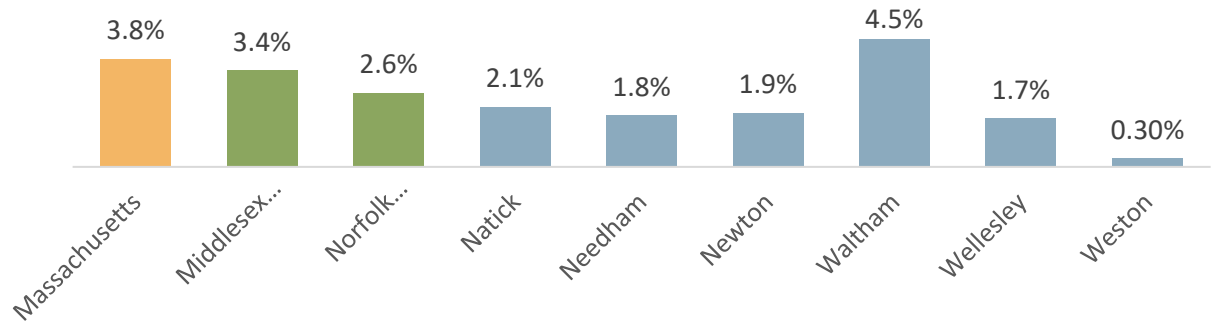
DATA SOURCE: Massachusetts COVID-19 Dashboard COVID-19 Vaccination by State and County through 8/1/22
NOTE: An individual is counted as fully vaccinated if they have received the number of doses required to complete the COVID-19 vaccine series for their age and all of these doses have been reported to MIIS. Pfizer recipients under 5 years of age require three doses of vaccine; all other Pfizer recipients require two doses. Moderna and Novavax recipients require two doses of vaccine. Janssen/Johnson&Johnson recipients require one dose of vaccine.

Access to Services

Access to Health Insurance

Health insurance helps individuals and families access needed primary care, specialists, and emergency care. As shown in **Figure 78**, in 2020 2.6-3.4% of adults aged 18 to 64 years of age across Norfolk and Middlesex Counties did not have health insurance, slightly below the prevalence across Massachusetts (3.8%). All of the cities/towns in the NWH service area had lower percentages of adults without health insurance except for Waltham (4.5%)

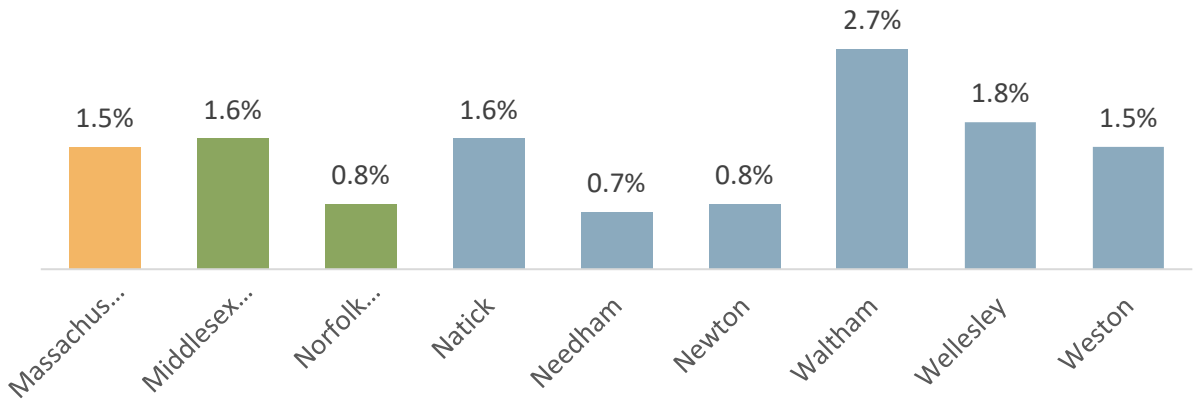
Figure 78. Percent of Adults 18 to 64 Years Old without Health Insurance, by State, County, and City/Town, 2020



DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020

In 2020 1.5% of children under 19 years of age in the state did not have health insurance (**Figure 79**). Of the cities/towns in the NWH service area, Waltham (2.7%), Wellesley (1.8%), and Natick (1.6%) had higher percentages of children without insurance compared to the state.

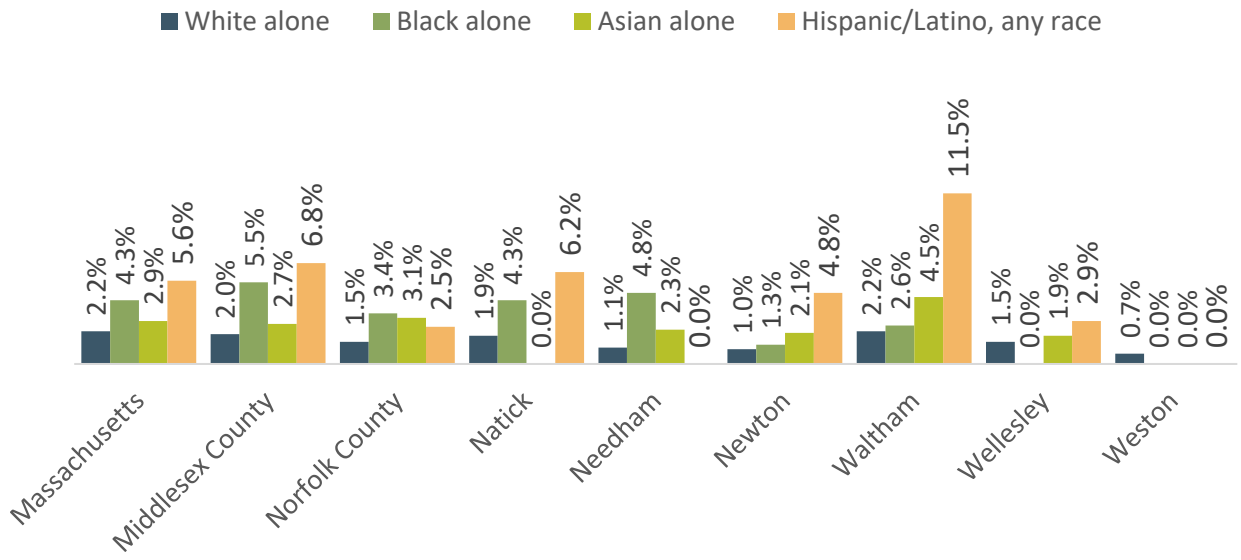
Figure 79. Percent of Children Under Age 19 without Insurance by State, County, and City/Town, 2016-2020



DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020

In 2016-2020, approximately 5.5% of Black residents in Middlesex County did not have health insurance, compared to approximately 4.3% of Black residents in the state overall (**Figure 80**). During this period, a higher proportion of Black residents in Natick (4.3%), lacked health insurance relative to other towns within the service area. In Waltham, a higher percent of Hispanic/Latino (11.5%) residents lacked health insurance than any other racial group in the city. In Waltham, 4.5% of Asian residents lacked health insurance, a proportion that exceeded the state average (2.9%). Focus group participants and interviewees highlighted immigrant populations as particularly struggling with barriers to care related to health insurance; one individual described this reality - "One of the biggest challenges [for immigrant populations] is health insurance – most people don't have insurance and if they do, they do not know how to use it."

Figure 80. Racial Composition of Population without Insurance by State, County, and City/Town, 2016-2020



DATA SOURCE: US Department of Commerce, Bureau of the Census, 5-Year Estimates, American Community Survey, 2016-2020

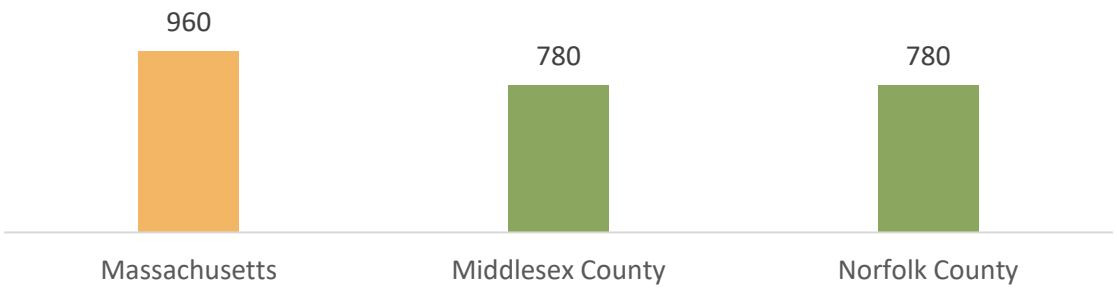
Access to Healthcare

As shown in **Figure 81**, in 2019 there was one primary care physician per 780 residents in Middlesex and Norfolk counties, a ratio that was approximately 19% lower than the ratio for Massachusetts (960:1) overall.

However, the difficulty of finding a provider can be greater for specific populations. For example, according to the Newton community needs assessment, Hispanic and Latino residents reported additional difficulty finding and accessing multi-language providers.[34] In addition to language barriers, focus group participants and interviewees depicted cultural and social barriers to care for immigrant populations; one participant said, “Within immigrant communities there is a lot of skepticism because they [healthcare systems] are an extension of the government. I think if we could address that skepticism through making services more accessible it would be a great first step.” Participants also discussed how barriers to care are further heightened for newly-arrived immigrants; one participant explained, “If someone has been in the country for under 5 years, they get very limited healthcare, and then there is a whole process of paperwork to get healthcare if they're even eligible.”

[34] Center for Governmental Research. 2022. "Newton Community Needs Assessment." https://www.newtonma.gov/government/health-human-services/social-services/community-needs-assessment

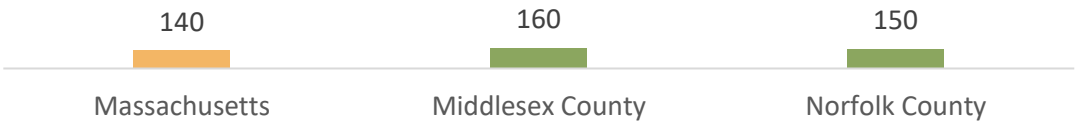
Figure 81. Ratio of Population per One Primary Care Physicians by State and County, 2019



DATA SOURCE: County Health Rankings & Roadmaps, Area Health Resource File/American Medical Association, 2022 (uses data from 2019)

In 2020, the ratio of Middlesex (160:1) and Norfolk (150:1) County population to mental health providers was slightly less favorable than the ratio for the state (140:1) (**Figure 82**). That is, for every 160 Middlesex County residents and every 150 Norfolk County residents, there was one mental health provider available, while on average a mental health provider was available per 140 Massachusetts residents.

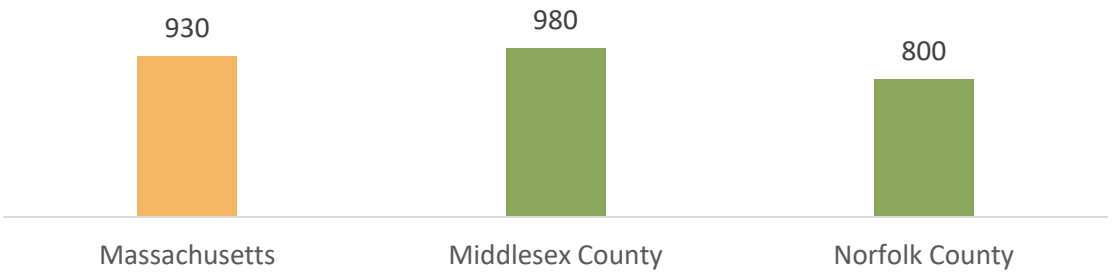
Figure 82. Ratio of Population per One Mental Health Provider by State and County, 2021



DATA SOURCE: County Health Rankings & Roadmaps, CMS, National Provider Identification, 2022 (uses data from 2021)

Norfolk County has the highest number of dentists for its population size (800 residents per dentist), more than the state (930 residents per dentist) and Middlesex County (980 residents per dentist) as of 2020 (**Figure 83**).

Figure 83. Ratio of Population per One Dentist by State and County, 2020



DATA SOURCE: County Health Rankings & Roadmaps, Area Health Resource File/American Medical Association, 2022 (uses data from 2020)

Access to Integrated Community Services

In discussing access to care, a common theme that resurfaced throughout focus groups and interviews was the need for an intentional investment into building integrated care networks that can provide holistic "wrap-around services" that are grounded in the nuanced and culturally-specific needs of diverse communities throughout the NWH service area. Focus group participants and interviewees alike acknowledged that healthcare services and resources for care exist, and entities like NWH have the capacity to build more programs to address community needs. However, participants depicted a disconnect between how services are created and provided, and the needs of residents that are meant to utilize them, ultimately creating barriers to access. One participant explained, "Sure there are many programs that could exist, that NWH could maybe invest money in, but we believe that even if these programs exist, if there is no way to access them, they aren't meaningful to the community. Accessibility is not just language but also empathy and sensitivity." They continued to describe the breadth of accessibility in stating "if you don't have accessibility in terms of language, making people feel safe, cultural understanding – people won't come and access these services...It doesn't matter how many programs exist if people can't access them." In response to the inaccessibility of services for various groups holding marginalized identities, participants explained, "Members from affected communities can provide the best representation for folks in [those] communities." They highlighted "knowledge" and "trust" as two of the main characteristics embodied by these community members that would make care more accessible.

Several participants referred to the Waltham Partnership for Youth- and NWH-supported wrap-around program in Waltham Public Schools as a successful model for care that provides "access to holistic services such as immigration, housing, and education." The argument for integrated services is supported by the idea that experiences of marginalized communities are "at the intersection of so many social determinants of health" meaning "everything is connected." Participants explained that a point of service with a healthcare or social service professional is an opportunity for information sharing that can address various needs pertaining to social determinants of health. One focus group participant depicts this concept in highlighting the need for information to be centralized - "People come [to a resource center] because they need help with rent, but then it turns out they also need help with immigration." They continued to explain that if folks at various points of service had a collective knowledge of resources related to many social determinants of health, "at least the people who provide those services can tell them [patients/community members] where other services are located, so people can learn how to access them."

Community Perceptions and Visions for the Future

Focus group and interview participants were asked to share suggestions for addressing identified needs and to depict their visions for the future. The following section summarizes and presents these recommendations for future consideration.

Top Issues for Action

When residents were asked to identify the top priorities for action in their community, transportation accessibility, affordable housing, mental health, substance use, access to care and services, chronic disease management and prevention, elder or senior care, and community investment and

empowerment were the most frequently discussed. Among those discussions, addressing systemic racism was a cross-cutting and overarching focus discussed across these domains.

Suggestions for Future Programs, Services, and Initiatives

Housing

Accessibility and affordability of housing was among the most commonly discussed issues in focus groups and interviews. Participants noted limited affordable housing options for low to middle income individuals. They discussed how the definition of affordability often relies on the town's median income, which does not necessarily reflect their own economic circumstances. Therefore, they are shut out of "affordable" housing. Participants also mentioned that despite increasing development, these new developments are not geared towards low to middle income households but are built as luxury units. Suggestions were made to increase the development and availability of affordable housing units for specific populations such as seniors and low-income residents. Participants also suggested improvements to the subsidized housing program as the application and approval process can take up to ten years.

Transportation

Transportation was identified as a priority concern in the NWH service area. Focus group participants suggested improvements to both the public transportation system and the active transportation or built environment. For example, in terms of improvements to the public transportation system, participants suggested creating protected bus stops, adding interconnected dynamic bus routes, ensuring reliability, and increasing accessibility for specific populations such as senior populations or folks living with a disability. Additionally, suggestions for improvements to the active transportation system and built environment include safer walking paths, protected bike lanes, and functional green space.

Chronic Disease Management and Prevention

Participants specifically noted the importance of chronic disease management and prevention. They mentioned the need for more proactive preventive screening efforts and improved built environments that were conducive to healthy living. For example, a participant discussed being at high risk of cancer to her provider and the provider was extremely proactive in ordering her the necessary screening and tests to monitor her health. The participants agreed that that level of care and concern is what they are looking for from the health system. They suggested that the root of the issue was that the health system prioritized profits over people, which lead to unsatisfactory care. They expressed the need for more one-on-one time with providers in order to build a trusted relationship where they know their provider has their best interests in mind. In addition to the health system, participants suggested improvements to the built environment to encourage healthier choices. Suggested improvements include safe and protected green spaces, walking trails, and sidewalks.

Mental Health

Availability of mental health services was identified by participants as a pressing concern. Participants across different domains suggested improvements to the mental healthcare system to ensure that services were more affordable, culturally sensitive, and readily available. Improved availability of services was particularly important to youth as they noted a high prevalence of mental health challenges experienced by younger populations. This population in particular made a connection between a lack of mental health services and youth engaging in substance use behaviors, expressing a need for more preventative mental health services to build coping mechanisms for daily stressors experienced by the youth population. Participants recognized efforts to incorporate mental healthcare into the school system as a strong response to the great need for these services, however folks identified a remaining

gap in the general availability of these services and made pointed requests for more multi-lingual providers. Older adults were also named as a specific subgroup that are particularly impacted by mental health challenges; participants suggested the implementation of volunteer programs for companionship care for seniors struggling with isolation. In addition to improvements to service delivery, participants expressed a need for more mental health focused outreach and education to all populations in order to build an awareness of the prevalence of mental health challenges in this community, reduce the stigma associated with mental health related challenges, and to curate a more open dialogue.

Substance Use

Substance use was presented as a priority issue for many participants. While there was some overlap with mental health in the concepts and themes that came up, like a need for more providers, substance use emerged as a standalone topic of concern. In discussing substance use, participants highlighted a need for more recovery and treatment services, placing particular focus on services that offered long-term support and care not just for the individual receiving treatment, but also for the support systems of that individual. In addition to an increase in treatment availability, participants expressed a need for a more concrete path to treatment; a lack in understanding of how to navigate crises and more general substance use services was explained to make it difficult for individuals to successfully reach treatment during times of great need. Participants explained that there is stigma surrounding substance use throughout the NWH service area, which was linked to experiences of isolation by those impacted by substance use. Participants further described this isolation to impede the sharing of knowledge and support by community members with shared experiences. Participants suggested a greater investment in community-wide educational outreach efforts to begin breaking down stigma and improving communication and dialogue around substance use challenges.

Older Adults

Many of the issues mentioned throughout the discussions were especially pronounced among older populations. For example, many participants mentioned the effects of a lack of affordable housing and rising rents for seniors who are on fixed incomes or are lower income. They noted that many seniors who would prefer to age in place can no longer afford to live in the places they've called home their whole lives. Transportation was also another issue that uniquely affects seniors as the transportation system can be difficult to navigate with the abundance of new technologies that are not always accessible or easy to understand. Additionally, they mentioned having trouble finding reliable transportation to specialty appointments that may be outside of their usual network and neighborhoods. Finally, mental health issues such as isolation specifically were mentioned numerous times as a major issue affecting older populations. Participants highlighted the need for some type of companionship care for older adults who may not have family or other support to periodically check in on them.

Access to Care

Access to care was highlighted as a priority by participants throughout most focus groups and interviews. Participants discussed difficulties in scheduling appointments in a timely manner for health issues, including those requiring urgent attention. Many folks explained, when making healthcare appointments, they were only able to schedule several months out, requiring them to resort to urgent care centers or emergency rooms. This lack of appointment availability was also presented as a challenge by parents attempting to schedule their children for physicals required by the school systems. Participants also noted complexities within healthcare systems, namely the navigation of health insurance, making it difficult to navigate, especially for immigrant populations and folks that speak languages other than English. Participants called for intentional efforts to be made by healthcare

systems to further develop their service models to encompass the diverse and nuanced needs of all community populations, in particular those holding marginalized identities and those most impacted by social determinants of health. In addition to increasing the availability of appointments, both in terms of offering more appointments generally and offering more appointments outside of normal business hours (e.g. 9:00am – 5:00pm), and the development of community-based health clinics or mobile health clinics, participants also suggested the integration of services by utilizing healthcare and social service interactions as an access point for resources that can also address various social determinants of health.

Workforce Development

Workforce Development as it relates to health care providers was an issue that participants noted as particularly important. They mentioned that a lot of the access to care issues that they were facing were likely due to a provider shortage and many of the issues with availability would be addressed if there were more providers. In addition, participants of color also suggested having more providers of color or more representative providers that come from the same community as them in order to better serve them. Participants also discussed the issue of direct service providers such as home health aides, mental health care providers, social workers, or case managers being under compensated which leads to providers being unable to live and work in the NWH service. They suggested the need to fairly compensate providers so they are able to continue providing services. In a different vein, workforce development issues also came up in the context of the older population as well. Older participants who are low-income or are still relying on an income from employment discussed difficulties in finding a job, especially due to difficulties navigating electronic job boards. They expressed the need for more support in learning new technologies and skills in order to help them find employment.

Community Engagement and Empowerment

Community engagement was a recurring theme that cut through all of the key topics discussed by focus group participants and interviewees. In discussing community needs and posing suggestions to address these needs, participants pointed to the fact that work to address these needs is already being done on the grassroots level by community members. Rather than re-inventing the wheel and attempting to build new initiatives to address the needs that have come out of this assessment, participants asked that healthcare systems, like NWH, instead intentionally and thoughtfully engage community leaders that are already doing this work and that fully understand the nuanced needs of their fellow community members. One participant expressed this in saying, “I would like to see real community involvement when it comes to determining next steps. Not just having people come in to the community, that’s really good, but hopefully in three years these organizations don’t need to go out of their way to have a CHNA happen. That they have people making these decisions from these communities.” Statements like this express participants’ desire to have community members that experience the day-to-day realities of the issues discussed in this assessment, in decision-making positions. “Having a seat at the table” would act as one form of sustained community engagement, which participants expressed is an important piece of their visions for the future.

Health and Racial Equity

Health and Racial Equity was discussed as a cross-cutting theme across the major issues that were mentioned. For example, when participants were asked about how and where they access care, a number of participants noted that they will actively avoid going to NWH due to the feeling that they would be discriminated against if they went there. They mentioned the history of racism and discrimination that existed and how they felt that if they to NWH for care, they would be receiving less quality care because of their identify. In order to address this, participants specifically suggested that

NWH do more outreach to affected communities in order to build trust and educate communities on changes and initiatives that they are engaging in to address this institutional racism.

Community Strengths
When focus group participants were asked about their overall view of the strengths of their communities, many folks identified a strong sense of community and general care for one another. One participant described their community as "very close," and one where "they [community members] help each other out." Another participant stated, "If you call someone, they will be right there and they will help you," a sentiment which was shared by another participant that said, "There is a community within the place. People are very caring in a sincere way."

KEY THEMES AND CONCLUSIONS

The NWH service area comprises cities and towns that are generally perceived as affluent, well-educated, and healthy. However, this general perception and overall well-being may mask difficulties faced by more marginalized members of these communities, especially in a time of such health and economic instability.

Synthesizing social, economic, and epidemiological statistical data with community perspectives and The accompanying 2022 Newton-Wellesley Hospital Strategic Implementation Plan (SIP) will further detail the prioritization process for these priorities and the planning underway in the system to address these community needs.

System-Wide Priorities

In addition to the key themes identified in this assessment related to the NWH service area, the larger Mass General Brigham system has identified priorities and strategies for key initiatives. This section details a statement by Mass General Brigham on these strategies

Statement from Mass General Brigham

Mass General Brigham Community Health leads the Mass General Brigham system-wide commitment to improve the health and well-being of residents in our priority communities most impacted by health inequities. Mass General Brigham's commitment to the community is part of a $30 million pledge to programs aimed at dismantling racism and other forms of inequity through a comprehensive range of approaches involving our health care delivery system and community health initiatives.

While not required to conduct a CHNA under current regulations, Mass General Brigham's belief in the critical importance of system-wide, population-level approaches resulted in our decision to have every hospital conduct a 2022 CHNA. Having all our hospitals on the same three-year cycle will prove invaluable in our efforts to eliminate health inequities by identifying system-wide priorities that require system-level efforts.

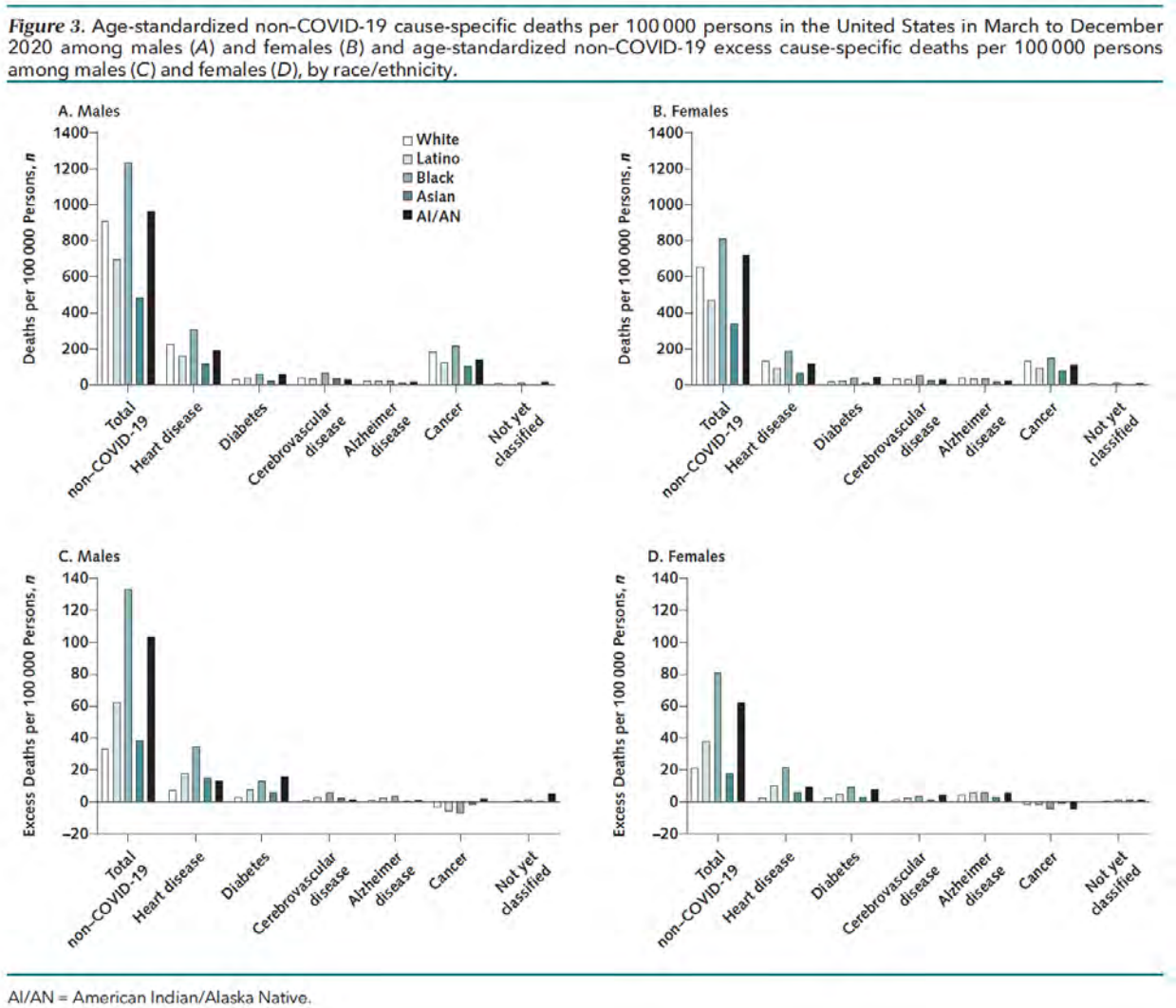
In addition to the priorities each hospital identifies that are unique to its communities, Mass General Brigham identified two system-level priorities: cardiometabolic disease and substance use disorder. These priorities emerged from a review of hospital-level data and prevalent trends in population health statistics. Our efforts within these priorities will aim to reduce racial and ethnic disparities in outcomes, with the goal of improving life expectancy.

Key Findings

In a national study of deaths during the first wave of the COVID-19 pandemic (March to December 2020), researchers explored non-COVID deaths and excess deaths, defined as the difference between the number of observed and number of expected deaths.

Nationally, non-COVID deaths disproportionately affected Black, American Indian/Alaska Native, and Latino persons (**Figure 84**). Moreover, when looking at excess deaths, the inequities worsened. The greatest disparities are seen for heart disease and diabetes. Inequities also exist for all cancer deaths but not excess cancer deaths.

Figure 84. Racial and Ethnic Disparities in Excess Deaths During the COVID-19 Pandemic, March to December 2020, Annals of Internal Medicine



Data Source: Sheils et al. Racial and Ethnic Disparities in Excess Deaths During the COVID-19 Pandemic, March to December 2020. Annals of Internal Medicine, Vol 174 No. 12. December 2021. 1693-1699

Massachusetts mortality data for 2019 reveal that heart disease and unintentional injuries, which includes drug overdoses, account for the second and third highest causes of death. As shown in **Figure**

85, the highest number of deaths among individuals from birth to age 44 were the result of unintentional injuries. However, among those 45 years of age and older, heart disease accounts for the highest or second highest cause of death across age group.

Figure 85. Top Ten Leading Underlying Causes of Death by Age, MA 2019

	Age Groups (number of deaths)								
Rank	<1 year	1-14 years	15-24 years	25-44 years	45-64 years	65-74 years	75-84 years	85+ years	All
1	Short gestation and LBW[1] (57)	Unintentional Injuries[3] (20)	Unintentional Injuries[3] (186)	Unintentional Injuries[3] (1319)	Cancer (2781)	Cancer (3446)	Cancer (3430)	Heart Disease (5622)	**Cancer (12584)**
2	Congenital malformations (58)	Cancer (17)	Suicide (67)	Cancer (241)	Heart Disease (1585)	Heart Disease (1786)	Heart Disease (2581)	Cancer (2641)	**Heart Disease (11779)**
3	SIDS[2] (21)	Congenital malform (9)	Homicide (43)	Suicide (202)	Unintentional Injuries[3] (1138)	Chronic Lower Respiratory Disease[5] (632)	Chronic Lower Respiratory Disease[5] (893)	Stroke (1260)	**Unintentional Injuries[3] (4094)**
4	Complications of placenta (19)	Other infect (8)	Cancer (27)	Heart Disease (193)	Chronic liver disease (383)	Unintentional Injuries[3] (340)	Stroke (629)	Alzheimer's Disease (1128)	**Chronic Lower Respiratory Disease[5] (2842)**
5	Pregnancy Complications (13)	Homicide (8)	Heart Disease (7)	Homicide (77)	Chronic Lower Respiratory Disease[5] (350)	Stroke (331)	Alzheimer's Disease (415)	Chronic Lower Respiratory Disease[5] (941)	**Stroke (2463)**
6	Respiratory distress (8)	Ill-defined conditions-signs and symptoms[4] (7)	Injuries of Undetermined Intent[3] (7)	Chronic liver disease (62)	Diabetes (312)	Diabetes (300)	Unintentional Injuries[3] (381)	Unintentional Injuries[3] (709)	**Alzheimer's Disease (1662)**
7	Bacterial sepsis of newborn (7)	Influenza & Pneumonia (4)	Diabetes (6)	Ill-defined conditions-signs and symptoms[4] (37)	Suicide (281)	Nephritis (221)	Diabetes (358)	Influenza & Pneumonia (612)	**Diabetes (1386)**
8	Necrotizing enterocolitis (6)	Suicide (3)	Influenza & Pneumonia (4)	Diabetes (29)	Stroke (212)	Septicemia (181)	Nephritis (339)	Nephritis (553)	**Nephritis (1280)**
9	Circulatory System (5)	Septicemia (2)	Ill-defined conditions-signs and symptoms[4] (4)	Stroke (29)	Septicemia (171)	Chronic liver disease (180)	Parkinsons (285)	Diabetes (381)	**Influenza & Pneumonia (1217)**
10	Intrauterine Hypoxia (4)	In situ neoplasms (2)	Chronic Lower Respiratory Disease[5] (2)	Injuries of Undetermined Intent[3] (26)	Nephritis (150)	Influenza & Pneumonia (179)	Influenza & Pneumonia (276)	Ill-defined conditions-signs and symptoms[4] (355)	**Septicemia (942)**
All Causes	**255**	**106**	**389**	**2,646**	**9,417**	**9,974**	**13,570**	**22,303**	**58,660**

Note: Ranking based on number of deaths. The number of deaths is shown in parentheses.

1. LBW: Low birthweight. 2. SIDS: Sudden Infant Death Syndrome. 3. Injuries are subdivided into 4 separate categories by intent: unintentional, homicide, suicide, and injuries of undetermined intent (deaths where investigation has not determined whether injuries were accidental or purposely inflicted). 4. Ill-Defined Conditions: Includes ICD-10 codes R00-R99. 5. The title of this cause of death has changed between ICD-10 and ICD-9. Chronic Lower Respiratory Disease (ICD-10 title) corresponds to Chronic Obstructive Pulmonary Disease (COPD) (ICD-9 title).

Data Source: Massachusetts Department of Health, Registry of Vital Records and Statistics, Massachusetts Deaths 2019

In Boston, heart disease mortality for Black and Hispanic residents was second only to COVID-19 in 2020.

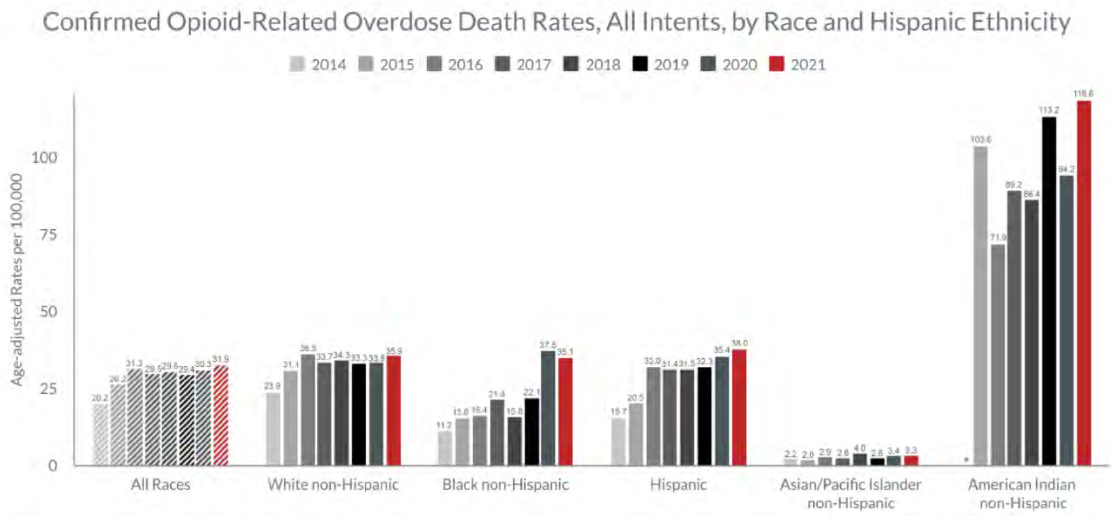
Figure 86. Leading Causes of Mortality in Boston by Race/Ethnicity, Age-Adjusted Rate per 100,000 Residents, 2020

	Boston	Asian	Black	Latino	White
1	COVID-19 138.4	COVID-19 95.1	COVID-19 238.1	COVID-19 143.5	Cancer 117.6
2	Cancer 117.4	Cancer 92.8	Heart Disease 183.6	Heart Disease 86.1	Heart Disease 113.1
3	Heart Disease 114.9	Heart Disease 55.4	Cancer 166.7	Cancer 78.8	COVID-19 103.5
4	Accidents 53.7	Cerebrovascular Diseases 22.2 †	Accidents 82.7	Accidents 59.5	Accidents 53.2
5	Cerebrovascular Diseases 27.4	Accidents 17.1 †	Cerebrovascular Diseases 52.8	Diabetes 27.4	Chronic Lower Respiratory Diseases 24.7

Data Source: Massachusetts Department of Public Health, Boston Resident Deaths, 2020

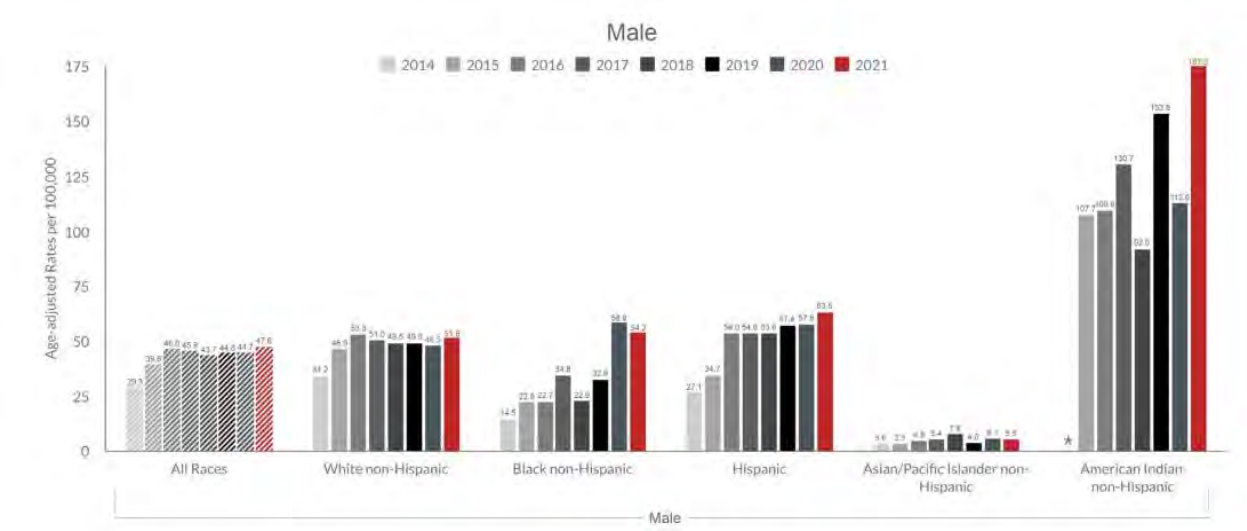
From 2014 to 2021, opioid-related overdose deaths in Massachusetts increased dramatically for Black and Hispanic residents (**Figure 87**). Death rates for American Indian residents have consistently and significantly outpaced deaths rates for all other races.

Figure 87. Massachusetts Opioid-Related Deaths, All



Data Source: MA Department of Public Health. https://www.mass.gov/doc/opioid-related-overdose-deaths-demographics-june-2022/download

Figure 88. Massachusetts Opioid-Related Deaths, Males



Data Source: MA Department of Public Health. https://www.mass.gov/doc/opioid-related-overdose-deaths-demographics-june-2022/download

Focus Areas

As Mass General Brigham develops and implements programming and supports that will reduce disparities in health outcomes for the two system priorities, our efforts will focus on the highest need communities across our hospital priority neighborhoods. We will also continue to support locally identified priorities at the hospital level.

Community Priorities for Action

Prioritization allows organizations to target and align resources, leverage efforts, and focus on achievable strategies and goals for addressing priority needs. Through a systematic, engaged approach that is informed by data, priorities are identified through an iterative process to focus planning efforts. This section describes the process and outcomes of the NWH CHNA prioritization process.

Newton-Wellesley Hospital Prioritization Process

The prioritization process was multifaceted and aimed to be inclusive, participatory, and data-driven.

Step 1: Input from Community Members and Stakeholders via Primary Data Collection

During focus groups and interviews, assessment participants were asked for input on the top priorities for action in their communities. Participants were asked about the most pressing concerns in their communities, and their highest priorities for future action and investment. Secondary data at the state-, county-, and town-level were also reviewed for particular areas of concern related to social, environmental, and health concerns.

Synthesizing social, economic, and epidemiological statistical data with community perspectives and discussions, this 2022 CHNA found a number of key priority areas for action related to community health:

- Housing Affordability
- Transportation
- Chronic Disease Management and Prevention
- Mental Health
- Substance Use
- Health of Older Adults
- Access to Quality Care
- Workforce Development
- Investing in Community Resources
- Sustained Community Engagement and Empowerment
- Health and Racial Equity

Newton-Wellesley Hospital Service Area Prioritization Process

2022 Assessment Study – Primary and Secondary Data Synthesis

- Synthesized data on social, economic, and health issues
- CHNA participants identified areas of concern and priority via key informant interviews and focus groups.

Previous Priorities and Initiatives

- Review of priorities determined by prior NWH CHNA-SIP processes in 2015, 2018, and 2021.

Mass General Brigham System-Wide Priorities

- Incorporation of priorities identified through assessment of regional community health data at the system level

Community Benefits Committee+ Prioritization Meeting

- Presented study findings and established priorities using selected criteria
- Local community leaders discussed study findings and other prioritization criteria, then refined and approved priorities

Step 2: Review of Previous Priorities and Current Related Initiatives

Considering priorities identified from prior CHNA-SIP processes was important, especially considering the great health and social challenges communities have faced in recent years related to the COVID-19 pandemic as well as the ongoing movement for racial justice. Previous and ongoing initiatives were also considered, in order to most efficiently use resources and existing partnerships. **Figure 89** shows priorities identified from the 2015, 2018, and 2021 CHNA-SIP processes.

Figure 89. Priorities from Previous Newton-Wellesley Hospital CNHA-SIP Processes

2015	2018	2021
Access to Care/ Transportation	Access to Care	
Substance Abuse	Substance Abuse	Substance Abuse
Mental Health	Mental Health	Mental Health
	Social Determinants of Health	Social Determinants of Health
	Chronic Disease Management & Prevention	Chronic Disease Management & Prevention
	Other Community Needs	
Elder Care		
Emphasis on Waltham		

Step 3: Incorporation of System-Wide Priorities

The Mass General Brigham healthcare system has identified system-wide priority areas including:

- Mental healthcare capacity
    - Workforce development
    - Expanded access to services
- Chronic disease management
    - Improving heart health
    - Addressing substance use disorders
- Nutrition security, equity, and access

Across all areas, initiatives will focus on inequities due to race, ethnicity, language, and disability status.

Step 4: Priority Refinement and Input from Community Benefits Committee+

In September 2022, members of the NWH CBC+ reviewed findings from the 2022 Community Health Needs Assessment and their impact on the most vulnerable populations identified (older adults, youth, immigrants, and people of color). CBC+ members also reviewed priorities from previous CHNA-SIP processes, and the Mass General Brigham system-wide priorities.

CBC+ members discussed assessment findings and contributed their own expertise in the ways these topics affected the local communities they serve. CBC+ members were asked to consider the Prioritization Criteria shown in **Figure 90** when selecting the top priorities to focus on for strategic planning.

Figure 90. Prioritization Criteria

Criterion	Key Questions
Burden	How much does this issue affect health in the community?
Equity	Will addressing this issue substantially benefit those most in need?
Impact	Can working on this issue achieve both short-term and long-term changes? Is there an opportunity to enhance access/accessibility?
Systems Change	Is there an opportunity to focus on/implement strategies that address policy, systems, and environmental change?
Feasibility	Is it possible to take steps to address this issue given current infrastructure, capacity, and political will?
Collaboration / Critical Mass	Are there existing groups across sectors already working on or willing to work on this issue together?
Significance to Community	Was this issue identified as a top need by a significant number of community members?

From this discussion, the following priorities were selected:

- **Housing Affordability**
- **Mental Health & Substance Use**
- **Access to Quality Care, with a focus on:**

    - Chronic disease prevention and management
    - Integration of services and healthcare
- **Transportation**

It was recommended that all priorities be addressed with the following cross-cutting strategies:

- Health and Racial Equity
- Workforce Development
- Sustained Community Engagement and Empowerment

Finally, all priorities should specifically consider the special needs of the communities' most vulnerable populations:

- Older adults
- Youth
- Immigrants
- People of Color

APPENDIX A: Review of Initiatives 2018-2020

Activities, Services and Programs listed in 2018 Implementation Strategy	Comment on Activity, Service and/or Program (e.g., collaborations, partnerships, successes, etc.)	Number of Individuals Served, Number of Classes Offered, etc.		
		FY18	FY19	FY20
Priority Area: Mental Health				
Priority population: Youth				
Increase and expand access to child and adolescent mental health services	The National Institute of Mental Health reports that 1 in 5 children or adolescents experience a mental health problem before the age of 18. Child and Adolescent Psychiatry Clinic and service serves NWH patients.	There were 3,276 clinic visits in 2018, a 39% increase over 2017. 15% of the clinic visits were referrals from local schools. In FY18, ED visits were 611, an 11% increase from the previous year.	There were 3490 clinic visits, a 5% increase over FY18, 15% of clinic referrals were from local schools. Child psych consults decreased by 8 % in Emergency Department. Expanded capacity with two child psychiatrists and two clinical social workers.	4000 patients were seen in the Child and Adolescent Clinic, a 14% increase over FY19. Offered telehealth visits starting in April 2020 due to COVID-19. 600 pediatric patients were seen for mental health care in the Emergency Department.
The Resilience Project expansion & collaboration	The Resilience Project is a school- and community-based initiative to promote the mental health and well-being of adolescents run by mental health providers at NWH. The Resilience project expands access to mental health services, fosters school partnerships, and develops and conducts parent programs.	The Resilience Project incorporated school teams into the 7 high schools in NWH primary service area. A child psychiatrist and social worker visited the schools over 10 times to address issues of mental health. Included consultations with Special Education educators, guidance	Child psychiatrist and social worker provided ongoing clinical consultation. Clinical team held 17 professional development events, 500 in attendance. Integrated psychologist into project team and expanded group-based supports.	A clinical social worker was hired to provide expanded referrals, resources, and virtual visits. A pediatric psychologist was hired to oversee The Resilience Project and provide additional clinical services. Project expanded to include 11 middle schools in six towns within hospital's service area, reaching 8,000

Activities, Services and Programs listed in 2018 Implementation Strategy	Comment on Activity, Service and/or Program (e.g., collaborations, partnerships, successes, etc.)	Number of Individuals Served, Number of Classes Offered, etc.		
		FY18	FY19	FY20
	Clinical team includes child psychiatrist, psychologist, and social worker who provide consultation and education to community.	counselors, school nurses, and administration.		students. Continued collaboration with 7 high schools (10,000 high school students). Group-based supports through parent skill building programs. 130 participants. Resilience Project team engaged with 1000 participants which included clinical consultation and professional development.
Provide professional development for school faculty and staff	Host annual Mental Health Summit that provides networking and collaboration opportunities for school professionals.	130 community members from NWH's Primary Service Area attended third annual summit focusing on student stress and wellbeing.	100 different school professionals attended fourth annual Summit focusing on resilience in education.	The fifth Summit had 120 in attendance, focused on balancing emotional health and academic success.
Conduct educational sessions and provide programming for student, parents, and community on youth mental health.	Created custom programming via Resilience Project: • "Raising Resilient Teens" & "Raising Resilient Kids": parent education sessions for	Started development of groups focused on Raising Resilient Teens, 45 parents attended the sessions.	60 parents attended Raising Resilient Teens sessions, 30 attended a follow-up drop-in group, and an alumni group was offered. Started the development of the "Building Resilience" series.	130 participants in Raising Resilient Teens and Kids program and Resilient Parent Drop-in group. Provided 20 psychosocial presentations for community,

Activities, Services and Programs listed in 2018 Implementation Strategy	Comment on Activity, Service and/or Program (e.g., collaborations, partnerships, successes, etc.)	Number of Individuals Served, Number of Classes Offered, etc.		
		FY18	FY19	FY20
	managing and preventing problems in children • "Building Resilience" Series: monthly series discussing topics such as vaping, school refusal, benefits of family mealtime, etc. • Professional development for school administrators		About 550 people attended 25 different events for parents through PTO's, local parent groups, faith-based organizations, and others. 100 people attended the film screening of "Like" with a panel discussion at the hospital.	parents, and professionals on mental health. Launched the "Building Resilience" series with monthly educational sessions for parents and community members. Topics included: school avoidance/refusal, marijuana/vaping, DBT. Published 3 community newsletters with mental health resources. Worked with local media to promote supportive information for parents during COVID-19.
Promote employment, education, and community involvement with support of the Youth Interpreters Program	NWH sponsors a significant portion of the Waltham Partnership for Youth Language Access for Civic Engagements (LACE) Program interns to train as interpreter liaisons with by Cross Cultural	20 Spanish/English bilingual teens trained as interpreter liaisons.	25 Spanish/English bilingual teens were trained as interpreter liaisons by Cross Cultural Communications, Inc. 20 community events were held hiring a total of 45 youth interpreters.	8 additional bilingual teens were trained as interpreter liaisons by Cross Cultural Communications, Inc. to become interpreters for community events. Expanded to include Haitian/Creole. 51 students were hired for 27 events.

Activities, Services and Programs listed in 2018 Implementation Strategy	Comment on Activity, Service and/or Program (e.g., collaborations, partnerships, successes, etc.)	Number of Individuals Served, Number of Classes Offered, etc.		
		FY18	FY19	FY20
	Communications, Inc. Program.			
Convene NWH Health in Higher Education Forums quarterly to address mental health concerns among young adults in college setting	NWH convenes quarterly meetings with local area higher education leadership to address prevalent mental health concerns on college campuses. Colleges include Wellesley College, Babson College, Bentley University, MassBay College, UMASS (Newton Campus), LaSalle College, Boston College, Brandeis University, Regis College, William James College, and others.	4 forums were held that focused on substance use, mental health, eating disorders, clinical care and dorm settings.	2 forums were held. Focused on: International travel and infectious disease, sexual assault and safety and substance use and wellness communities.	2 forums held. Focused on mental health & substance use, college and hospital collaborations, and the impact of COVID-19 on college campuses.
Priority population: Elders				
Conducted programs on social isolation and frailty for elder mental health by collaborating with community partners	Tai Chi has been identified to improve balance and wellbeing among elders. A Matter of Balance is an intervention that addresses fear of falling and prevent loss of function in elders through	82 elders participated in the Matter of Balance program 150 seniors attended annual senior supper.	Held 4, 12-week Tai Chi Sessions in collaboration with the Newton Senior Center. 120 community members participated in the program. 128 elders participated in the Matter of Balance program.	90 seniors participated in Matter of Balance. 1000 seniors participated in Newton Senior Center Tai Chi sessions. Tai Chi was offered virtually due to COVID-19 and , so a larger number of

Activities, Services and Programs listed in 2018 Implementation Strategy	Comment on Activity, Service and/or Program (e.g., collaborations, partnerships, successes, etc.)	Number of Individuals Served, Number of Classes Offered, etc.		
		FY18	FY19	FY20
	coping skills, fall risk reduction, and decreasing activity restrictions. NWH hosts annual senior supper for health education and socialization for seniors. Mindfulness workshops educate seniors about mind-body connection and overall health. Hosted at senior centers and elder housing facilities. SMART program, developed at Massachusetts General Hospital, provides education on coping tools to relive stressors encountered in day-to-day living. Collaborate with Healthy Connections (Waltham), Newton Senior Services, and Jewish Community Housing for the Elderly		150 seniors attended annual senior supper. 12 Mindfulness Workshops were conducted at area senior centers, approximately 200 seniors participated. Worked in partnership with multiple community agencies to include senior centers, housing facilities, and social service organizations.	community members could access the programming. 50 seniors attended annual senior supper. 3 Mindfulness Workshops were conducted at area senior centers, approximately 45 seniors attended. A pilot ran in 2020, with 10 Newton seniors attending the virtually-held SMART program. Expanded partnerships with multiple community agencies, to focus on balance and fall risk programming as well as expanding opportunities for socialization. Began the Senior Community Living Forum with independent and assisted living facilities, focused on COVID, and isolation.
Provide custodial	Provide housekeeping,	Explored opportunities to	Formally developed the Patient in Need program	Patient in Need program assisted

Activities, Services and Programs listed in 2018 Implementation Strategy	Comment on Activity, Service and/or Program (e.g., collaborations, partnerships, successes, etc.)	Number of Individuals Served, Number of Classes Offered, etc.		
		FY18	FY19	FY20
resources for vulnerable patients for a safe transition from hospital to home	laundry, grocery shopping, and prescription pick up	support a transition to home service.	to address immediate patient challenges in maintaining lifestyle, care, necessities. Assisted 104 patients.	130 patients in the categories of food, lodging, safety, and others. 30% increase over FY19.
Create an Elder Care Services Council that focuses on the needs of elders in the NWH community	See Appendix B for more information.			
Focus on needs of the caregiver in the arena of elder mental health	Create support programs for caregivers. • Conduct a Caregiver Self-care program in collaboration with community Council on Aging. • Pilot Caregiver mobile app in Waltham. • Offer Savvy Caregiver Training (The Healthy Living Center of Excellence) to NWH community caregivers.	Took part in focus groups and preliminary work on the pilot Caregiver mobile app. App was never launched by initiating group.	Held a community education series titled "Partners in Caregiving." 90 people attended.	
Priority population: Maternal				

Activities, Services and Programs listed in 2018 Implementation Strategy	Comment on Activity, Service and/or Program (e.g., collaborations, partnerships, successes, etc.)	Number of Individuals Served, Number of Classes Offered, etc.		
		FY18	FY19	FY20
Expand maternal mental health services through staffing, clinical tools, and communication resources	One out of seven women experience depression or anxiety during pregnancy or postpartum. Postpartum depression affects 10-15% of the NWH maternal patient population.	Created the Maternity Services Council with a focus to specifically address depression and mental health concerns in maternal patients, see appendix B for more details.	NWH hired a social worker for Perinatal Mood and Anxiety Disorder Initiative, 105 referrals in first six months of the program. Collaborated with 3 OB practices to pilot using screening for maternal patients at 24 weeks prenatal, 6 weeks postpartum, and 6 months postpartum. Development of a postpartum support group for new mothers.	337 patients referred in 2020. 537 since the program began in May 2019. Social work coverage increased to 24 hours. Expanded the Post-Partum Mothers Support group to two days per week with 11-15 new moms attending each session. Shifted to virtual during COVID-19. Expanded presence on the web for on-going education and information sharing.
Provide opportunities for community education on postpartum depression and maternal wellness.		A lecture on post-partum depression was held.	Community lecture on postpartum depression had 40 attendees. Established web-based platforms for education and information sharing.	Held a community-wide lecture with four workshops focused on healthy pregnancy, 30 attendees.
Priority population: Immigrants				
Improve cultural competency in mental health services for immigrant communities	Make materials available in a variety of languages. Involve bi-lingual and culturally diverse	Provided 6844 completed Interpreter Service requests, including face-to-face,	Provided 7365 completed Interpreter Service requests, including face-to-face, telephonic, video, ASL.	Provided 10,616 completed Interpreter Service requests, including face-to-face, telephonic, video,

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	clinicians in outreach efforts. Provided clinical staff with training on providing patient advocacy that included instructions on cultural factors. Provided hospital-wide communication on utilizing interpreter services. Included how to access Interpreter Services in new employee orientation. Educated and raised awareness on cultural competence through an on-line education platform Provided clinical staff with training on providing patient advocacy that included instructions on cultural factors.	telephonic, video, ASL.	Provided translated documents for: discharge instructions, patient rights, menus, and patient education.	ASL. A 44% increase over FY19. Provided translated documents for: discharge instructions, patient rights, menus, and patient education and patient guidebook. Ensured that the website and signage was available in the top five NWH languages: English, Spanish, Russian, Chinese – Cantonese, Chinese-Mandarin. Translated COVID Safe Care guidance in 12 languages, including COVID-19 Hotline information. Translated FAQ documents. Distributed materials to over 4000 Waltham residents a community which was highlighted as a hot-spot community in the pandemic.
Priority Area: Substance Use				
Expand access to and resources of the	NWH's Substance Use Service (SUS) provides	SUS clinicians consulted >100 new patients and	SUS clinicians completed 337 patient visits (68% increase	SUS clinicians completed 800 patient visits (137%

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Substance Use Service.	consultative and outpatient services to adults with substance use disorders using a multidisciplinary approach.	completed >200 patient referrals from primary care, inpatient care, and emergency department clinicians.	over FY18) for those referred by NWH primary care, inpatient Hospitalist service, and emergency department clinicians.	increase over FY 19). There was a 350% increase in new patient visits (FY20 = 284 vs. FY19 = 63). Patients were referred by NWH primary care, inpatient Hospitalist service, and emergency department clinicians. Expanded the SUS Service team to include a recovery coach and a licensed clinical social worker. Recovery Coach conducted weekly support sessions (via zoom during COVID-19). There have been 200 participants involved in the sessions.
Educate clinicians, pharmacists, and public health officials on best practices and roles in pain management and addiction	Expert substance use clinicians continued providing training in pain management and addiction to clinicians via education.		SUS clinicians provided education and training to medical personnel.	Piloted a Primary Care Physician Champion to provide consult and training on prescribing guidelines, tools, and safety in a primary care setting. Works as a liaison for referrals

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				and transition of care between PCP practices and SUS clinic. Medical grand rounds were conducted and open to the medical community, the focus was specific to addiction and COVID-19.
Address stigma associated with substance use by collaborating with community partners and other outreach efforts	SOAR Natick, which stands for Supporting Outreach and Addiction Recovery, is a support group for those with a loved one suffering from substance use disorder. The Purple Flag project plants purple flags in public spaces to represent Massachusetts residents that have died from an opioid overdose in the past year. Public displays were designed to encourage community and hospital staff		Partnered with SOAR Natick during International Overdose Awareness Day and National Recovery Month on two displays, one at NWH and another in the surrounding community. The Opioid Project displayed artwork and recordings of personal stories of people affected by the opioid epidemic. The Purple Flag Project displayed flags as a reminder of lives lost to the opioid epidemic in Massachusetts. Clinical and administrative staff involvement in community efforts.	NWH continued its partnership with SOAR Natick during International Overdose Awareness Day and National Recovery Month on two displays, one at NWH and another in the surrounding community. The Opioid Project displayed artwork and recordings of personal stories of people affected by the opioid epidemic. The Purple Flag Project displayed flags as a reminder of lives lost to the opioid epidemic in Massachusetts.

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	engagement to reduce stigma around addiction. NWH staff and clinicians served in leadership roles on community initiatives and collaborations with local health departments, police, fire, and schools. Involvement included Newton Prevention, Awareness, Treatment and Hope (PATH).and MetroBoston Project Outreach, in addition to others.			On-going clinical and administrative staff involvement in community efforts.
Provide resources to community partners for needed substances.	Distribute EpiPens to community partners and locations.		Provided 104 doses of EpiPens to local fire departments and colleges.	Provided 100 doses of EpiPens to local fire departments and colleges.
Provide substance use education and resources.	Substance use resources and treatment options were provided at all events. Provide education forums to various organizations throughout the	Conducted a community wide lecture on Vaping and Juuling. Created a Juuling Tool Kit that was distributed to community public health	Conducted community wide education through lectures, forums, and school-based curriculums on vaping, marijuana, and substance use with internal and external experts for various community	Conducted community wide education through lectures, forums, and school-based curriculums on vaping, marijuana, and substance use with internal and external experts for

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	community including education to school programs with youth, parents, and educators.	departments, schools, and parents.	organizations, parents, youth, and educators.	various community organizations, parents, youth, and educators. A variety of mediums were used such as film documentaries, Q&A, personal story sharing, research. Events were conducted virtually post-March 2020.
Collaborate with local community-based organizations, local and statewide agencies to address the opioid crisis.	NWH collaborated with the Middlesex District Attorney's office to create the Charles River Regional Opioid Task Force The task force meets monthly and brings community stakeholders together to focus on a collaborative, public safety approach to addressing the opioid crisis.		The hospital supported monthly forums with multidisciplinary community partners to promote education, community programming, sharing of data, exchange of best practices, and opportunities for collaboration for Charles River Regional Opioid Task Force.	Programming shifted to a virtual format, which allowed for increased collaboration with community organizations. Members of the NWH SUS clinical team and community benefits regularly participated and presented at the meetings
Provide prevention mechanisms to address substance use	Access and use of Narcan is an effective option for treating drug overdose. NWH provides Narcan and training to community	NWH dispensed 79 naloxone kits to patients in the Emergency Department. Provided 340 doses of Narcan to local community	NWH dispensed 61 naloxone kits to patients in the Emergency Department. NWH provided 300 doses of Narcan to local community partners	NWH dispensed 66 naloxone kits to patients in the Emergency Department. Provided 250 doses of Narcan to local community partners

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	partners to support their efforts of dealing with the opioid crisis. Naloxone kits are also made available to those who present at the hospital with an opioid overdose. MedSafe receptacles accepts controlled (Schedules II-V), non-controlled, and over the counter medicines. These receptacles can reduce unintended and illegal use of drugs by providing safe disposal options. Maintain use at hospital pharmacy location.	partners police and fire, public health, schools, and shelters. Provided training to community partners, as necessary. Made the MedSafe receptacle available to patients, visitors and community.	police and fire, public health, schools, and shelters. Provided training to community partners, as necessary. Made the MedSafe receptacle available to patients, visitors and community.	– police and fire, public health, schools, and shelters. Provided training to community partners, as necessary. Made the MedSafe receptacle available to patients, visitors and community.
Community Referral Resource database	*Partner with Massachusetts Health and Hospital Association to develop and promote a Community Referral Resources database for use in continuing care for SUD patients.*			Provided resources to the community through the SUS Clinic and Integrated Care Management and Community Health Workers and Behavioral Health Coaches.
Priority Area: Access to Care				

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Improve access to primary care for school aged children by providing care, addressing social determinants of health, and collaborating with community partners.	The Pediatric Primary Care Clinic (PPCC) and NWH Waltham Family Medicine provide medical care to children and adolescents who are uninsured and/or who experience primary care access challenges. Clinics also provides help with food access, behavioral health, and financial counseling for MassHealth Applications. Clinicians collaborated on agency boards to promote primary care access by partnering Newton Boy's Girls Club, Mass Medical Society's School Health Committee, local colleges and universities, YMCAs, and local Boards of Public Health	The pediatric clinic had 523 visits, continued to receive youth referrals, and provided care to 30 uninsured patients awaiting Mass Health approval. Expanded language interpretation for clinics through hospital contract. NWH clinicians served on various community boards and in leadership positions in the NWH primary communities.	There were 491 visits to the pediatric clinic, continued receiving youth referrals, and provided care to uninsured patients. Collaborated with Waltham Public Schools to provide bi-lingual information on care access. NWH clinicians served on various community boards and in leadership positions in the NWH primary communities.	There were 375 visits to the pediatric clinic, continued receiving youth referrals, and provided care to uninsured patients. The newly hired Waltham Community Health Worker provided support and resources related to social determinants of health. NWH clinicians served on various community boards and in leadership positions in the NWH primary communities.
Expand palliative care services	Expand palliative care service into outpatient and community settings, see	Palliative Care Council focused on access to palliative care in outpatient	Support the exploration of a care model to expand palliative care in	Palliative Care Council continued to support the exploration of the possibilities for

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	further detail in Appendix B.	settings, see Appendix B.	hospital and provider practice locations.	growth of palliative care access into outpatient and primary care settings.
Convene DPH regarding access and care in hospitals and community	Convene Departments of Public Health and local community agencies on a quarterly basis to communicate challenges, share best practices, review services, and strategize solutions.	NWH Emergency Department provided data on a quarterly basis in the areas of top five diagnosis, overdose, and behavioral health	Topics included Stop the Bleed program, vaping diversion and cessation programs, tools for data gathering, substance use, and behavioral health. NWH Emergency Department provided data on a quarterly basis in the areas of top five diagnosis, overdose, and behavioral health.	Topics included behavioral health, safety, and COVID-19. NWH Emergency Department data is provided on a quarterly basis in the areas of top five diagnosis, overdose, and behavioral health. Increased frequency of meetings and consistent communication due to COVID-19. This preexisting structure eased communication during COVID-19.
Care Finder service	NWH's Care Finder Program makes primary or specialty appointments for those in need of care including Medicaid and uninsured patients.	Total year end call volume was 8000 calls.	Total year end call volume for was 8000 calls	Total year end call volume was 7500 calls.
Expand access for health appointments	Expand hospital use of Circulation/Lyft Non-Emergent transport service to	Facilitated 411 rides through the Circulation/Lyft platform for ease	Facilitated 1,507 rides through the Circulation/LyftPlatform. This was an increase of	Facilitated 1422 rides through the

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and discharge transportation	enable patients to come to and leave the hospital with greater ease. Provide Taxi vouchers through Veteran's Taxi for certain low-income populations that have difficulty accessing transportation for healthcare services.	of access to and from hospital care. Taxi voucher program provided Veteran's Taxi for clients of homeless shelters, residents of low-income housing, and seniors.	over 200% compared to FY18. Veteran's Taxi provided vouchers for residents of low income housing to have ongoing access to needed healthcare services.	Circulation/Lyft platform. Expanded use of Circulation/Lyft by the Emergency Department, Cancer Center, and Integrated Care Management Program. Provided taxi vouchers from Veteran's Taxi for residents of low-income housing to have on-going access to needed healthcare services.
Convene NWH Health in Higher Education Forums	NWH Health in Higher Education Forums meet quarterly and bring together hospital and college leadership to strategize on access to care of college age patients/students.	Approximately 25 leaders attended each forum. Forum topics included mental health, depression, opioid use, availability of cannabinoids with marijuana recreational use approval, eating disorders, and communicable diseases in dorm settings.	Approximately 25 leaders attended each forum. Forum topics included mental health, depression, opioid use, international travel, sexual violence, and wellness communities.	Approximately 30 leaders attended each forum. Forum topics included mental health, depression, and opioid use. Experts addressed COVID-19 concerns. Shared safety strategies for students including testing resources, residential living, and others.
Expand "off hours" clinics	Explore/expand development of "off hours" clinics			

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	in areas where patients do not have daytime flexibility for medical visits/treatments. Pursued through a broader hospital strategy to include consideration for community impact.			
Address basic needs for patients' medical condition with no alterative options	Multidisciplinary teams link patients to ongoing clinical and social services including food, lodging, safety, and other needs.		Aided 104 patients.	Aided 130 patients, a 30% increase over FY20.
Incorporate community health worker (CHW) in NWH primary service area communities.	Community health workers linked families to community resources and offered ongoing support for accessing services.		Waltham practice location hired a community health worker to navigate patient/family needs related to social determinants of health needs.	Expanded CHW role in the Waltham community. Hired a CHW to serve the Newton and Needham. Exploring CHW roles in the Natick, Weston, and Walpole.
Collaborate with home care providers to address COVID-19	Convened the assisted and independent living facilities in NWH communities to respond to COVID-19 pandemic. Forums shared content expert information,			25 assisted and independent living facilities gathered for first meeting. Given the positive feedback, the forum will continue quarterly.

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	relayed best practices, and aligned services.			
Priority Area: Social Determinants of Health (SDOH) including Built Environment, Social Environment, Housing, Violence and Trauma, Education, Employment				
Built Environment				
Promote enhanced food access and healthy eating	Wellness Collaboration with Healthy Waltham mobile food pantry with cultural and age group considerations Support the Summer Eats program alongside Waltham Boys & Girls Club that provides children	Summer Eats program served 33% more free meals to Waltham youth.	Includes breakfasts, snacks, lunch and dinner. In 2019 there was a 15% increase in meals served from 2018 and a 56% increase over 2017.	Supported Summer Eats adjustment due to COVID-19 while still addressing hunger needs.

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	with free meals during the summer. Distributed promotional material about the program in both Spanish and English.			
Waltham Wellness Collaboration	Supports Healthy Waltham collaborative that works to promote healthy and active lifestyles. Supports Waltham Connections for Healthy Aging, a model that promotes healthy aging for local seniors that face economic, ethnic, or other barriers. Activities include: • Walking Waltham initiative to engage entire community (ages 2-96) and get more people walking, reduce obesity,	Walking Waltham initiative focused on Waltham's natural spaces and city streets. Held 1 physician led "Walk with a Doc" sessions, 60 seniors attended the session. Supported Healthy Waltham on implementing a new school wellness policy. Actively participated in Waltham Connections program. Conducted in-school programming for healthy eating and nutrition.	Continued Walking Waltham. Held 7 physician led "Walk with a Doc" sessions, 60 seniors at each session, 400 total. Supported Healthy Waltham to participate in the School Health Advisory Committee to implement policy change as necessary. Actively participated in Waltham Connections program. Continued programming for healthy eating and nutrition.	"Walk with a Doc" suspended due to COVID-19. Partnered with Healthy Waltham to distribute food to 800 clients, up from 200, during COVID-19. NWH provided additional financial support, COVID-19 care kits, and 61 flu vaccines at a mobile food market site. Continued participation in Waltham Connections for Healthy Aging. Continued programming for healthy eating and nutrition.

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	and combat stress. • "Walk with a Doc" sessions with seniors to promote health education, physical activity, and socialization. • Conduct in-school programming around healthy eating and choices for Waltham youth			
Social Environment				
Support Waltham Partnership for Youth Transportation study	Sponsored the Waltham Partnership for Youth (WPY) Rides Together study to address transportation needs of youth and families. The study considers how transportation systems can be designed to serve all people more efficiently, affordably and safely.	The study examined existing policy and practice in Waltham around transportation; engaged community members to identify gaps in current infrastructure; and proposed possible solutions.	The study identified three priorities to improve outcomes for transportation in Waltham. Engaged and collaborated with stakeholders to make changes.	Continued efforts to address the need for efficient affordable and safe transportation options in the City of Waltham,.
Housing				

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Engage with housing facilities	Partner with low-income housing facilities (seniors and others) to provide flu vaccines, educational programming, and clinical advisement	Explored possibilities of clinical linkages with housing facilities.	Continued to engage in conversations regarding NWH clinical care embedded in local housing facilities Began discussions for providing educational programming to low income housing facilities in Newton.	Program launch was put on hold due to COVID-19.
Provide health programming to homeless shelters	Provided resources during COVID-19 (burner phones, masks, PPE supplies). Gave consultation for creation of testing site at the center.	Provide items and resources to local homeless shelters. Conducted annual flu clinics at shelters.	Provide items and resources to local homeless shelters. Conducted annual flu clinics at shelters.	Provided tangible and intangible supports to homeless shelters during COVID-19 to include PPE supplies, burner phones and clinical consultation. Conducted annual flu clinics at shelters
Improve culturally competent health care	Address the hospital's adequacy in delivering culturally competent care to vulnerable patient populations	Provided education on use of and access to Interpreter Services. Improve language access signage throughout the campus.	Provided education on use of and access to Interpreter Services. Improve language access signage throughout the campus.	Hospital created an Office of DEI and appointed a Chief to lead the efforts, hospital wide. Integrate NWH strategic imperatives and MGB United Against Racism objectives. Expanded education on services provide through Interpreter Services to enhance language access for patients and

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				community members.
Violence and Trauma				
Expand NWH domestic and sexual violence program.	The Domestic Violence/ Sexual Assault (DV/SA) Program provides free, voluntary, and confidential services to patients and employees who are experiencing domestic violence, family violence, and sexual assault. The DV/SA program includes counseling, consultation, advocacy, education, partnerships including: • Supported capacity building of DV specialists in community including healthcare providers, institutions, and probate	The DV/SA program served over 250 survivors, provided over 1,000 healthcare providers and multidisciplinary professionals.	The DV/SA program served over 500 survivors. Program provided 1500 hours of safety planning, counseling, and advocacy for survivors. Implemented domestic and sexual assault violent training for healthcare providers across state and locally. Held conference on trauma and oppression in the childbearing year, the Black maternal health crisis, transgender parents, and the impact of the political climate on immigrant parents and their children.	The DVSA program served over 734 survivors, 45% increase over FY19. The program provided 1000 hours to survivors. Additional thousands of hours were devoted to community education, training, policy development, and collaboration. Program provided $17,000 in emergency funding to victims for basic needs through the Domestic and Sexual Abuse Council. Provided COVID-19 self-care informational materials in multiple languages, COVID-19 Care Kits, and PPE to shelters

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	and family court • In-kind donations and expertise to local shelter			and DSV organizations.
Oversight and participation in the National Sexual Assault Nurse Examiners (SANE) Telenursing Center at NWH	NWH's National TeleNursing Center (NTC) uses telehealth to support the delivery of quality, trauma-informed care for sexual assault patients.	The NTC provided education to hundreds of providers across the country to improve quality of DV/SA services and expanded access to national SANE protocols.	Program staff continue to serve on the project management team of the National SANE TeleNursing Center (NTC). The Center served six pilot sites across the nation.	The SANE Center served eight pilot sites across the nation on a 24/7 basis, providing real-time consultation to clinicians serving survivors of acute sexual assault at military installations, on Native American reservations, and in rural parts of the country.
Expand trauma-informed care approach	DV/SA program is part of a multidisciplinary Team, including the SANE program, several local district attorney's offices, and multiple local police departments, known as the Custody Awareness Collaborative (CAC), that infuses trauma informed practices into local	Supported CAC program by expanding collaboration to include campus police forces and Title IX coordinators.	Supported CAC by translating a toolkit into Spanish, advised on and facilitated the publication of "Like I am Invisible": IPV Survivor Mothers' Perceptions of Seeking Child Custody through the Family Court System.	The partnership trained numerous community-based victim services through education platforms, trainings and consultations.

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	police departments.			
Address abuse in vulnerable populations: elders, LGBTQ, immigrants	Grow accessibility for Latin, Spanish speaking, and undocumented survivors who are disproportionately at risk. The DV/SA program continued collaboration with REACH Beyond Domestic Violence. Participated in abuse later in life partnership alongside REACH Beyond DV, Springwell Elder Protection Services, Middlesex County DA Office. Trains community-based victim services providers and detectives in 7 counties. Build capacity around LGBTQ partner abuse and trauma.	Continued participation in abuse in later in life partnerships. DV/SA placed a bilingual intern with Latinas Know Your Rights Program with REACH and Greater Boston Legal Services. Continued other collaborative programs and activities including: • culturally and linguistically specific support groups • expressive art therapy groups • community education events were marketed in Spanish, with bilingual materials and interpretation available. • weekend retreat for female and genderqueer survivors • "Night of Healing" for	Provided a $50,000 grant to REACH Beyond Domestic. Began hiring a bilingual social worker in Waltham to better serve Latinx survivors of abuse and their children. Of REACH's total number of clients, over half are of Latina descent. Continued collaborative programming with REACH: • Culturally and linguistically specific support groups • Expressive art therapy • Community education series for parents concerning bullying (bilingual in Spanish, interpreter provided) Partnered to provide programing to address partner abuse and trauma in LGBTQ communities. • Partnered with The Network/ La Red to present a day-long conference on LGBTQ	Continued collaboration with REACH Beyond Domestic Violence and Greater Boston Legal Services. Directly served over 150 Latinx survivors in Waltham, 60 families received emergency assistance, and 60 survivors received UVisas and asylum status. The DSV Council supported resources translation into 13 languages.

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		survivors of sexual assault	• panel presentation on "Breaking the Silence: Confronting Domestic Violence in LGBTQIA Communities" at Brandeis University. • Participate on the LGBTQIA Domestic and Sexual Violence Coalition.	
NWH Health In Higher Education Forums quarterly	Address sexual violence within the college age population through Health in Higher Education Forum meetings dedicated to college student health issues including sexual violence. Local area higher education leadership attends including Deans of Student Life, Directors of Student Health, Medical Directors, Public, Safety Leadership, and Chaplain Services.	NWH convened quarterly meetings with local area higher education leadership to address prevalent health concerns on college campuses.	NWH continued to convene quarterly meetings, approximately 25 leaders attend each forum, and sexual violence was discussed.	Continued quarterly forums, pivoted to virtual format during COVID-19.
Create a hospital council focused on domestic and sexual abuse	See Appendix B for further details.			
Employment & Education				

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Participate in internship programs and provide healthcare career exposure	NWH participated in Waltham Partnership for Youth and Newton Health and Human Services Internship programs. Provide opportunities for youth to gain career exposure and learn from professionals about career opportunities. Provide student and adult populations through healthcare career exposure through fairs, internships, and career-focused opportunities. Partnered with One Family, Inc. to develop an educational program for clients in the OneFamily Scholar Program. NWH staff attend career fairs, club meetings, and spoke at events to educate attendees on healthcare career options.	Hosted two student interns from the Newton Mayor Youth Internship Program through Newton Health and Human Services. Hired two Waltham High School students through the Waltham Partnership for Youth summer Internship program for exposure in imaging and rehabilitation departments. Began planning for a Lunch and Learn event to be held in October 2018 alongside OneFamily Scholar Program. Began planning for a Career Night to be held at NWH focusing on careers that require less than four-year degrees, certificate programs, or formal schooling.	Established a three-year plan to provide sponsorship for the Youth Intern Coordinator at Waltham Partnership for Youth. Hired 14 Waltham High School students through the Waltham Partnership for Youth Summer Internship. 4 students were offered employment at the conclusion of the program. Held a Lunch and Learn at NWH for the One Family Scholars Program to expose adults to healthcare environment. Held a Career Night at NWH focused on careers requiring a two-year degree, certificate programs, or alternative training. Geared to high school students. Had 70 attendees.	Hired 20 Waltham High School students through the Waltham Partnership for Youth Summer Internship. Provided support to WPY for the Youth Intern Coordinator. Conducted weekly career exploration sessions for community teenagers through the NWH Volunteer Program, 38 student volunteers attended. Held a virtual NWH Career Event over two evenings with 75 attendees.

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Provide work-skill based opportunities	NWH provides work skill Based opportunities for students and adults through the NWH vocational volunteer program.	Provided 126 individuals adult and youth in vocational programs with work placement opportunities. Individuals contributed over 8000 hours of service in the year.	Provided 84 adult and youth individuals, in vocational programs, with separate, ongoing work placements. Individuals contributed over 5000 hours of service in the year.	Provided 47 individuals adult and youth in vocational programs with separate, on-going, placement opportunities. Program was suspended due to COVID-19.
Workforce Development Council	See Appendix C for further details			
Priority Area: Chronic Disease Prevention and Management				
Conduct community-based outreach for health education, promotion, and disease prevention	NWH conducts a series of screenings, clinics, health awareness programs in the community. • CPR/First Aid certification for childcare, domestic violence workers, and parents living in homeless shelters with medically complex children • Conduct specialty clinics and screenings including blood	NWH conducted 7 specialty clinics/screenings in the community. NWH administered 970 flu vaccines at 14 flu clinics held at various locations in the NWH service areas. Partnered with Mt. Auburn Hospital to offer an 8-week Freedom From Smoking class smoking cessation class in Waltham at Charles River Health Center. 11 individuals signed up for the class, with 2 participants	NWH conducted 10 specialty clinics/screenings (senior centers, housing complexes) in the community including blood pressure screenings, advanced care planning, nutrition, stroke prevention, and safe driving. NWH administered 1103 flu vaccines at 13 flu clinics. 60 NWH clinical experts spoke at various community agencies and school event. 54 Domestic Violence workers were CPR/First Aid trained.	NWH conducted blood pressure and sports clinics. Several annual screening events were not held due to COVID-19 but addressed these topics through virtual programming. 50 NWH clinical experts spoke at various community agency and school events, and 600 individuals attended community health educational programs. Senior Webinar series focused on telehealth and

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		FY18	FY19	FY20
	pressure and sports injury • Support publication of Waltham Senior Center Newsletter, and translated it into Spanish • Created the Senior Webinar Series during COVID-19 to address increased isolation among seniors.	completing the program. 55 NWH clinical experts spoke at various community agencies and school events, and created a monthly online Hot Topics segment for health education. 220 childcare workers. 64 Domestic Violence workers, 15 parents, who are residents of the Home Suites family homeless shelter, were CPR trained.		cardiac care during COVID-19. 220 seniors attended.
Programs to address mobility function and fear of falling programs	See elder mental health under mental health priority	82 seniors took part in the Matter of Balance program.	Seniors took part in Matter of Balance (128) and Tai Chi programs (120).	90 seniors participated in the Matter of Balance Program. 1000 seniors took part in Tai Chi programming conducted by the hospital.
Promote home safety and safe care for seniors	Provide home care services to vulnerable populations through Neighbors Who Care (Waltham) and	Explored opportunities to provide at home services for patients returning to the community.	Supported outside organizations with this expertise.	Supported outside organizations with this expertise.

Activities, Services and Programs listed in 2018 Implementation Strategy	Comment on Activity, Service and/or Program (e.g., collaborations, partnerships, successes, etc.)	Number of Individuals Served, Number of Classes Offered, etc.		
		FY18	FY19	FY20
	Newton At Home (Newton).			
Support programing to patients and caregivers for cardiac care issues	Offer Cardiac care support programming to patients and caregivers to address issues associated with cardiac care. Create Cardiovascular Council, see Appendix B.			
Provide cancer education and screening options to at-risk populations	NWH Cancer Center conducts annual Empowered Health, Empowered You focusing on self-care and cancer prevention in community. Also conducts annual Cancer Survivorship event.		40 patients were seen during the annual skin cancer screening event. 100 attendees participated in Empowered Health/ Empowered You women's cancer event. 90 attended cancer survivorship event (90 attendees),	102 individuals attended Empowered Health/Empowered You event, held virtually due to COVID-19. 120 individuals attended survivorship program, held virtually due to COVID-19.
Support local health & wellness initiatives	Send NWH representatives to community health, wellness, and safety events education events.	NWH had representatives at 20 health community events such as Think Pink, car seat safety, scout first aid, and advanced care planning.	NWH had representatives at 100 health community events including: Swim Safety Event in partnership with Jewish Community Center, Living Well, Dying Wisely"	Due to COVID-19, in person events were suspended. NWH representatives participated in many virtual programs with schools, health departments,

Activities, Services and Programs listed in 2018 Implementation Strategy	Comment on Activity, Service and/or Program (e.g., collaborations, partnerships, successes, etc.)	Number of Individuals Served, Number of Classes Offered, etc.		
		FY18	FY19	FY20
	NWH clinicians serve on local boards providing outreach to community.		in partnership with Good Shepard Community Care, and a Loneliness Forum in partnership with the Middlesex District Attorney's Office. Additional involvement was in collaboration with schools, businesses, chambers, senior living facilities, and others.	businesses, and others.
Priority Area: Other Identified Community Health Needs				
Expand and conduct emergency preparedness	NWH facilitates emergency planning in the community by: • Participating in local, state, and regional emergency preparedness planning • Convening community partners for emergency management planning. • Serving in leadership capacity for local emergency management	Conducted 4 Active Shooter Drills in City of Newton. Conducted 1 tabletop exercise with Waltham Provided 25 hemorrhage control kits for Newton Public Schools. Provided City of Newton with replacement Halo seals for kits.	Conducted Stop the Bleed sessions for community First Responders (10 attendees) and to school nurses. Presented program to Public Health Leaders. Conducted a Massachusetts Emergency Management Agency functional exercise for the Boston Marathon. Hosted an Emerging Infectious Disease Conference for	Conducted 2 Active Shooter Drills in City of Newton. Conducted drills with Newton Fire and Cataldo Ambulance. Conducted a tabletop exercise with Waltham. Provided hemorrhage control kits for Newton Public Schools, as needed. Provide City of Newton with replacement Halo seals for kits, as needed.

Activities, Services and Programs listed in 2018 Implementation Strategy	Comment on Activity, Service and/or Program (e.g., collaborations, partnerships, successes, etc.)	Number of Individuals Served, Number of Classes Offered, etc.		
		FY18	FY19	FY20
	and disaster planning. • Partner with multiple agencies to prepare for the Boston Marathon. NWH also offers trainings and resources for emergency preparedness in the community including: • Tabletop exercises are discussion-based sessions where team members meet to discuss roles during emergency response. • Stop the Bleed is a training program from the American College of Surgeons that teaches people how to stop bleeding in severely injured persons.	Conducted a Massachusetts Emergency Management Agency functional exercise for the Boston Marathon Conducted Mutual Aid Coordinating Entity and Urban Area Strategic Initiative presentations. Conducted numerous other presentations on emergency management to community organizations Hosted a disaster training in partnership with National Disaster Interfaith Network for Boston area chaplains. 30 community chaplains attended and received certification.	hospitals and public health partners. Planned and conducted Active Shooter Drills in City of Newton. Conducted drills with Newton Fire and Cataldo Ambulance. Conducted tabletop exercise in Waltham.	Boston Marathon planning suspended due to COVID-19. Addressed COVID-10 by convening community partners for planning, ensured regular meetings, and served as a content expert.

Activities, Services and Programs listed in 2018 Implementation Strategy	Comment on Activity, Service and/or Program (e.g., collaborations, partnerships, successes, etc.)	Number of Individuals Served, Number of Classes Offered, etc.		
		FY18	FY19	FY20
	• HALO seals are high-performance occlusive dressings that can treat entrance and exit wounds.			
Develop partnerships and collaborations to address community health needs.	NWH created a model to expand community engagement, outreach, and services in areas identified in the 2018 CHNA. The model is known as The Collaborative for Healthy Families & Communities (CHF&C), and it includes 8 councils. The CHF&C is run by a Medical Director, a Director, and program outreach coordinator to facilitate the CHF&C collaborative. Each council has 20-35 members, 50 percent of councils are made up of community members who are passionate or have	Started planning for the addition of the following councils: • Domestic and Sexual Violence Council • Elder Care Council Examples of annual lectures included: • The Resilience Council held a screening and panel discussion of the film Screenagers. • The Collaborative held a lecture and discussion on Juuling and Vaping in schools.	Created the following additional Councils: • Domestic and Sexual Violence Council • Elder Care Council • Substance Use Council • Work Force Development Council • Cardiovascular Council Annual lectures included 6 lectures focused on postpartum depression, youth mental health, substance use, domestic and sexual violence, caregiving, health careers were held. Attendance ranged from 20 to 160 community members at each lecture.	500 people attended the Council programs virtually during COVID-19. Over 150 individuals were involved on the 8 councils. See Appendix A for further details on the work of councils.

Activities, Services and Programs listed in 2018 Implementation Strategy	Comment on Activity, Service and/or Program (e.g., collaborations, partnerships, successes, etc.)	Number of Individuals Served, Number of Classes Offered, etc.		
		FY18	FY19	FY20
	subject area expertise. Each council has two co-chairs that are community members and meets 4 times a year. Full list of Councils: • Resilience Council • Palliative Care Council • Maternity Services Council • Domestic and Sexual Abuse Council • Elder Care Services Council • Workforce Development Council • Substance Use Council • Cardiovascular Health Council Each council explores an initiative that addresses an community need related to the area of focus. Each Council also conducts an annual	Both events had over 100 attendees.		

Activities, Services and Programs listed in 2018 Implementation Strategy	Comment on Activity, Service and/or Program (e.g., collaborations, partnerships, successes, etc.)	Number of Individuals Served, Number of Classes Offered, etc.		
		FY18	FY19	FY20
	lecture for the community and promotes engagement and advocacy around their focus area.			

APPENDIX B: Review of Initiatives 2021

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
Priority Area: Mental Health	
Youth Mental Health	
The Resilience Project is an innovative school and community-based initiative designed to promote the mental health and well-being of adolescents. It provides support to students, parents, educators, counselors and communities with school personnel, customized educational programming and improved access to treatment services.	The goals of the Resilience Project are to expand clinical access to mental health services, foster school partnerships, and develop and conduct parent and community programs. All three goals have seen growth during FY21 through increased patient volume, enhanced school collaborations, and expansion of offerings and participants attending community and parent programs.
Create a regular platform for parent and community education and awareness on the topic of mental health.	Pivoted to a fully virtual format to continue providing The Resilience Project's Building Resilience series, which are free educational outreach programs for educators and community members. During this school year alone, this series offered 10 webinars to date. Examples of topics covered included promoting resilience and wellbeing for children and adolescents, dialectical behavior therapy and acceptance and commitment therapy-informed tools, how to have difficult conversations with children and teens, supporting students with special needs during COVID-19, how to talk with kids about racism, inclusion and social justice, and preparing students for the transition to college/post-secondary education.
Address parenting education and the development of skill-building tools for mental health and resilience.	Expanded the number of workshop cycles from two to three sessions per year of Raising Resilient Teens, a popular offering for parents. This psychoeducational, seven-week workshop for parents and caregivers of teens, is led by a child and adolescent psychiatrist and a clinical psychologist. The group also offers an Alumni Drop-In Group for parents and caregivers who have completed the workshop but would like an ongoing connection with other parents and support from the workshop facilitators. Each session was at capacity with a waiting list. More than 140 parents have participated in these sessions since the program was launched in 2017.
Create school-specific mental health programming to include a clinical consultation service and training.	Provided training and clinical consultation to more than 450 educators throughout the school year; 62 percent of these programs were delivered to middle school personnel, and 38 percent were delivered to high school personnel. Attendees to these trainings included school administrators, teachers, school nurses, guidance counselors, school-based speech and language pathologists, school nurses, special educators, school psychologists, social workers and school adjustment counselors.
Provide Educator Training Sessions, Professional Development and Clinical Consultation Programs	Provided 27 training sessions, professional development and clinical consultation programs to educators. Examples of this outreach included consulting schools on interventions to support students who were experiencing school refusal behaviors and managing educator stress while also generating and delivering new professional development content on

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
	topics such as educating students with special needs during COVID-19 and supporting students and staff with school re-entry in the context of the pandemic. One of the most popular and well-received talks this school year was entitled Resilient Schools: Supporting Staff Self-Care, Pivoting in Times of Change and Building Engagement with Students in a Virtual World.
Provide specific outreach to Newton and Waltham Public Schools.	Accommodated specific school requests, including presenting talks on youth mental health and resilience at school-based forums on social-emotional development for families in the Newton Public Schools and the Waltham Public schools, with attendance reaching nearly 90 participants combined. During 2020-2021, The Resilience Project had 14 touchpoints with the Newton Public Schools, spanning their middle and high schools, with 50% of those touchpoints happening in middle schools. During 2020-2021, The Resilience Project had 18 touchpoints with the Waltham Public Schools, spanning their middle and high schools.
Provide opportunity for collaboration with middle and high schools on the issue of mental health.	Organized and presented the fifth annual educational summit, The Compassionate Classroom: Balancing Emotional Health and Academic Success, on October 2 (provided in a virtual format). Featured speakers included Jonathan Kleiman, Senior Program Director at Challenge Success, who presented The Well-Balanced Student: Avoiding Stress and Overscheduling During the Pandemic and Beyond, Richard Weissbourd, EdD, Senior Lecturer, Harvard Graduate School of Education and Co-Director, Human Development and Psychology Program, Kennedy School of Government, presented Cultivating Caring, a Commitment to Justice and Wellbeing in Children. The session was attended by nearly 130 school staff members.
Support local initiatives focusing on mental health.	NWH clinical staff was represented on numerous local committees, and task forces across communities that focus on mental health in adolescents.
The Resilience Project Council (youth mental health), within the Newton Wellesley Community Collaborative, is an innovative school-and community-based initiative designed to promote the mental health and well-being of adolescents.	The Resilience Council, comprised of 22 community and hospital members, meets three times per year and focuses on key initiatives that include: providing support to students, parents, educators, counselors and communities through collaborating with school personnel, customized educational programming, and improved access to treatment resources.
Provide mental health care services to patients in the Child and Adolescent Clinic and in the Emergency Department.	In FY21, 4500 children were seen in the Child and Adolescent Clinic (a 17% increase over FY20). The outpatient clinic also saw a doubling in new patient referrals, including referrals from pediatricians and from schools participating in The Resilience Project. In FY21, 735 patients were seen for mental health care in the Emergency Department. This is a 102% increase over FY20. Young teens aged 13 and 14 represent the highest proportion of such ER visits.
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 aged 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 patients 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

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
	- Implementing practical strategies to manage common challenges including hair loss, hospital visits, and communication with children's schools In FY21, PACT provided 232 free individual consultations and 51 group therapy visits for 92 patients. PACT has also expanded its clinical team from two to four clinicians to continue to meet the growing need for support and guidance for parents with cancer.
Elder Mental Health	
Reverse or prevent loss of function and disablement commonly associated with fear of falling among older persons.	In FY21, the Matter of Balance Program served 40 participants for a total of 1,875 since inception in 1997.
Provide a group experience to reduce maladaptive ideas and beliefs about falls. Set realistic goals for increasing activity. Change their environment to reduce fall risk. Promote exercise to increase strength & balance.	Strength and Balance classes are held twice per week with 25 attendees per class. Held virtually and open to the whole community. Build confidence and tools for maintaining balance. Class creates a level of socialization and engagement among attendees.
Conduct Tai Chi classes to promote balance. Provide an outlet for group interaction and socialization among seniors through Tai Chi.	Tai Chi class is held once per week, virtually open to the whole community. 25 attendees per class. Continued positive feedback from program participants. This has enabled patients and caregivers to interact in new ways despite disease related conditions.
Provide a source of health education and socialization for local seniors in the community.	Held 5 virtual senior events with focuses on exercise, staying healthy and safe and home, dealing with loneliness and loss and navigating the Covid-19 pandemic. 445 seniors attended. Also held ongoing virtual group fitness classes including tai chi, stretch and strengthen and balance classes. 115 participants.
Provide a source of health education and socialization for local seniors in the community.	Transitioned senior socialization outlets to occur virtually. Created a "community" for those who attended to ask questions and have conversations around health topic areas. In FY21, program topics included home safety, nutrition, neurological changes, heart health, and Covid-19.
Reproductive Mental Health	
Identify patients who are experiencing depression and/or anxiety during pregnancy and postpartum that affects 10-15% of the NWH maternal patient population. Provide outreach and intervention by a clinical social worker (LICSW).	Continued the growth of the Perinatal Mood and Anxiety Disorder Initiative. Over 1000 patients have been referred to the PMAD social worker since the program began in May 2019. On average, receiving 28-50 new patients monthly, communicating with 30 plus patients a week. Successfully shifted to virtual visits during Covid-19
Extend the post-partum screening tool further after pregnancy.	Collaboration with 3 OB practices using The Edinburgh Postnatal Depression Scale to screen pregnant and postpartum patients between 24-28 weeks prenatally, 6 weeks postpartum, and 6 months postpartum. NWH is the first Partners hospital to screen at 6 months postpartum. To respond to the increase in patient referrals, social work hours have increased to 28 hours.
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.

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
Provide on-going methods of support for maternal patients.	Group support sessions conducted twice per week (virtually during Covid-19) for new moms. Held by NWH mid-wife. Open and general discussion as well as specific topic areas with content experts, i.e., pediatric dentistry, sleep deprivation, nutrition, etc. Approx. 11 new moms attend each session. Extremely positive feedback from participants on the impact of having a support resource. "Having a virtual community of moms that are sharing what they are going through helped me survive mentally when I was isolated with a newborn in a pandemic. It gave me community, comfort, helpful advice, and something to look forward to each week as a new mom in the trenches with a new baby.
The Maternity Services Council, within the Collaborative for Healthy Families & Communities (CHF&C), is focused on improving Maternity Services during pregnancy and after delivery with a special mission to increase awareness and improve treatment of pregnancy-related depression.	The Maternity Services Council is comprised of 25 hospital and community members and meets three times per 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.
Provide opportunities for community education on post-partum depression and maternal wellness.	Held three community-wide webinars. 112 attendees. The Collaborative Council continued to expand its presence on the web for on-going education and information sharing.
Priority Area: Substance Use	
Collaborate with local health departments and other community agencies.	NWH convenes eight meetings per year with local health departments. Goals are to communicate challenges, share best practices, review services, and strategize solutions on access and types of care, in hospital and in community. Other community agencies are invited, as needed. Topics discussed include substance use, behavioral health, Covid-19 protocols, and safety. Having the structure already in place helped to facilitate ease of communication and solution building during the many Covid-19 surges. NWH Emergency Department data is provided on a quarterly basis to a wide array of community partners in the areas of top five diagnosis, overdose, and behavioral health.
Access and use of Narcan is an effective option of treating drug overdose. The use of this resource in the community is a need for various agencies. NWH is able to provide Narcan and training to our community partners to support their efforts of dealing with the opioid crisis.	Access and use of Narcan is an effective option of treating drug overdose. The use of this resource in the community is a need for various agencies. NWH is able to provide Narcan and training to our community partners to support their efforts of dealing with the opioid crisis. In FY21, NWH provided 174 doses of Narcan to local community partners, police and fire, public health, schools and shelters. Provided training to community partners, as necessary.
Provide preventive substance use resources to ED patients and families	In FY21, NWH dispensed 54 naloxone kits to patients in the Emergency Department with diagnosis of opioid overdose.
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.
Provide education on various forms of substance use.	Conducted two community wide lectures on alcohol use, impact with Covid-19, and the intersection of substance use and mental health with internal

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
	and external experts. A variety of mediums were used such as film documentaries, Q&A, personal story sharing, and research. Resources and treatment options were provided at all events. Events were conducted virtually. Additional education forums were provided to various organizations in the community. Numerous clinicians provided education to school programs with virtual audiences of youth, parents and educators.
Provide education to clinicians and pharmacists and public health officials on role in pain management and addiction.	Expert substance use clinicians provided training in pain management and medical management of addiction. An annual substance use NWH medical grand rounds was held and open to the medical community. Additionally, the following clinical education was presented: Medical Management of Addiction: A Pain Management Perspective; Co-managing Pain and Addiction: A Practical Approach for the Pain Care Provider; Care Considerations for our Patients with Opioid Use Disorder. NWH continues to offer Suboxone waiver training for Newton Wellesley medical staff. The trainings are committed to helping clinicians to identify when Suboxone is appropriate and to help them to initiate, monitor and maintain treatment. The sessions are now being held four times a year, virtually, and include lectures, interactive case-based discussions, and patient presentations on their road to recovery. Since 2017, 273 care providers have participated in these waiver trainings.
Provide resources to community partners for needed substances.	Provided 100 doses of EpiPens to local fire departments and colleges.
Use the hospital as a site to increase public awareness on the opioid epidemic and decrease stigma around substance use.	For the third year, partnered with SOAR Natick during International Overdose Awareness Day and National Recovery Month to bring two displays to the community internal and external to the hospital. The Opioid Project displayed artwork and recordings of personal stories to bring to life the human costs of the opioid epidemic. The Purple Flag Project displayed a visible and startling reminder of lives lost to the opioid epidemic in Massachusetts. Both displays encouraged engagement by hospital staff and community and were efforts to reduce the level of stigma around addiction. Staff, hospital administrative and clinical leadership, patients, families, and community members attended the event. The Purple Flags were on display during September and October 2021 and coincided with the Boston Marathon which takes place in front of NWH. In addition to the annual remembrance event, this brought additional awareness to the need for reducing stigma associated with substance use. Two of the SUS Clinic clinical leaders ran the marathon in support of raising awareness for substance use.
Provide care to substance use patients in the SUS clinic.	SUS front-line clinicians (MD's, PA, Recovery Coach and Social Worker) completed 2465 patient visits (5x the number seen in 2018). Patients were referred by NWH primary care (31%), inpatient Hospitalist service, and emergency department (60%) clinicians. Patients presented with alcohol disorder (70%), opioid disorder (13%).
Collaborate with various local multi-community, and state-wide agencies to address the opioid crisis.	In FY21, NWH staff and clinicians played a leadership role on various community initiatives and collaborations with local health departments, police, fire and schools. Involvement included Newton PATH and Boston Bulldogs, in addition to others. The hospital continues to partner with the Middlesex District 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

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
	best practices. Members of the NWH SUS clinical team and community benefits regularly participated and presented at the meetings.
The Substance Use Council, within the Newton-Wellesley Collaborative for Healthy Families and Communities (CHF&C), is focused on the recognition and treatment of substance use, outreach and education of the community and providers.	The Substance Use Council, comprised of 20 community and hospital members, represent both clinical and societal perspectives. The Council meets 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.	Numerous hospital-wide efforts continue around safe opioid prescribing under the direction of medical leaders and are championed within Primary Care leadership. These activities include the NWH Opioid Advisory Committee which works to monitor opioid prescribing patterns to help identify and support NWH clinicians needing additional support, standardized postsurgical opioid prescribing guidelines, and one-on-one PCP outreach to support chronic pain and substance use patients with physician-led support.
Provide support options for those experiencing substance use addiction.	Recovery Coach conducted twice weekly group support sessions (one virtual, one in-person). 88 groups have been held in FY21. There are, on average, 10 people per group who are between the ages of 25 to 83 years old.
Priority Area: Social Determinants of Health	
Transportation	
Provide transport options to facilitate transition to and from hospital care	Facilitated 1427 rides through the Modivcare/Lyft platform (previously Circulation) for ease of access to and from hospital care. Among areas using this service are the Emergency Department, Cancer Center, and Integrated Care Management Program.
Emergency Preparedness	
Convene community partners for emergency management planning. Serve in leadership capacity for local emergency management and disaster planning.	Convened and participated in numerous local, state and regional planning meetings, committees, and initiatives for emergency management planning. Collaborated with EMS, Fire, Police, City Services, Health and Human Services, and others on emergency preparedness.
Conduct community-wide emergency management exercises and drills.	Conducted 2 Active Shooter Drills in City of Newton. Conducted drills with Newton Fire and Cataldo Ambulance. Conducted a tabletop exercise with Waltham.
Serve as key convener for Boston Marathon preparation and planning. Conduct functional planning exercises	Successful preparation and completion of Marathon Event. Conduct an After-Action review.
Provide community education in the area of emergency management and disaster planning.	Conducted numerous presentations on emergency management to community organizations.
Collaborate, coordinate, and communicate with community partners related to emergency planning efforts.	In response to Covid-19, served as a key community contributor in on-going extensive planning sessions for Covid-19 response. Convened partners regularly to ensure consistent communication with local departments of health (every six weeks - 6/8 times per year), first responders, and others. As a hospital served as a content expert to multiple agencies and in many forums.

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
Community Health Needs Assessment (CHNA) and Community Health Implementation Plan (CHIP)	
Conduct community health needs assessment.	Collected primary and secondary data (both quantitative and qualitative) to identify unmet health needs in the six NWH service communities (Natick, Needham, Newton, Waltham, Wellesley, Weston) from a variety of sources and inventory programs currently available to address those needs. Process considered health needs broadly and include data and analysis on social, behavioral, and environmental factors that impact health in the community. Special emphasis during the community health needs was placed on identifying health disparities, and particular types of health differences that are closely linked with economic, social, or environmental disadvantage.
Create a Community Health Implementation Plan (CHIP) after the community health needs assessment is complete. The CHIP supports specific programs or activities that are associated with significant needs identified in the Community Health Needs Assessment and establishes measurable short and long-term goals for each program or activity.	Created a Community Health Implementation Plan with four target populations identified. Four distinct priorities were established with four Goals. Four sub-priorities are listed specifically under the SDOH priority. Twenty- six strategies were established along with specifics success measures. In addition, community partnerships were identified to complete the priority and timelines were outlined.
Demonstrate active involvement and as a key decision maker by the Hospital's Community Benefits Committee and all required sector representation throughout the entire CHNA and CHIP process.	Three meetings were held throughout the process for active engagement on sources of primary and secondary data and identification of key stakeholders. In addition, to present and solicit input on key findings. Significant engagement took place on the development of the CHIP to include priority areas and target populations. The Committee has community representation with members who are racially, culturally, and ethnically diverse. In addition, the composition of hospital leaders and staff are from a number of different operational groups, as well as clinical and non-clinical areas.
Demonstration by hospital leadership for support for the Implementation Strategy.	CHNA was presented at the July 2021 Board of Trustee meeting. CHIP was presented at the December 2021 Board of Trustee meeting. Board members asked questions and gained a better understanding of the process and the content of the findings. The Board fully endorsed the Implementation Plan.
Community Collaborative	
Creation of a model for enhanced community engagement, extension of outreach, and expanded services in areas identified in the NWH community health needs assessment.	Further developed the operational framework of the Community Collaborative. The multi-pronged approach includes the development of community-oriented clinical programs, community educational programming, and community engagement through council involvement. The Collaborative leadership includes a director, and a program outreach manager. Council leadership is a dyad model with a community chair and a hospital-based clinical champion for each council.
Established Community Collaborative Councils that address identified health needs.	Maintain 8 community-focused councils: Cardiovascular Council, Domestic and Sexual Abuse Council, Elder Care Council, Maternity Services Council, Palliative Care Council, Resilience Project Council, Substance Use Services Council, Workforce Development Council.
Involve community in the NWH Community Collaborative.	Each council has approximately 20 members with a total of 160 community members involved across all 8 councils. These community members include those who have expertise on the subject for their council as well as those passionately engaged on the focus area. Chairs or for each of the councils are community members. Each Council meets three times per year.

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
Provide community programming and education through the Community Collaborative.	Each Council conducts community programming to provide education on the topic area. The platform for these programs switched to be virtual during Covid-19. The result was a growth in attendance given ease of access. In total there were 22 events held with over 1440 individuals who attended the Council programs.
Foster the continued development of 8 Councils that address identified unmet health needs in the NWH communities.	Supported the work of 8 Councils: the Resilience Council, a school-based initiative focused on mental health in adolescents; the Palliative Care Council with a focus on expansion of access to palliative care in inpatient and outpatient settings; the Maternity Services Council with a focus to specifically address depression and mental health concerns in maternal patients; the Domestic and Sexual Abuse Council focused on multilingual and access to supports for victims of abuse; the Elder Care Services Council focused on addressing fall prevention and social isolation; the Work Force Development Council to provide employment to low-income youth in the surrounding community; and the Substance Use Council focused on increasing capacity for primary care clinicians to address addiction evidenced in community patient populations.
Community Statewide Initiative	
The Community Statewide Initiative extends the CHI program across the Commonwealth, addressing the historic realities that availability of CHI resources is uneven throughout the Commonwealth. The three primary purposes: 1. To provide local grants for Health Priority strategies and policy action in areas of the Commonwealth historically underserved by DoN CHI resources; 2. To provide support for regional and collaborative CHIP) processes across the Commonwealth; and 3. To fund tools and resources to support system-wide and local evaluation of CHI programs.	According to DON-CHI requirements, $708,084. was disbursed into the statewide initiative fund.
The Hospital and engaged community, participate in a transparent and public process in selecting and distributing DON-CHI funds	Newton-Wellesley Hospital (NWH) awarded a $1.9 million grant to WATCH Community Development Corporation (WATCH CDC) and MetroWest Collaborative Development (Metro West CD) to address housing insecurity in the communities surrounding the hospital. WATCH CDC, located in Waltham, and Metro West CD, located in Newton, will collaborate to reduce inequities in housing security of low-income tenants, particularly among communities of color and immigrant communities in Natick, Needham, Newton, Waltham, Wellesley, and Weston. NWH identified housing insecurity as the focus of its Community Based Health Initiative (CHI) following a comprehensive review of critical needs in the area, in collaboration with an Advisory Committee comprised of key community stakeholders. Through this four-year grant, beginning in October 2021, NWH will invest $1.9 million into the WATCH CDC and Metro West CD collaborative, which will build on existing case management-based housing clinics, with particular emphasis on reaching out to and serving low-income and immigrant tenants. The collaborative will

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
	also heighten awareness of the mental health needs of clients experiencing housing insecurity, with the assistance of a mental health consultant, and provide emergency financial assistance at its clinics. In addition, the collaborative will hire a Job and Financial Planning Coordinator to mentor clients to greater financial self-sufficiency. Both organizations will work to expand the stock of affordable housing and increase protections for tenants through community organizing and advocacy. Given the DON process timeline, funding is not being disbursed until FY22.
"Foster a successful CHI process that includes robust community engagement, transparency in decision-making, accountability for planned activities, and demonstrable community health impact. "	Established an Advisory Committee and Allocations Committee that was diverse so as to reflect the larger community. Many members, including those on the NWH Community Benefits Committee as well as the DPH required sectors, were represented. The combined work of these committees established the CHI health priority and strategy. In making these decisions, the committee reflected and incorporated what had been identified in the most recent NWH CHNA and NWH CHIP. They also considered the DON Health priorities and the EOHHS/DPH Focus Issues. The Committee developed funding parameters and processes, reviewed proposals and made the final selection for a grantee. The Committees met a total of seven times during the process.
Access to Services	
Provide resources for assistance with basic needs related to patients' medical condition when no alternative option is accessible.	Provided assistance to 155 patients in the categories of food, lodging, technology, safety, and others. This was a 19% increase over FY 20 for number of patients assisted. Program administered through a multidisciplinary team. In addition, patients are linked to on-going clinical and social services.
Direct Newton-Wellesley Hospital engagement with community networks and coalitions for the purpose of information sharing and providing a hospital liaison.	Consistent clinical and administrative hospital leader representation and active engagement at the Waltham Interagency Network, Needham Community Crisis Intervention Team, Waltham Homeless Assistance Coalition, Waltham and Newton Chambers of Commerce and others. This was of particular importance over the past few years in order to inform of Covid-19 trends and protocols. On the reverse, the hospital was successfully able to more fully understand the challenges being experienced in the community. It was often stated that for the hospital to be present in this way was impactful in furthering and developing relationships with the community.
Provide Employee Assistance Services to City of Newton employees.	Enabled ease of access to EAP services for City of Newton employees.
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.
Partner and support community efforts focused on Senior Wellness.	Collaborated with local senior centers, YMCA's, housing complexes, and others on health education and senior wellness activities. Focused on nutrition, mental health, advanced care planning, heart health and others.
Employment and Education	
Provide students with meaningful summer job experiences and mentoring.	NWH Virtual Summer Jobs program, in partnership with Waltham Partnership for Youth and Lasell University, focused on career exploration for healthcare careers the included clinical and non-clinical positions, and those with varied levels of education and financial commitment. The interns also had an on-site tour and interactive session in the NWH Simulation

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
	Center, Fitness Center, and a Q&A with hospital leadership. The program also included enrollment in a choice of two courses that were held virtually, enabling the interns to earn college credits. The third component of the program was a series of skills building workshops.
Provide opportunities for youth to gain exposure to the health care environment and learn from professionals about career options.	Conducted weekly career exploration sessions for community teenagers through the NWH Volunteer Program. Focused on both clinical and non-clinical roles and innovation in healthcare. Held virtually due to Covid-19. 220 student volunteers attended the sessions each week.
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.	Hired 18 Waltham High School students through the Waltham Partnership for Youth Summer Internship program with the goal of providing paid opportunities that cultivate professional skills and allow for the exploration of future career interests. This was the largest number of students sponsored by one organization. The format of the program was innovatively re-designed due to Covid-19. Through a partnership with Lasell University the students were enrolled in one of two courses: Health Psychology and Foundation Health Professions. All 18 students completed the course and received college credit and were paid at $15 per hour for 32 hours per week. In addition, over the 6 weeks, the students attended weekly hospital career focused sessions with panelists from all different areas of the hospital. A total of 25 NWH staff participated in the career exploration sessions. For the entire WPY intern program (100 interns), 43% were from low- or lower-income households, and 65% were of nonwhite race and ethnicity
Support on-going youth work force development initiatives in the community.	Continued sponsorship for the Career Exploration and Training Coordinator at the Waltham Partnership for Youth. Position is responsible for the placement, training, and development of over 100 summer interns (a 56% increase over FY20) in the City of Waltham as well as conducting the Teaching for Social Justice curriculum and additional youth development initiatives for Waltham youth.
Provide work-skill based opportunities for students and adults through the NWH vocational volunteer program.	Provided structure for individuals, both adult and youth, in vocational programs with separate, on-going, placement opportunities to learn, practice and be exposed to workplace skills. NWH Volunteer Services maintained affiliation with 20 schools and organizations despite the suspension of on-site services due to Covid-19.
Provide outlets for exposure to health-related educational and employment opportunities to those with less economic stability and means to pursue education opportunities.	Held a virtual NWH Career Event over two evenings with 55 attendees. Made available to high school students, adult learners, NWH employees, and school guidance counselors. A keynote speaker, and career focused panels were a part of each program. In particular, departments and staff were chosen to represent healthcare areas that require less than four-year degrees, certificate programs or no formal schooling. 10 staff participated in the sessions.
Provide community outreach to student populations to expose individuals to healthcare careers.	Staff took part in numerous fairs, club meetings and spoke at events to educate attendees on healthcare career options.
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	The Work Force Development Council, comprised of 25 community and hospital members, meets three times per year and focuses on key initiatives that include Waltham summer youth intern program, student and community exposure to healthcare careers across all levels, and opportunities for building career-based networks. The goal is for the hospital to serve as a career hub, through collaborations and partnerships that can provide opportunities for youth to enhance family financial security.

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
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.	Identified a WFD Community Chair with professional expertise in work force development based in the community college level.
Form partnerships to promote youth development and leadership skills.	Partnered with SparkShare as a community facilitator with a goal of empowering young people to be change agents in their communities and in their own lives by listening, connecting, and building partnerships. Participated in two SparkShare Mini Summits and participated in multiple planning sessions to created content development to optimize youth engagement.
Provide skills based learning and transferrable workplace skills for young teens. Provide paid employment to youth. Engage teens in the community using their skills to further health education.	Sponsored the Waltham Partnership for Youth Language Access for Civic Engagements (LACE) Program. 12 new bilingual teens were trained as interpreter liaisons by Cross Cultural Communications, Inc. Both Spanish and Haitian-Creole translation were part of this year's program. A translation (writing) training course was also part of the program. The program provides paid employment, transferrable skills and possibility for career development. Adds a component of community engagement by having teens interpret at community events that focus on substance use, mental health, use of technology, school processes, and other topics. A total of 15 teens were hired at 10 events throughout the year. Allows outreach events to occur at locations with culturally and linguistically diverse venues.
Promote and foster value for multicultural and multilingual backgrounds among youth.	Provided a means of income, mentorship, and development of leadership and empowerment skills among the youth involved in the youth interpreter program. From a student participant: R. completed the Interpreter training during the Fall of 2020 during the pandemic and it has been incredible to watch confidence build during such a difficult time. In R. words, "I struggled a bit at first because interpreting is not as easy as it seems, but now I can confidently say that I am ready for anything. The experience has been amazing, and I would definitely recommend it!"
Engage with local school districts on opportunities to expand and think innovatively on the intersection of workplace/career exposure and academic curriculum.	Newton-Wellesley staff representatives on the Waltham High School Health Assisting Program Advisory Committee Meeting and the Waltham High School to Career Work Team.
Reduce ethnic and cultural disparities in graduation and dropout rates in Waltham. The target population is focused on Waltham students who are recent immigrants or refugees, and primarily are English Language Learners.	2021 marks the second year of a four-year grant to Waltham Partnership for Youth (WPY) to implement Wraparound Waltham. Designed as a multi-agency collaborative led by WPY, Wraparound Waltham (WAW) works in partnership with Waltham Public Schools to support newcomer students attending Waltham High School (WHS). Wraparound Waltham aims to: -Support newcomer students who are primarily Spanish speaking from Latin America -Provide non-academic supports to students fostering community, connection, and belonging -Increase access to mental health support, basic needs support, legal support, and other resources -Increase high school persistence and graduation among newcomers. Wrap Around Waltham, the Collaborative grantee comprised of five identified community partners (Waltham Partnership for Youth, Waltham Boys and Girls Club, Children's Charter, The Right to Immigration Institute, Doc Wayne) work collaboratively with Waltham Public Schools for student referrals. Status: - 37 students

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
	received WAW services in 2020-2021. 100% of these students were Newcomers, Latin American and Spanish speaking. - 35 of the 37 had a documented need for non-academic support at the time of referral. - 26 of the students were more fully active in WAW and had ongoing connections with the Wraparound Coordinator and to community partners for on-going engagement and support. - Recognizing the importance of working with students as early as possible, 87% of these active students were referred to while in 9th or 10thgrade. - Despite the impact of Covid, 100% of the active WAW students met with the Wraparound Coordinator during the Fall 2020 and Spring/Summer 2021. - During the Spring/Summer 2021, $68,000 was secured for Wraparound families to avoid eviction. - Support services received for 2021 were as follows: 39% - food; 42% - housing; 15% - Wi-Fi; 100% - community resources; 69% flex funds; 15% hygiene products - 22 of the 26 active WAW students advanced to the next grade level at the end of the academic year.
The Wraparound Waltham student population of interest includes 9thand 10thgrade students at time of referral who are newcomers to the U.S. (did not attend elementary school in U.S.). The expectation is that most referred students are Spanish-speaking English Language Learners (ELL) from Latin America.	All active students during the 2020-2021 academic year were: 100% Newcomers, Latin American, and Spanish-speaking. Recognizing the importance of working with students as early as possible, 87% of active students were referred while in 9th or 10th grade.
Referred students are newcomers likely to benefit from mental health support and/or opportunities to socialize and form positive relationships with peers and adults. Students and their families or caregivers are also likely to face one or more of the following: - Housing or food insecurity - Economic pressure to work, - Lack of basic needs or transportation, - Lack of access to healthcare services, - Legal issues related to immigration status	The COVID-19 pandemic significantly increased the case management needs of students and their families. Significant efforts were made to assist students and their families with applications for financial assistance for rent, utility bills, and basic needs. These efforts were particularly time consuming for those families that did not qualify for the Emergency Rental Assistance Program. Throughout the 2020-2021 academic year, active Wraparound students received housing and financial assistance, as well as assistance accessing food, Wi-Fi and hygiene products. Needs for assistance changed over the course of the year as the pandemic wore on. While the need for food and hygiene products declined from fall to spring, the need for housing and flex fund assistance increased, as did the focus on connecting students to community resources. During the Spring/Summer 2021, WPY helped secure $68,000 for Wraparound families to avoid eviction.
Once referred, the Wraparound Coordinator partners with Children's Charter, Doc Wayne, Waltham Boys & Girls Club and The Right to Immigration Institute to provide students with non-academic supports, and the Wraparound Case Manager assists students with accessing community resources.	Doc Wayne: -23 of 27 active students in Fall 2020 participated in at least 1 Doc Wayne session -9 of 26 active students in Spring/Summer 2021 participated in at least 1 Doc Wayne session Children's Charter: -14 of 27 active students in Fall 2020 participated in at least 1 Childrens Charter session -10 of 26 active students in Spring/Summer 2021 participated in at least 1 Children's Charter session -6 students participated in one-on-one sessions with Children's Charter in Fall 2020 and Spring/Summer 2021 The Right to Immigration Institute (TRII): -6 of 27 active students in Fall 2020 or their families received support from TRII -12 of 26 active students in Spring/Summer 2021 or their families received support from TRII
Wraparound Waltham is a collaborative of educators and service providers, led by WPY,	22 of the 26 Wraparound students who were active in Spring/Summer 2021, advanced to the next grade level at the end of the academic year. 3 of the 26

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
working to address disparities in high school graduation and dropout rates among Waltham students by providing individualized supports that address both the academic and non-academic needs of students and families.	Wrap Around students who were active in Spring/Summer 2021 graduated at the end of the academic year.
Make impact in the lives of immigrant students and their families.	Wraparounds Holistic Approach to Supporting Advancement: Guidance counselors referred two Guatemalan boys (from a family of six) to Wraparound. They both participated in the virtual Childrens Charter and Doc Wayne support groups. During interactions with the head of the family, a number of critical needs were identified, including a history of domestic violence, unsafe and unstable housing, loss of income due to pandemic, and language and literacy issues. The eldest son, a WHS senior, planned to leave school to help his family. Through Wraparound, the student got individual support from Doc Wayne and the Wraparound Case Manager. The Wraparound Case Manager was able to find the financial resources to help the family with rent; obtain a pro bono lawyer to work with the landlord; got the Waltham Health Department involved to deal with a cockroach infestation; helped the mom get new P-EBT cards and SNAP benefits; and collaborated successfully with another community agency to move the family into public housing. In addition, the Case Manager successfully raised money to help the family buy a new refrigerator. In the end, the oldest child who wanted to quit school to help his mom, graduated from high school in June 2021.
Adapt program in response to Covid19.	COVID-19 pandemic resulted in school and business closures. This reality greatly affected the early development and implementation of this new initiative. As the pandemic wore on, Wraparound staff, experiencing their own pandemic challenges and stressors, witnessed the needs of students and their families intensify. At the same time, Wraparound partners had to develop strategies to create a welcoming and supportive environment for newcomer students without the benefit of being in space together. This was extremely difficult, particularly for those components of the program that rely on physical activity to build community and connection. As the 2020-2021 academic year continued to be virtual, Wraparound students became increasingly difficult to engage in group programming. In addition to the challenges of engaging and serving youth, Wraparound partners experienced several challenges to building a strong collaborative. Specific areas of challenge were staff turnover and vacancies, means of communication and follow-up, and effective communication.
Beginning in Fall 2021, Wraparound began a new approach to student engagement: the Welcome Class. In this approach, all newcomer students take a class as part of their school schedule. This class is designed to promote connections among newcomers, increase their ability to navigate Waltham High School, and	The Welcome Class accommodates 25 students and lasts eight weeks. During this block, which is co-facilitated by the WHS Academic Case Manager and the Wraparound Community Resource Navigator (formerly the Wraparound Case Manager), students are oriented to the school as a group using a structured and systematic approach. Students are introduced to Wraparound Partners and services through a panel presentation. The Welcome Class serves as a vehicle for newcomer students to be referred directly to Collaborative partners and other community partners for services, as needed.

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
raise awareness of school and community resources.	
The Welcome Class serves as a vehicle for newcomer students to be referred directly to Collaborative partners and other community partners for services, as needed.	The Welcome Class: Increases the overall number of students supported by Wraparound. -Improves coordination with WHS through co-facilitation of the class. -Improves the process for developing Student Success Plans by completing them as part of the class. -Increases student awareness of and connection to community resources and Wraparound supports. -Creates a sense of community by creating -cohorts of newcomer students. The WHS Academic Case Manager completes regular 1-1 check-in meetings with students after they've completed the Welcome Class, to continue relationship building, monitor students' academic and non-academic progress, and refer students back to the Wraparound Community Resources Navigator if the student would benefit from additional services.
Implementation of a Welcome Center at the Middle School.	The Welcome Center, open to students of any grade and their families, is based on a pilot program implemented in Spring 2021. The Center is designed to assist students and their families with navigating the school community and accessing community resources. Staffed by the Wraparound Community Resource navigator and school personnel, the Center offers Spanish-speaking students and their families a physical place to go for assistance with everything from accessing the school's online portal to enrolling in English language classes to obtaining referrals to community resources.
Evaluation and progress monitoring of the Wrap Around Waltham Initiative.	UMASS Donahue Institute provides an annual program summary and on-going progress reports. *2020-2021 available for review.
Food Security and Nutrition	
Convene community partners on aspects of nutrition security and equity. Representation on community organizations focused on food access.	Representation on the Newton Food Pantry Advisory Board. Began discussions with the Newton Health and Human Services to convene a food access work group. On-going partnership with Healthy Waltham.
Focus on the following three goals: 1. Support and expand existing commitment to food access 2. Build and support capacity and partnerships with internal and external organizations working to expand food access 3. Improve geographic reach of food access partnerships	A total of $100,000 grant funding awarded by Mass General Brigham Community Health to organizations in the local Newton Wellesley hospital service area. 1. Waltham Boys and Girls Club: Year-long meals and weekend packs for 1,200 youth during school, breaks, summer 2. Heathy Waltham: Provision of food for 2,000 families for Summer 2021 3. Newton Food Pantry: Gift card program (groceries, diapers, kid friendly snacks) for 500 households
Violence and Trauma	
Provides free, voluntary, and confidential services to patients, employees and community members who are experiencing domestic violence, partners abuse, sexual assault/abuse, and/or stalking.	In FY21, the program served over 778 distinct survivors of violence and abuse. This is a 48% increase from FY19 and shows consistent increases in the demand for services from FY20. Staff not only saw a significant increase in demand for direct services, but also in complexity, lethality, and acuity within the demand
Expand Domestic Violence services in the community and to Spanish	In FY21, NWH was able to resume providing REACH Beyond Domestic Violence with a $50,000 grant to better serve Latinx survivors of abuse and

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
speaking, immigrant survivors of partner abuse.	their children. Of the 300-400 families that REACH works with per year, approx. 100 are new in any given year. More than half of the total number of survivors/heads of household are Latina most with relatively recent and extremely traumatic immigration experiences.
Continue to increase safety, health and well-being of patients and employees by providing comprehensive services to those experiencing domestic and sexual violence.	In FY21, the program provided 1000 hours of safety planning, counseling & advocacy to survivors. In addition, thousands of hours of additional time were devoted to community education, training, policy development, & collaboration with community organizations.
Grow accessibility for Latin, Spanish speaking, and, in particular, undocumented survivors (who are disproportionately at risk).	In FY21, the program continued collaboration with REACH Beyond Domestic Violence and Greater Boston Legal Services to directly serve over 175 Latinx survivors in Waltham. In addition, the partnership assisted over 60 survivors to apply for U Visas and Asylum based on violence they experienced in their home countries or while in the US while also ensuring that families received emergency rental assistance, relocation assistance, utility assistance, and assistance with other basic needs such as food. Once again, a bilingual-intern was placed with the Latinas Know Your Rights Program resulting in culturally and linguistically specific support groups. In addition, a notable number of community education events were marketed in Spanish, with fully bilingual materials and interpretation available including those related to Covid-19. Additionally, with the generous support of NWH Community Benefits program, the DVSA program has continued to expand upon outreach efforts that began in FY19, when NWH provided $17,000 in emergency funding to victims for basic needs such as housing, rent, utilities, and food as well as Covid-19 self-care informational materials in multiple languages.
Continued participation in implementation of the DOJ- funded National SANE Tele-nursing Center. The hospital provides space for the Center & technical expertise and education to providers across the country	The Center currently serves eight pilot sites across the nation on a 24/7 basis, providing real-time consultation to clinicians serving survivors of acute sexual assault at military installations, on Native American reservations, and in rural parts of the country. In FY21, the NTC provided technical assistance and education to hundreds of providers across the country to include Alaska, Arkansas, South Dakota, and Texas. Influenced expanded adherence to national SANE protocols and contributed to institutionalizing the advocacy response at several pilot sites (most notably in MA). This, in addition, to its core work of serving as clinical presence for survivors and their providers during real-time post-assault exams across the country. During FY 21 NTC staff/MA SANE has applied to be on a DOJ/OVC Technical Assistance (TA) grant to support the development of 10 new national SANE Programs that will also be funded by DOJ/OVC. Ten MA Hospitals that are currently receiving TeleSANE services: 1. Martha's Vineyard Hospital, 2. Nantucket Cottage Hospital 3. North Shore Medical Center 4. Baystate Franklin Medical Center 5. Good Samaritan Medical Center 6. Metrowest Medical Center 7. Athol Hospital 8. Sturdy Memorial Hospital 9. Beverly Hospital 10. Saint Annes Hospital NTC is still in a partnership with Hopi Health Care Center, although their SANE Program has not been operational during the Covid-19 pandemic.
Work to build options for support and empowerment groups through alternative modalities.	Program staff facilitated a Creative Flow expressive arts workshops series for survivors of violence and abuse, many of whom are still living with their abusive partner because of COVID. Program staff facilitated Transforming

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
	Trauma Support Group, a skill-building group for survivors of violence abuse that offered psychoeducation regarding the impact of trauma on mind, body, and spirit as well as opportunities to practice mindfulness, embodiment, and grounding exercises. Program Staff supported the work of FORGE (national antiviolence organization that offers education and technical training to address the needs of transgender and non-binary individuals) and MenHealing (national organization providing help for male survivors of sexual assault, sexual abuse, and sexual trauma during childhood or as adults) to launch Voices of Healing: Trans & Nonbinary Survivors SPEAK OUT. The event will utilize expressive arts to showcase diverse stories of survivorship and healing from trans and nonbinary survivors who have experienced any kind of sexual victimization. DVSA program partnered with TSS to offer two online nutrition groups in the community one for trauma survivors, and another for trauma workers. DVSA program partnered with TSS to offer a 6-month trauma-informed yoga group for survivors of violence, abuse, and trauma in the community. Program staff continue to facilitate both Domestic Violence Support and Empowerment groups and Seeking Safety groups at Genesis House. Genesis House is the local residential center for mothers with substance use disorders. Approximately 90% of the participants there have experiences of severe violence and abuse. Program staff co-facilitated a 5-week, Spanish-language Expressive Flamenco pilot group using body modalities to address immigration trauma, racism, partner and sexual abuse with the Latinas Know Your Rights Project. Program staff co-facilitated a 10-week, Spanish-language virtual leadership and empowerment workshop for survivors of domestic abuse. Topics included: What is a Leader? DV: What is it? And What Can You Do to Help? DCF: Who Are They and What Do They Do? Employees Rights, Legal Systems and the Courts, Immigration Update: DACA, Immigration Remedies for Survivors of Violence & Abuse, Family Courts and Public Benefits, Parenting and Coping with Stress. Program staff became trained as a Men Healing clinical team member and joined The Weekend of Recovery (WOR) and Day of Recovery Facilitator Team. WOR clinicians are highly skilled trauma clinicians, utilizing current ethical and best practice evidence-based standards of trauma treatment. Weekend of Recovery retreats are three-day healing workshops for male survivors of sexual abuse, sexual assault, or sexual trauma as a child or as an adult. DVSA program supported MenHealing with obtaining $2,500 grant from NWH Community Benefits to fund a pilot program to support programming and curriculum building aimed to support partners, family, and friends of male survivors. In addition to the above, program staff continued to provide support and technical assistance to the leadership of the SNAP (Survivors Network of those Abused by Priests) group that operates on the NWH campus.
The Domestic and Sexual Abuse Council, within the Community Collaborative, is focused on enhancing access for survivors who face linguistic and cultural barriers and providing increased awareness and education on domestic and sexual abuse.	The Domestic and Sexual Abuse Council, comprised of 20 members, meets three times per year. The Council has been instrumental in disseminating emergency resources to victims of abuse and reacting to partner needs.

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
Priority Area: Chronic Disease Prevention and Management	
Access to Care	
Provide primary care to children and adolescents who are uninsured or present other challenges interfering with accessing primary care.	In FY21, provided care to pediatric uninsured patients while they were in the application phase for Mass Health so as not to delay school entry. Volume was significantly lower this year for children served.
Provide Community Health Worker support to patients and linkages to the community.	Expanded communities served by NWH Community Health Workers to now include Waltham, Newton, Needham, Natick, Weston and Walpole. CHW's provide navigate access to necessary services both clinical related, but predominantly within the areas of the social determinants of health. Those areas of greatest need are education/employment, food access, and housing insecurity. CHW are educated and have successfully formed partnerships with local community service organizations.
Make appointments for those in need of accessing clinical services for either primary or specialty care.	In FY21, the hospital's Care Finder program facilitated scheduling appointments for patients in need of a physician or hospital service. Total year end call volume was 9012 calls (a 20% increase over FY20).
Provide Interpreter Services to the Newton-Wellesley Hospital patient population.	Provided 12,974 completed Interpreter Service requests, including face-to-face, telephonic, video, ASL. A 20% increase over FY20.
Ensure that Interpreter Services are available in all areas of the hospital.	Introduced a mobile video platform for interpreter services expanding access and efficiency of service. Increased the number of devices to 30. Also provides a video option for American Sign Language. Overwhelming positive feedback from the staff, providers, patients, and families. The top five hospital departments utilizing interpreter services were Emergency (3756 - completed interpreter requests), Medicine, Surgery, Cardiology and Urgent Care Walk-In.
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 area of interpreter resources. Implementation and training for staff on New Audio/Video IPAD technology for patients took place in all patient care areas, inpatient and ambulatory, as well as off-site locations. Reference and resource materials were provided to areas.
Provide patient information documents in translated languages.	Provided translated documents for: discharge instructions, patient rights, menus, patient education, and patient guidebook. Through system-wide efforts, the patient portal has also been made available in multiple languages. Assessment in clinical areas with high multi-lingual patient populations is on-going to translate needed patient materials. NRC Patient Satisfaction Surveys, currently sent out in the following languages: English, Spanish, Khmer, Arabic, Haitian Creole and Chinese. In December 2021, two interpreter questions were added to all of Mass General Brigham's patient experience surveys: (1) Patients will first be asked if they needed an interpreter, and then (2) If they got an interpreter when they needed it. For the community, materials on Covid-19 and flu were translated into multiple languages.
Provide information about the full range of insurance programs offered by EOHHS and the Health Connector	In FY21, 2 NWH Certified Application Counselors (CACs) contributed to the estimated 65 patient financial counselors that served patients who needed assistance with their coverage.
Conduct community flu clinics.	In FY21, NWH administered 556 flu vaccines. Six clinics were held at flu clinics held at the NWH Ambulatory Care Center, 159 Wells Ave Newton, and 2 clinics were held at the Healthy Waltham Food Pantry on-site location.

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
	Promotion of the flu clinics located in Waltham were communicated in Spanish.
Representation and involvement on local community boards and activities.	Numerous NWH clinicians and staff served on local community boards and offered their specialized perspectives on strategic initiatives. These included health departments, youth organizations, business chambers, and other non-profit agencies.
Support local initiatives that promote health and wellness.	NWH had various levels of staff participate in education and wellness programs held by community organizations. Topics ranged from mental health, Covid-19, senior wellness, and others.
Provide health awareness and disease prevention programs.	In FY21, NWH conducted 3 virtual screening education events for the community, including breast cancer, lung cancer and skin cancer screening events. In-person screening events were not held due to Covid-19. Covid-19 specific educational forums were held for community seniors, parents, and others to inform them about the pandemic, explain proper protocols, and to explore next steps. Post- sessions, resource materials were sent to program attendees for further detail on follow up care.
Provide opportunities for physical exercise and wellness.	The NWH Wellness Center shifted all exercise and wellness programming to be free of charge to the community over a virtual platform. All programs are specifically geared to the senior community. Six classes are offered per week. Approximately 150 class participants per week.
Seniors	
Convene a Senior Living Community Forum for local assisted living and independent living, and as appropriate, long term care facilities. Provides an opportunity to share content expert information, relay best practices and align services.	Four Senior Living Forums were held this year with approx. 25 attendees at each Forum. Forum has multidisciplinary leadership with the Chief Medical Officer, Medical Director, Physician Health Organization, Case Management, Population Health, and Community Benefits. Topics have included Guardianship, and Delirium in Older Adults.
Enhance senior wellness, specifically related to balance through the Matter of Balance program and Tai Chi programming.	Programs held in partnership with local senior centers. Transitioned to virtual and expanded access to a larger number of individuals to participate. The Matter of Balance Program resumed this year. Tai Chi session held once a week. All seniors in any of the six NWH communities had the opportunity to participate. Promoted through the Senor Centers
The Elder Services Council, within the Newton-Wellesley Community Collaborative, is focused on the socialization of elders as well as falls prevention.	The Elder Care Council is comprised of 23 hospital and community members. The Council was able to expand its community representation on the council and meets 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, and addressing risks related to falls.
Clinical Research	
Conduct research studies related to Covid-19 to explore the safety and effectiveness of treatments.	Conducting 7 research studies related to Covid-19. Various treatments are being explored through studies as well as studies related to the rate of disease progression for Covid-19 patients
Conduct research in the area of innovation in health.	Research to determine if education and exercise for joint replacement surgery remotely guided by the mymobility mobile telehealth application paired with the Apple Watch is just as good, or better, than current standard education and outpatient physical therapy after joint replacement.

Activity, Service, and/or Program	Number of Individuals Served, Number of Classes Offered, etc. In FY21
Conduct research related to chronic diseases.	Study being conducted to look at if adding another drug to the medical care that people with heart failure are already receiving could better control heart failure.

APPENDIX D: Community Benefits Committee Members

Name	Community	Title
Kaytie Dowcett	Waltham	Executive Director, Waltham Partnership for Youth *(Committee Chair)
Lauren Lele	NWH	Senior Director, Community Health
Kosha Thakore, MD	NWH	Chief DEI, NWH
Mohini Daya, MD	Primary Care, NWH	Medical Director of Primary Care – Newton-Wellesley Medical Group
Jhana Wallace	Wellesley	Community Health Coordinator, Board of Health
Linda Walsh	Newton	Commissioner, Health and Human Services
Tiffany Zike	Needham	Asst. Director, Dept Public Health
Mike Boudreau	Natick	Director, Dept Public Health
Josephine MacNeil	Newton	Housing Advocate
Gihan Suliman	Waltham	Community Health Manager, Charles River Community Health Center
Myriam Michel	Waltham	Executive Director, Healthy Waltham
Rev. Brandon Crowley	Newton	Senior Pastor, Myrtle Street Baptist Church
Katie Connolly	NWH	Vice President, Development & Community Engagement
Josephine Pang	NWH	Manager, DSV Program
Liz Booma, MD	NWH	Chief, Child and Adolescent Psychiatry
Duke Collier	NWH	Past - NWH Board Chair
Steve Sullivan	NWH Board	NWH Board Trustee; Co-Chair, Palliative Care Council
Kim Gerard	NWH	Manager, Community Outreach
Maria DiMaggio	Waltham	Communications and Development Director, Healthy Waltham
Deanne Bruno	NWHPHO	Medicaid ACO Project Specialist
Donlyn Cannella	Waltham	Assoc Dir of Community Services, Springwell
Mike Jellinek	Newton	Child Psychiatrist; Past - NWH President; Past - Medical Director of Community Collaborative

APPENDIX E: Community Benefits Committee Plus Members

Name	Community	Title
Genoveva Tavera	Waltham	Community Organizer, WATCH CDC
Javier Duque	Waltham	Creative Director, idArt
Mignonne Murray	Weston	Director, Weston Council on Aging
Emily Kuhl	Newton	Case Manager, Newton Senior Services
Shin Yi-Lao	Newton	Director of Public Health Services, Newton Health and Human Services
Sue Ross	Newton	Executive Director, The Second Step
Katie Sugarman	Natick	Prevention and Outreach Program Manager & Drug-Free Communities Grant Program Director, Natick 180 - Natick Health Department
Shaylyn Davis/Amanda Berman	Newton	City of Newton Planning and Development
Alejandro Bracamontes	Waltham	Executive Director, The Right to Immigration Institute
Gemima St. Louis	Newton	Associate Vice President for Workforce Initiatives & Specialty Training Center for Workforce Development Associate Professor, Clinical Psychology Department , William James College
Sara DeMedeiros	Newton	Vice President of Mission Advancement, West Suburban YMCA
Regina Wu, MD	Newton	President, Newton Food Pantry

APPENDIX E: Secondary Data Sources

U.S. Census/American Community Survey
Centers for Disease Control and Prevention
Health and Use Risk Factors of Massachusetts Youth Survey
MetroWest Adolescent Health Survey
Newton Youth Risk Behavior Survey
Waltham Public Schools Youth Risk Behavior Survey
Weston Youth Health Assessment
County Health Rankings & Roadmaps
Federal Bureau of Investigation
Inpatient Hospital Discharge Data from CHIA (Center for Health Information and Analysis)
U.S. Department of Agriculture
Map the Meal Gap
Policy Map
Feeding America
Massachusetts Department of Health
Massachusetts Death Registry
Massachusetts Cancer Registry
Massachusetts Violent Death Reporting System
Massachusetts Bureau of Infectious Disease and Laboratory Science
Massachusetts Bureau of Substance Abuse Services
Massachusetts Office of Data Management and Outcomes Assessment
Massachusetts Population Health Information Tool (PHIT)
Massachusetts Department of Elementary and Secondary Education
Massachusetts COVID-19 Dashboard
Massachusetts Coalition for the Homeless
Newton Food Pantry Needs Assessment
Newton Community Needs Assessment
Healthy Waltham
Waltham Healthy Aging Summit

APPENDIX F: Key Informant Interview Guide

Health Resources in Action

Newton-Wellesley Hospital CHNA

Primary Service Area: Natick, Needham, Newton, Waltham, Wellesley, and Weston

Key Informant Interview Guide

Goals of the Key Informant Interview

1. To determine perceptions of the strengths and needs of these communities, and identify sub-populations most affected
2. To explore how these issues can be addressed in the future
3. To identify the gaps, challenges, and opportunities for addressing community needs more effectively

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****NOTE: QUESTIONS IN THE INTERVIEW GUIDE ARE INTENDED TO SERVE AS A GUIDE, NOT A SCRIPT.****

I. **BACKGROUND**

- Hello, my name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to talk with me today.
- A few months ago, Newton-Wellesley Hospital began undertaking a comprehensive community health assessment effort to gain a greater understanding of the health of community residents, how health needs are currently being addressed, and whether there might be opportunities to address these issues more effectively. The data from this assessment will inform the priorities for future investments into the community in the next several years on the upstream factors that affect health.
- We recognize this is a unique time we are in. Given the coronavirus crisis, an assessment of the community's needs and strengths is even more important. The pandemic has brought to light both the capabilities and the gaps in our healthcare system, public health infrastructure, and social services networks.
- As part of the community health assessment process, we are conducting interviews with leaders in the community and focus groups with residents to understand different people's perspectives on these issues. We greatly appreciate your feedback, insight, and honesty. The findings from these conversations will inform decisions around future investments to improve the community's health.
- Our interview will last about 45-60 minutes. After all the data gathering is completed, we will be writing a summary report of the general themes that have emerged during the discussions. We will not include any names or identifying information. All names and responses will remain confidential. Nothing sensitive that you say here will be connected directly to you in our report.
- Do you have any questions before we begin?

***Note to interviewer – if people have any questions regarding the process or Newton-Wellesley Hospital, please refer them to Lauren Lele* LLELE@PARTNERS.ORG

****Priority questions are in blue. If short for time, focus on these questions. ****

II. **INTRODUCTIONS (5-10 MINUTES)**
   a. Can you tell me a bit about yourself and the community that you live in?
      i. Probe: What has been your experience with trying to access social services or healthcare services?
      ii. Probe: Are you involved in any community organizations? What is the role of that organization in your community?
   b. Prior to the pandemic, what were some of the biggest challenges in the community?
      i. Probe: During the pandemic, what were some of the biggest challenges you faced? What new challenges do you anticipate going forward?

III. **COMMUNITY PERCEPTIONS AND SOCIAL/ECONOMIC FACTORS (15-20 MINUTES)**
   a. How have you seen the community change over the last several years?
   b. What do you consider to be the community's strengths/assets?

   For the following questions, please consider issues and concerns your community had BEFORE the pandemic, issues RELATED TO the pandemic, and issues and concerns you anticipate will arise as a result of the pandemic and its economic consequences.

   c. What do you think are the most pressing health concerns in the community? (PROBE FOR HEALTH ISSUES NOT DIRECTLY RELATED TO COVID-19).
      i. Ex. Mental health care, chronic disease management, substance use, access to care, etc
      ii. What population groups (geography, age, race/ethnicity, immigration status, gender, income/education, etc) are most affected by these issues?
      iii. How has [HEALTH ISSUE] affected your community?
         1. Probe: In your experience, what are people's biggest barriers to addressing [HEALTH ISSUE]?
         2. Ex. Cost or economic hardship, transportation, stigma, attitudes towards seeking services, built environment, availability/access to resources or services, knowledge of existing resources/services, social support, discrimination, insurance coverage, etc.
   d. What are some of the communities' biggest concerns/issues in general? What challenges do residents face in their day-to-day lives?
      i. Ex. transportation, affordable housing, discrimination, financial stress, food security, violence, employment stability, cultural belonging, language access, impacts of climate change/environmental issues.
      ii. Probe: How do these structural issues/factors affect the health issues of concern that we previously discussed?
      iii. Probe: What do you see as gaps in services that are needed to help people address these issues?
   e. What are some of the communities' priorities related to racial equity and health?
      i. Probe: What are some current efforts in place that you know of working to address health inequities?

IV. **PRIORITY SPECIFIC SECTION – SPECIFIC QUESTIONS ON PARTICULAR ISSUES, DEPENDING ON WHO THE INTERVIEW IS. SELECT QUESTIONS TAILORED TO INDIVIDUAL EXPERTISE AND ASK A FEW QUESTIONS IF NOT BROUGHT UP YET. (10-15 MINUTES)**

Mental Health Care

a. Could you describe the issues related to mental health that are facing the community?
    i. Probe: Are there any specific mental health issues that are affecting diverse populations at a higher rate?
b. What are the particular barriers related to accessing mental health services that are affecting people?
    i. Probe: What are some additional barriers that diverse populations may face when trying to access mental health?
c. What are some ways to improve access to mental health services for diverse populations?

Chronic Disease Prevention and Management

d. What are some improvements that you would like to see made to the community's environment that could be made to promote health?
e. What are some of the major barriers related to accessing preventive or primary care services that are affecting people?
f. What are some ways to improve access to preventive care, especially for diverse populations?

Nutrition and Food Insecurity

g. Could you tell me a bit about how food insecurity affects the community?
    i. Probe: How does food insecurity affect diverse populations specifically?
h. What does the current infrastructure look like to address food insecurity in the short term? (ex. Networks of food pantries, SNAP benefits at farmer's markets, etc).
    i. Probe: In the community, how easy or difficult is it to access a variety of cultural groceries or foods?
i. What else do you feel needs to be in place in order to meaningfully address food insecurity in the long-term?
j. What role can institutions, such as hospitals, play in addressing food insecurity?

Substance Use

k. Could you describe the issues related to substance use that are facing the community?
l. What are the most significant barriers related to accessing substance use services that are affecting people?
    i. What additional barriers do diverse populations face when trying to access substance use services?
m. What are some promising models, programs, or initiatives that you've seen to address substance use?
    i. Probe: What made them successful?
    ii. Probe: How did they address health inequities?

Immigrant/Minoritized Population Health

n. What are some of the specific challenges around immigration issues or discrimination that your communities face?
o. What should health care and social service providers consider when treating health and other issues in diverse populations?
p. How can institutions best respond to the needs of diverse groups?

Senior or Older Populations

q. What are some of the most important health issues that senior populations in the community are currently facing?
r. What are the most significant barriers that seniors are facing when trying to access health care?
    i. Ex. Transportation, insurance coverage gaps, etc
s. How can institutions, such as hospitals, best respond to the unique needs of senior populations?

Youth

t. What are some of the most important health issues that youth in the community are facing?
    i. Probe: What are the most pressing concerns as it relates to their physical health specifically?
    ii. Probe: What are the most pressing concerns as it relates to their overall well-being and development?
u. How can institutions, such as hospitals, best respond to the unique needs of youth populations?

SDOH

v. **Community violence and safety**
    i. What are the major concerns of the community related to violence and safety?
    ii. Could you describe the relationship between the community and the local police?
        1. Probe: What initiatives/programs, if any, have been implemented to address racial inequities in the criminal justice system?
    iii. What are some promising violence prevention programs that you've come across and would like to see implemented?
        1. Probe: What aspects of the program made it successful?
        2. Probe: How might these programs alleviate or exacerbate inequities in the criminal justice system?
w. **Housing affordability**
    i. What are the most significant barriers that the community experiences as it relates to affordable and healthy housing?
        1. Probe: What are some additional barriers that diverse populations face related to affordable and healthy housing?

ii. What has been working well to improve access to healthy, affordable housing?
    1. Probe: How do these address the racial inequities in housing?
iii. How can institutions, such as hospitals, support efforts to address affordable housing?

x. **Economic stability**
    i. Could you describe the issues that the community is facing related to economic or job security?
        1. Probe: What are the unique issues that diverse populations face related to economic/job security?
    ii. What are the biggest barriers that people are facing when they are looking for employment?
        1. Probe: What are the additional barriers that diverse populations face when looking for employment?
    iii. What are the most important resources that the community needs to improve workforce development?

y. **Transportation**
    i. What are some ways that transportation insecurity affects the community you work with?
        1. Probe: What are some additional barriers that diverse populations may face when trying to access transportation?
    ii. Could you describe the current transportation infrastructure in the community you serve?
        1. Probe: how easy or difficult is it to navigate the system?
    iii. What are some improvements to the public transportation infrastructure that would have the most impact in the long-term?
        1. Probe: What are important considerations to think about to ensure that transportation barriers are not exacerbated for diverse populations?

V. **VISION FOR THE FUTURE (5-10 MINUTES)**
    a. I'd like you to think ahead about the future of your community. When you envision the community 3 years from now, what would you like to see?
        i. Probe: What do you see as the immediate next steps in working towards this vision?
        ii. Probe: What do you think needs to be in place to support sustainable change?
        iii. Probe: What do you see as your organization's role in supporting this change?
    b. We've talked about a lot of issues today, thinking about what would make the most impact, who is most affected by the issues, and how feasible it is to make change – What do you think are the 3 highest priority issues for action? What issues are the most important to make greater investments in?

VI. **CLOSING**

Thank you so much for your time and sharing your opinions. Your perspective about the communities you work with will be a great help in determining how to improve the systems that affect the health of this population. Before we end the discussion, is there anything that you wanted to add that you didn't get a chance to bring up earlier? Thank you again. Your feedback is valuable, and we greatly appreciate your time and for sharing your opinion.

APPENDIX G: Focus Group Guide

Health Resources in Action

Newton-Wellesley Hospital CHNA

Primary Service Area: Natick, Needham, Newton, Waltham, Wellesley, and Weston

Focus Group Guide

Goals of the focus group:

1. To determine perceptions of the strengths and needs of the community
2. To explore how these issues can be addressed in the future
3. To identify the gaps, challenges, and opportunities for addressing community needs more effectively

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I. **BACKGROUND**

- Hello, my name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to talk with me today.
- This discussion will last about 60 minutes. [DEPENDING ON FORMAT OF FOCUS GROUP] Please turn on your video, if possible, so that we can all see each other speaking. As a reminder, please keep yourself on MUTE until you want to speak.
- We're going to be having a focus group discussion today. You are here because we want to hear your opinions. I want everyone to know there are no right or wrong answers during our discussion. We want to know your opinions, and those opinions might differ. Please feel free to share your opinions, both positive and negative, and please be respectful of any differences in opinion that someone else may have.
- For some background, a few months ago, Newton-Wellesley Hospital began undertaking a comprehensive community health assessment effort to gain a greater understanding of the health of residents and how the community's needs are currently being addressed. As part of this process, we are having discussions like these around the region with a wide range of people - community members, government officials, leaders in the faith community, health care and social service providers, and staff from a range of community organizations. We are interested in hearing people's feedback on the strengths and needs of the community and suggestions for the future. We will use the information you provide to help develop a Strategic Implementation Plan to address the priorities you have for your communities.
- We will be conducting several of these discussion groups. After all the groups are done, we will be writing a summary report of the general opinions that have come up. In that report, we might provide some general information on what we discussed tonight, but I will not include any names or identifying information. Your responses will be strictly confidential. In the report, nothing you say here will be connected to your name. Your ability to access services will not be impacted in any way.
- **We plan to audio record these conversations just to ensure we have captured the main points of the discussion in case there are any interruptions in the notetaking.** Only the analysts at

Health Resources in Action, who are writing the report, will be listening to the audio recordings. Does anyone have any concerns with me starting the recording now?

- Are there any questions before we begin our introductions and discussion?

II. **INTRODUCTIONS (10 MINUTES)**

Now, first let's spend a little time getting to know one another. When I call your name, please unmute yourself and tell us: 1) Your first name; 2) what city or town you live in; and 3) something about yourself you'd like to share– such as how many children you have or what activities you like to do for fun. [AFTER ALL PARTICIPANTS INTRODUCE THEMSELVES, MODERATOR TO ANSWER INTRO QUESTIONS]

III. **COMMUNITY ASSETS AND CONCERNS (10-15 MINUTES)**

Now, we're going to move to talking more about the community that you live in.

a. To start with, how would you describe your community?
b. If someone was thinking about moving into your community, what would you have said are some of its biggest strengths/positives?
c. What are some of the biggest issues or concerns in your community?

1. **PERCEPTIONS OF HEALTH ISSUES, HEALTHCARE, AND BARRIERS**
    a. What would you say are the top three health issues faced by your community?
        i. Probe: Do you agree with this list? Is there anything missing?
    b. What do you see as the biggest barriers or challenges to addressing these issues?
    c. What do you think the community should do to address these issues?
        i. Probe: What would these efforts look like and who would be involved in them?

IV. **SPECIFIC PROBES FOR DISTINCT ISSUES OF CONCERN**

Mental Health Care

a. Could you describe the issues related to mental health that are facing your community?
    i. Probe: Are there any specific mental health issues that are affecting the diverse populations in your community at a higher rate?
b. What are the barriers related to accessing mental health services that are affecting people?
    i. Probe: What are some additional barriers that diverse populations in your community may face when trying to access mental health?
c. What are some ways to improve access to mental health services for diverse populations?

Chronic Disease Prevention and Management

a. What are some improvements that you would like to see made to your community's environment that could be made to promote health?

i. Ex. More green space, wider sidewalks, safer parks, etc.

b. What are some of the major barriers related to accessing preventive or primary care services that are affecting people in your community?
c. What are the tools that you need to be able to access health care?

Nutrition and Food Insecurity

a. Could you tell me a bit about how food insecurity affects your community?
    i. Probe: How does food insecurity affect diverse populations specifically?
b. What services do you know of that people in your community go to for food? (ex. Networks of food pantries, SNAP benefits at farmer's markets, etc.).
    i. Probe: In your community, how easy or difficult is it to access foods that are important to your culture?
c. What else do you feel needs to be in place in order to meaningfully address food insecurity in your community in the long term?
d. What are the ways that institutions, such as hospitals, can help to address food insecurity in your community?

Substance Use

a. Could you describe the issues related to substance use that are facing the community?
    i. Probe: If you feel comfortable, can you share if you know anyone who is engaged in substance use? How has that affected you?
b. What are the most significant barriers related to accessing substance use services that are affecting people?
    i. What additional barriers do diverse populations face when trying to access substance use services?
c. What are some promising models, programs, or initiatives that you've seen to address substance use?
    i. Probe: What made them successful?
    ii. Probe: How did they address health inequities?

Immigrant Health

a. What are some of the specific challenges around immigration issues or discrimination that your community faces?
b. What should health care and social service providers consider when treating health and other issues in diverse populations/your cultural group?
c. How can institutions, such as hospitals, best respond to the needs of diverse groups?

Senior or Older Populations

a. What are some of the most important health issues that senior populations are currently facing?
b. What are the most significant barriers that seniors are facing when trying to access health care?
    i. Ex. Transportation, insurance coverage gaps, etc.

c. How can institutions, such as hospitals, best respond to the unique needs of senior populations?

Youth

a. What are some of the most important health issues that youth in your community are facing?
    i. Probe: What are your most pressing concerns as it relates to their physical health specifically?
    ii. Probe: What are your most pressing concerns as it relates to their overall well-being and development?
b. How can institutions, such as hospitals, best respond to the unique needs of youth populations?

Social Determinants of Health

a. **Community violence and Safety**
    i. What are the major concerns in your community related to violence and safety?
    ii. Could you describe the relationship between your community and the local police?
        1. Probe: What initiatives/programs, if any, have been implemented to address racial inequities in the criminal justice system?
    iii. What are some promising violence prevention programs that you've come across and would like to see implemented?
        1. Probe: How might these programs alleviate or exacerbate inequities in the criminal justice system?
b. **Housing affordability**
    i. What are the most significant barriers that you or your community experience as it relates to affordable and healthy housing?
        1. Probe: What are some additional barriers that diverse populations face related to affordable and healthy housing?
    ii. How hard is it to find housing that is appropriate for you/your family?
        1. Probe: What do you look for when searching for housing?
    iii. How can institutions, such as hospitals, support efforts to address affordable housing?
c. **Economic stability**
    i. Could you describe the issues that your community is facing related to economic or job security?
        1. Probe: What are the unique issues that diverse populations face related to economic/job security?
    ii. What are the biggest barriers that people are facing when they are looking for employment?
        1. Probe: What are the additional barriers that diverse populations face when looking for employment?
    iii. When people or families that you know are dealing with financial hardship, what are some of the issues that are most weighing on them?

1. Probe: How do they deal with that?

iv. What are the most important resources that the community needs to improve financial security or workforce development?

d. **Transportation**

i. What are some ways that transportation insecurity affects your community?

1. Probe: What are some additional barriers that diverse populations may face when trying to access transportation?

ii. Could you describe the current transportation infrastructure in your community?

1. Probe: Have you used public transportation before? How easy or difficult is it to navigate the system?

iii. What are some improvements to the public transportation infrastructure that would have the most impact in the long-term?

1. Probe: What are important considerations to think about to ensure that transportation barriers don't become worse for diverse populations?

V. **VISION OF COMMUNITY HEALTH IMPROVEMENT AND INVOLVEMENT**

a. I'd like you to think ahead about the future of your community. When you envision the community 3 years from now, what would you like to see?

i. Probe: What do you see as the immediate next steps in working towards this vision?

ii. Probe: What do you think needs to be in place to support sustainable change?

iii. Probe: What do you see as your organization's role in supporting this change?

b. We've talked about a lot of issues today, thinking about what would make the most impact, who is most affected by the issues, and how feasible it is to make change – What do you think are the 3 highest priority issues for action? What issues are the most important to make greater investments in?

VI. **CLOSING**

a. Thank you so much for your time. Your perspective about the communities you live in will be a great help in determining how to improve the systems that affect the health of this population.

b. That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today?

c. [TALK ABOUT NEXT STEPS OF THE PROCESS, SPECIFICALLY HOW PARTICIPANTS CAN GET INVOLVED FURTHER OR RECEIVE THE FINAL REPORT OR SUMMARY OF THE REPORT.]

d. Thank you again. Have a good afternoon.

APPENDIX H: Key Informant Interview and Focus Group Participants

Key Informant Interviews

NAME	ORGANIZATION	POSITION
Dorothy Kitakufe Mugabi	Africano	Parents Coordinator
Elise Mason Josh Ostroff	Transportation for Massachusetts	Community Engagement Manager Interim Director
Emily Kuhl	Newton Senior Center	Social Worker
Alison Fondo	Disability Law Center	Attorney
Genevra Valvo Josue Teo	Waltham Public Schools	ELL Teachers
Alejandro Bracamontes	The Right to Immigration Institute	Executive Director
Carolyn Montalto	Community Day Center	Executive Director
Annette Poirier	Bristol Lodge Soup Kitchen/Single Men's and Women's Shelters	Program Director

Focus Group Organizers and Participants

ORGANIZER / PARTICIPANTS	COMMUNITY	LANGUAGE(S)
Myrtle Baptist Church	Newton	English
SOAR Natick	Natick	English
Waltham Partnership for Youth	Waltham	English
Newton Housing Authority and Newton Community Development Foundation	Newton	English
WATCH CDC	Waltham	Spanish
Newton Food Pantry Clients	Newton	English, Mandarin, Spanish
Healthy Waltham	Waltham	Spanish
Bilingual English Learning Advisory Council (BELPAC)	Waltham	Spanish