October 2022

Newton-Wellesley Hospital

2022-2025 Strategic Implementation Plan

Mass General Brigham
Newton-Wellesley Hospital

Health Resources in Action
Advancing Public Health and Medical Research

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Executive Summary

This executive summary provides an overview of the Newton Wellesley Hospital (NWH) 2022-2025 Community Health Needs Assessment (CHNA) and Strategic Implementation Plan (SIP).

Improving the health of a community is essential to enhancing the quality of life for residents in the region and supporting future social and economic well-being. NWH engaged in a rigorous planning process to improve the health of residents in its primary service area (Natick, Needham, Newton, Waltham, Wellesley, and Weston), fulfilling the requirements under the Affordable Care Act and continuing this best practice in community health. This effort included two phases: (1) a Community Health Needs Assessment (CHNA) to identify the health-related needs and strengths of the region and (2) a Strategic Implementation Plan (SIP) to identify major health priorities, develop goals, select strategies, and identify partners to address these priority issues across the region.

Impact of COVID-19 & Related Considerations

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 aligned their 2022 CHNA-SIP with the same cycle as the other institutions within the Mass General Brigham system. The postponement of longer-term planning efforts also allowed for getting beyond the time of the acute phase of the COVID-19 pandemic.

Health Equity Approach

NWH utilized the social determinants of health framework to guide the CHNA and SIP process. This framework examines how individual health outcomes are influenced by upstream social and economic factors such as housing, educational opportunities, food access, and economic stability. The CHNA describes social and economic determinants and reviews key health outcomes among residents of the Newton-Wellesley Hospital service area. The SIP prioritizes addressing these upstream factors to promote health equity, the principle that all people have a fair and just opportunity to be healthy.

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, feedback, and active participation from the expanded Community Benefits Committee (CBC+) regarding health and social challenges in their area and recommendations for how to address these concerns.

CHNA Key Findings

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 key concerns related to social, environmental, and health issues. Synthesizing social, economic, and epidemiological statistical data with community perspectives and discussions, this 2022 CHNA identified several key priority areas for action related to community health improvement, including:

- 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

Process for Developing the Strategic Implementation Plan

During September to October 2022, HRiA led a facilitated process with NWH's expanded Community Benefits Committee members (CBC+). The expanded committee is comprised of 11 community leaders and advocates who were invited to work alongside the established 22 members of the NWH Community Benefits Committee (CBC) to provide strategic oversight of the CHNA-SIP process. The CBC+ was formed to provide input and guidance on the assessment and continued to provide critical input throughout the prioritization and planning process for the SIP, ensuring a continuity of perspective throughout these processes (see Appendix A, B and C for a list of Committee members and planning participants).

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 (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.

As a result of these facilitated discussions, CBC+ members organized the key findings from the CHNA into the following priorities for the Strategic Implementation Plan:

- **Housing Affordability**
- **Mental Health & Substance Use**
- **Access to Quality Care, with a focus on:**
    - Chronic disease prevention and management
    - Integration of services and healthcare, i.e., navigation and wrap around services
- **Transportation**

In addition, CBC+ members recommended that all priorities be addressed with the following cross-cutting strategies:

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

Following the prioritization discussion, HRiA led a two-day, virtual SIP planning session in September that included mapping current and emerging programs and initiatives against current needs identified in the CHNA. In addition, CBC+ members engaged in decision-making regarding which existing programs and initiatives would be continued and which new programming/activities to consider. All areas highlighted by the 2022 CHNA are being addressed at different levels within the 2022-2025 Strategic Implementation Plan (e.g., priority level/goal, area of focus level/objective, and/or cross-cutting strategic themes/strategies). This plan is meant to be reviewed quarterly and adjusted to accommodate emerging issues that merit attention.

Vulnerable Populations Addressed by this Strategic Implementation Plan

- **Older adults**
- **Youth**
- **Immigrants**
- **People of Color**

Social Determinants of Health Issues Addressed by this Strategic Implementation Plan

- High cost of living, including cost of healthcare services
- Housing affordability
- Access to healthy food, as it relates to chronic disease prevention and management
- Transportation, as it relates to access to care
- Economic stability and workforce development

Partnership Development & Ongoing Collaborations

NWH continues to build and maintain relationships with partner organizations in the community to ensure their community health improvement work is carried out collaboratively. Partners include school systems, senior services organizations, social services agencies, youth development groups, local cities and towns, faith-based community organizations, immigrant services, public health, housing organizations, DSV, food access networks, mental health and substance use partners, transportation providers, and others. NWH identified key partners who collaborate on strategies in this SIP; they are featured in the SIP matrixes on the following pages. *The Newton-Wellesley Community Collaborative*, (formally The Newton-Wellesley Collaborative for Healthy Families and Communities (CHF&C)) was formed in 2017 to identify opportunities and enhance services to meet the health and wellness needs of patients, families, and communities served by NWH. The Collaborative contains eight councils around focus areas of need identified in previous CHNAs. Each council has approximately 20 members, with representation of community members, community stakeholders, and NWH staff. The councils serve as a vital bridge by ensuring community members' and stakeholders' voices are heard while addressing documented needs identified in the CHNA.

The Councils meet three times per year to address health needs by focusing on their four objectives of Ambassadorship and Advocacy, Community Education and Outreach, Programmatic Impact, and Philanthropy. The eight councils are listed by name below:

- Cardiovascular Health Council
- Domestic and Sexual Abuse Council
- Elder Care Council
- Maternity Services Council
- Palliative Care Council
- Resilience Council (youth mental health)
- Substance Use Services Council
- Workforce Development Council

NWH Strategic Implementation Plan

Cross-Cutting Strategic Themes

Health and Racial Equity, Workforce Development, Continuous/Sustained Community Engagement and Empowerment

- **Health and Racial Equity**: Recognizing, understanding, and accepting our communities through the lens of racial, cultural, and linguistic differences. Exploring implementation of community-grounded strategies for change and creating infrastructures that enable navigation through community-based advocacy and support.
- **Workforce Development**: Acting on efforts of employment recruitment, selection, and retention as well as developing and filling the pipeline.
- **Community Engagement and Empowerment**: Outreaching to grassroots experts, to include leadership development, resourcing/support, and intentionally creating space for community leaders to share expertise and lend voice to inform and shape decision-making. Engaging community leaders to build capacity and affect systems change in larger infrastructures.

Strategic Implementation Plan Snapshot

Priority Area	Goal
Priority Area 1: Housing Affordability	Goal 1: Establish resources to enhance the availability of equitable, safe, affordable, and accessible housing for the most vulnerable individuals and families within the six communities in NWH's service area.
Priority Area 2: Mental Health & Substance Use	Goal 2: Increase prevention, access to treatment, and recovery services for mental health and substance use, and address issues of stigma in collaboration with providers, patients, and the community ensuring that demographic, cultural and linguistic differences are thoughtfully considered in initiative/program design.
Priority Area 3: Access to Quality Care	Goal 3: Increase equitable access to quality care and services to improve and promote preventative health, provide outlets to support health navigation and wrap around services, and address equity in the areas of race, language, and socioeconomic status.
Priority Area 4: Transportation	Goal 4: Eliminate barriers to, and expand accessible, affordable, and flexible transportation to essential services.

Priority 1: Housing Affordability

Priority Area 1: Housing Affordability **Goal 1: Establish resources to enhance the availability of equitable, safe, affordable, and accessible housing for the most vulnerable individuals and families within the six communities in NWH's service area.**		
Outcome Indicators	**Baseline**	**Target**
• Number of collaborations/partnerships with housing related organizations within the NWH communities	50	9 TBD
• Amount of funding provided related to housing security	$730,011 (Funding provided to date of the NWH DON 4-year grant)	$1,169,989 Remaining NWH DON grant funding
• Number of residents impacted by outreach efforts to prevent eviction	225	
• Amount of Tenant Assistance Funds dispersed	$67,000	
• Number of ways information on housing insecurity was shared with the community (residents, local and state level, partners, hospital) with designation for the specific NWH communities		
• Number of referrals by DON grantee organizations for clients for mental health services	13	
• Number of clients served in the Housing and Basic Need Clinic	540	
• Number of Job and Financial Management Clinic Workshops held	48	
• Number of attendees at the Job and Financial Management Clinic Workshops	180	
• Number of one-on-one assistances provided to Job Clinic attendees	51	
• Housing advocacy efforts undertaken to include identified methods utilized to educate hospital leadership, community leaders and others to be informed regarding the focus area of housing		

Priority Area 1: Housing Affordability
Goal 1: Establish resources to enhance the availability of equitable, safe, affordable, and accessible housing for the most vulnerable individuals and families within the six communities in NWH's service area.

Strategies/Initiatives	Person(s) Responsible	Timeline (Y1, Y2, Y3)	Hospital Contribution	Other Recommended External Funding Sources
1. Convene and engage with representation from within the six surrounding communities and hospital representatives to learn the unique housing needs and issues of each community.	CBC+ WATCH CDC MetroWest CDC	Y1 - ongoing	Staff time Grant funding	
2. Leverage advocacy efforts from MGB Community Health/United Against Racism to advocate for governmental laws, policies, and funding to support safe, affordable, and accessible housing, including the development/creation of housing, in an equitable manner.	MGB Community Health/United Against Racism	Y1- ongoing Annual update to CBC on advocacy and legislative efforts	Staff time space	
3. Create a white paper/talking points to enable hospital leadership (to include Board members and Community Benefits Committee members) and others to be informed and possess baseline knowledge to be effective advocates on housing needs in the NWH communities and share with their networks.	CBC+ WATCH CDC MetroWest CDC	Y1 Q4 or Y2 Q1	Staff time	
4. Provide education to elevate conversations about the connection between safe housing and healthy living. a. Partner with local housing-related organizations to provide educational programming and informational resources to vulnerable populations. b. Educate hospital staff and public on housing as a social determinant of health c. Help advocacy on behalf of partner organizations to connect health and housing.	CBC+ Partner Organizations Population Health/CHW	Y2	Grant Funding In-Kind Donations Staff Time Demographic-specific data collection	
5. Share hospital efforts and data with organizations who are already doing the work to assist with advocacy to expand housing availability and support of equitable housing.	Community Health CBC+ Partner Organizations	Y1 - ongoing	Staff time Data source	

Priority Area 1: Housing Affordability

Goal 1: Establish resources to enhance the availability of equitable, safe, affordable, and accessible housing for the most vulnerable individuals and families within the six communities in NWH's service area.

Monitoring/Evaluation Approach

- Collect data from community engagement activities
- Collect community data on trends in affordable housing
- Collect data from Community Health Worker referrals and SDOH tracking
- Collect data results from the NWH Determination of Need awarded in Oct. 2021 from WATCH CDC and MetroWest CDC

Potential Partners

- Adult Service Organizations
- Can Do, Newton
- Chambers of Commerce
- Community Day Center
- Health and Human Services Departments and Organizations
- Homeless Assistance Coalition, Waltham
- MetroWest Community Development Corporation
- Newton Housing Authority
- Waltham Housing Authority
- Watch CDC, Waltham

Priority 2: Mental Health & Substance Use

Priority Area 2: Mental Health & Substance Use **Goal 2: Increase prevention, access to treatment, and recovery services for mental health and substance use, and address issues of stigma in collaboration with providers, patients, and the community ensuring that demographic, cultural and linguistic differences are thoughtfully considered in initiative/program design.**		
Outcome Indicators	**Baseline**	**Target**
• Number of patients seen in NWH Child and Adolescent Clinic	4500	
• Number of patients seen in the NWH Substance Use Clinic	2465	
• Area MH/SU, suicide rates (Data source: MetroWest Adolescent Health Survey, Youth Risk Behavior Survey (YRBS))	Current	Less than current
• Number of MH/SU focused educational programs offered (NWH and partners)		
• Number of MH/SU partners/coalitions engaged overall (NWH and partners)		
• Number of MH/SU partners/coalitions engaged who serve immigrant populations		
• Number of students completing the Welcome Class Program through Wrap Around Waltham	136	
• Percent of students in the Wrap Around Program who graduated or progressed to the next grade level.	95%	
• Number of support programs, services, and resources provided to youth, older adults, and immigrants.		
• Number of survivors of violence and abuse served	378	
• Number of MH/SU-based internships created and offered through Paid Internship Programs (e.g., Waltham and Newton)	0	2

Priority Area 2: Mental Health & Substance Use
Goal 2: Increase prevention, access to treatment, and recovery services for mental health and substance use, and address issues of stigma in collaboration with providers, patients, and the community ensuring that demographic, cultural and linguistic differences are thoughtfully considered in initiative/program design.

Strategies/Initiatives	Person(s) Responsible	Timeline (Y1, Y2, Y3)	Hospital Contribution	Other Recommended External Funding Sources
1. Connect the MH/SU prevention coalitions in the NWH catchment area to share learnings, best practices and facilitate alignment/ collaboration to enhance impact.	Community Health, NWH Substance Use Service, NWH Child and Adolescent Psychiatry Division Service area mental health and substance use coalitions (e.g., SOAR Natick, Natick 180, local public health departments)	Y1, Y2, Y3	Staff Time Meeting space	Federal grants (Drug Free Communities Grant)
2. Incorporate opportunities for MH/SU careers in the career platform for the NWH Workforce Development Council. a. Support High School career education framed with a social justice lens that focuses on the need for more MH/SU providers; the need for more providers of color who speak multiple languages to promote careers in MH/SU and encourage opportunities for those from diverse backgrounds (scholarships, career pathways, stipends for internships with local colleges/universities, etc.).	NWH WFD Council Waltham Partnership for Youth	Y1, Y2, Y3	NWH Financial contribution Staff time Space Materials/supplies	Accelerate the Future (family foundation) focused on grants for MH WFD; William James College scholarship program and community coaching program

Priority Area 2: Mental Health & Substance Use
Goal 2: Increase prevention, access to treatment, and recovery services for mental health and substance use, and address issues of stigma in collaboration with providers, patients, and the community ensuring that demographic, cultural and linguistic differences are thoughtfully considered in initiative/program design.

Strategies/Initiatives	Person(s) Responsible	Timeline (Y1, Y2, Y3)	Hospital Contribution	Other Recommended External Funding Sources
3. Conduct information gathering and exploration for a liaison model between schools and other non-clinical, youth-serving spaces where clinicians can be placed (ecosystem approach to understanding/addressing MH/SU needs across the lifespan) to increase the presence of clinical staff in community settings. Emphasize culturally and linguistically appropriate approach with a roundtable vs top-down process. a. Identify best practices within established and emerging community programs. b. Support and partner with clinical providers to enhance incentives that increase the presence and retention of clinicians in high-need, non-clinical spaces (schools, community settings, elder service centers, etc.). c. Convene providers and school personnel to understand what is working/not working to inform sustainability and improve a model. d. Enhance partnerships with schools to understand needs/gaps and provide education and prevention services for youth and families, prioritizing diverse representation	Community Health and CBC+ School systems and youth organizations	Y1, Y2, Y3 Y1: Establish a steering committee. Conduct information gathering Y2: conduct gap analysis, identify best practices Y3: Report on Recommendations Build partnerships - ongoing	Staff time Support resources	
4. Offer group therapeutic services to newly arrived immigrant students and their caregivers upon registration to schools.	Waltham Partnership for Youth	Y1, Y2, Y3 Y1: build partnerships, conduct gap analysis, plan Y2 + Y3: Implement and evaluate	Hospital Grant Funding	

Priority Area 2: Mental Health & Substance Use
Goal 2: Increase prevention, access to treatment, and recovery services for mental health and substance use, and address issues of stigma in collaboration with providers, patients, and the community ensuring that demographic, cultural and linguistic differences are thoughtfully considered in initiative/program design.

Strategies/Initiatives	Person(s) Responsible	Timeline (Y1, Y2, Y3)	Hospital Contribution	Other Recommended External Funding Sources
5. Provide culturally and linguistically appropriate education on what MH/SU looks like within different populations based on their needs, in partnership with community groups that work with them, including: a. Older adults and families/caregivers b. LGBTQIA+ and families/caregivers c. Domestic and Sexual violence (DSV) Survivors d. BIPOC community and families/caregivers e. Immigrant population and families/caregivers	Community Liaisons with NWH NWH Senior Living Community Forum organizations	Y1, Y2, Y3	Staff Space for events Materials and supplies	
6. Address stigma associated with mental health and substance use in at risk populations due to cultural, racial, and diverse demographics.	Community Health Community Partners	Y1 - Ongoing	Staff Space	
7. Enhance, expand, and promote community training on QPR Suicide Prevention, Youth Mental Health First Aid that exist already in NWH communities.	NWH & CBC+ partners already engaged	Y1, Y2, Y3 In implementation phase in some communities; build capacity in other communities to offer		
8. Equitably promote and support different, culturally, and linguistically appropriate options for community recovery services including recovery coaches, 12-Step programs, mentorship programs, medication-assisted recovery, youth recovery high school, diversion programs for youth, etc.	NWH & CBC+ partners and providers	Y1, Y2, Y3 (Some in practice already, expand Y2-3)	Staff time	

Priority Area 2: Mental Health & Substance Use

Goal 2: Increase prevention, access to treatment, and recovery services for mental health and substance use, and address issues of stigma in collaboration with providers, patients, and the community ensuring that demographic, cultural and linguistic differences are thoughtfully considered in initiative/program design.

Monitoring/Evaluation Approach

- Collection of participation and demographics for Coalition events
- Collection of Child and Adolescent Clinic and Substance Use Clinic data
- Collection of data from school-based initiatives (to include demographic-specific data)
- Collection of data from community engagement activities
- Collection of data from resulting efforts through community partnerships and coalitions
- Collection of two-year BRFSS and YRBS data related to MHSU
- Collection of impact from collaborations with DSV partners.
- Establish platforms to gather ongoing community input from priority populations (focus groups, etc.).
- Internship program reports

Potential Partners

- Africano
- Asian Task Force Against Domestic Violence
- Black Future Fund
- Boston Aera Rape Crisis Center
- Community Coalitions re: SU prevention
- Councils on Aging/Senior Centers
- DSV: Reach, Second Step, BARCC
- Families for Depression Awareness
- Higher Education Institutions
- Local Health Departments
- Men's Healing
- MetroWest Care Connection
- OutMetroWest
- REACH Beyond Domestic Violence
- Saheli
- School Districts
- Second Step
- Senior Living Community organizations
- Third party groups that can help access providers
- W2B2 Youth Wellness Collaborative
- Waltham Partnership for Youth
- Wayside Youth and Family Support Network
- NWH Child and Adolescent Psychiatry Division
- NWH Community Collaborative Councils (Resilience, Substance Use, Workforce Development, Elder Care, Maternity Services, Domestic and Sexual Abuse)
- NWH Domestic and Sexual Violence Program
- NWH Substance Use Service

Priority 3: Access to Quality Care

Priority Area 3: Access to Quality Care Goal 3: Increase equitable access to quality care and services to improve and promote preventative health, provide outlets to support health navigation and wrap around services and address equity in the areas of race, language, and socioeconomic status.		
Outcome Indicators	**Baseline**	**Target**
• Number of free/subsidized screenings conducted by the hospital, on-site or in the community (by demographics, type of screening, and by multi-language availability)	3	
• Number of educational programs focused on screening provided	7	
• Number of MGB mobile health van visits to NWH service area	0	2
• Number and type of supports provided by community health workers	51	
• Number of community ambassadors recruited		
• Number of caregiver support resources provided		
• Number of events held or participated in where clinical providers go out into NWH communities		
• Number of participants engaged in NWH community education programing (with collection of data on race, age, gender, community, and primary language spoken)	2000	
• Number of technology education session participants (with collection for race, age, gender, community, and primary language spoken)	1	

Priority Area 3: Access to Quality Care **Goal 3:** **Increase equitable access to quality care and services to improve and promote preventative health, provide outlets to support health navigation and wrap around services and address equity in the areas of race, language, and socioeconomic status.**				
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Recommended External Funding Sources**
1. Provide free or subsidized, culturally appropriate and population-specific chronic disease **screening and management** (e.g., cardiovascular and cancer care, diabetes, hypertension). a. Provide multi-lingual outreach and reminders. b. Establish regular interactions of healthcare providers to community gatherings that are in the community to reach the vulnerable and marginalized populations. c. Advocate for more MGB mobile van access in NWH service area.	CBC+ MGB Community Health Cardiovascular and Cancer Care Departments Community organizations for screenings and healthcare referrals	Y1, Y2, Y3	NWH staff Mobile health van	
2. Build relationships with community partners to provide **health and nutrition education** for the prevention and reduction of chronic disease (e.g., cardiovascular and cancer care, diabetes, and hypertension). a. Utilize NWH resources on nutrition education and training. Promote education opportunities through collaboration with community-based organizations (CBOs). b. Explore providing a presence of dieticians (with translators) to food pantries to have casual conversations with guests. c. Provide culturally relevant meal demonstrations at community settings. d. Work with CBOs to disseminate health information and resources via relevant and trending social media platforms	CBC+ Community food pantries/markets and locations, MGB Nutrition Security and Equity Advisory Group Cardiovascular Dept. NWH Food as Medicine	Y1, Y2, Y3	Staffing. Education materials in multiple languages	
3. Partner with food services organizations to improve education and outreach regarding awareness of and equitable access to healthy foods.	NWH Food as Medicine Program, Nutrition Security and Equity Work Group (NWH and community partners) Community food pantries/markets and locations	Y1, Y2, Y3	Staff time	

Priority Area 3: Access to Quality Care **Goal 3:** **Increase equitable access to quality care and services to improve and promote preventative health, provide outlets to support health navigation and wrap around services and address equity in the areas of race, language, and socioeconomic status.**				
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Recommended External Funding Sources**
4. Work with communities to identify and increase the number and capacity of community-based ambassadors and/or navigators. a. Utilize ambassadors and/or navigators for two-way communication and knowledge sharing between community health workers and NWH providers (e.g., cultural considerations for clinical care). b. Support ambassadors to provide health education and coordinate care for vulnerable residents.	CBC+ NWH Pop Health – Community Health and Navigation	Y1, Y2, Y3		
5. Partner with trusted Community Based Organizations to identify individuals from local communities who are interested in healthcare positions with high vacancy rates, and positions identified as being needed in vulnerable communities. a. Establish systems for related internships and shadowing of providers. b. Develop programs with local colleges for exposure to the field of community health work and/or community ambassador. c. Create shadow opportunities with community health workers.	NWH Work Force Development Council, Higher Education Institutional partners, NWH Community Health			
6. Identify and bolster existing community resources and services for caregivers. a. Work with communities to support caregivers as care-coordinators and decision-makers.	CBC+ Local senior service organizations	Y1, Y2, Y3		
7. Promote programs that educate older adults on the use of smart phones and computers to access medical services and transportation options (e.g., TRIPS in Brookline, Welcome to the Digital Age in Waltham, many volunteer run) by getting information in the hands of providers.	Community Health CBC+ Senior Service Agencies	Y1, Y2, Y3	Staff time Translations Services Supplies	
8. Provide information and/or education to community members on the availability of telehealth, and use of technology during medical care appointments. (e.g., via Senior Webinar Series).	Community Health, NWH Clinicians	Y1, Y2, Y3	Staff time Translation Services	

Priority Area 3: Access to Quality Care **Goal 3:** **Increase equitable access to quality care and services to improve and promote preventative health, provide outlets to support health navigation and wrap around services and address equity in the areas of race, language, and socioeconomic status.**				
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Recommended External Funding Sources**
9. Increase healthcare presence in vulnerable communities. a. Inform and raise awareness among hospital leaders, the community, and policy makers of the need for bi/multi-lingual primary care providers that specialize in underserved populations. b. Explore with education and training institutions, opportunities for exposure and training of "the next generation." c. Explore establishing a school-based clinic in Waltham. d. Identify local community groups and partners to provide health education programs and clinical services. e. Increase the outreach to community groups such as first responders and personal care providers to provide early detection of chronic disease symptoms and informational resources f. Provide health outreach (screenings, education, etc.) in multiple languages, as needed. g. Expand relationships with organizations, institutions, and individuals to establish trusted partnerships.	CBC+ Medical providers, Hospital Services	Y1, Y2, Y3	Planning and implementation support Staff Investment in community engagement Grants for CBOs	
10. Work with CBOs to identify and support opportunities for demographic data collection and analysis	Community Health Community Resources	Y1, Y2, Y3		
11. Support community partners who provide **technology or access to technology** for use in accessing essential services.	Community Partners	Y1, Y2, Y3		

Priority 4: Transportation

Priority Area 4: Transportation **Goal 4: Eliminate barriers to, and expand accessible, affordable, and flexible transportation to essential services.**		
Outcome Indicators	**Baseline**	**Target**
• Number/amount of outreach conducted (with collection of data on race, age, gender, community, and primary language spoken)		
• Number of groups, individuals, communities that the transportation inventory is shared.	0	
• Program utilization/participation for ModivCare	1427	
• Number of transportation assists as measured by CHWs (dashboard)		
• Number of community gatherings where information and resources on transportation is provided (with data collection on communities and settings of vulnerable populations).	0	4

Priority Area 4: Transportation **Goal 4: Eliminate barriers to, and expand accessible, affordable, and flexible transportation to essential services.**				
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Recommended External Funding Sources**
1. Work with partners to assess existing transportation initiatives/services. Conduct an inventory by town to include the extent of multi-lingual options. a. Determine what training/information the service provides with respect to transporting articular populations (e.g., older adults, people with disabilities, vision/hearing impairment), languages drivers/providers speak, level to which programs are promoted in various languages, etc. b. Determine if transportation available to all essential services in addition to healthcare should be identified	CBC+ Councils on Aging (COA's) Higher Education Institutions for possible graduate student intern resources	Y1 – 1a and 1b – Identify resources for conducting the inventory. Engage in planning for the inventory	Project staff	
2. Share the inventory with community partners, hospital providers and those serving the community in various capacities. a. Identify outlets for sharing/distributing the information (e.g., via website(s), community gatherings, libraries, community centers). b. Identify and create a method for replication of the inventory on an annual basis.	CBC+ Community partners Community Health	Y2 – 2a Y3 – 2b	Website development (NWH and/or towns) Supplies and materials (printing, etc.) Translation services	
3. Promote and provide educational sessions for older adults and their caregivers to help them drive more safely (e.g., conducting **Carfit** training for trainers and/or sessions) and to understand use of transportation resources.	Community Health COA's	Y1, Y2, Y3	Space Hospital Staff	
4. Explore ways to provide tran**sportation funds directly to community members** in need vs. utilizing contracts with transportation providers (e.g., transportation allocations for eligible community partners).	Community Health	Y1, Y2, Y3	Funding	
5. Share transportation resources with patient **navigators and CHW's** to assist with patient transportation needs.	Community Health Community Health Workers/Navigators Clinical Providers	Y1, Y2, Y3	Staff time Upkeep of Dashboard	
6. Identify and advocate for **transportation policies** in our communities, and keep partners informed of MGB legislative initiatives as appropriate.	Community Health CBC+ Chambers of Commerce	Y1, Y2, Y3	Staff time	

Priority Area 4: Transportation Goal 4: Eliminate barriers to, and expand accessible, affordable, and flexible transportation to essential services.				
Strategies/Initiatives	**Person(s) Responsible**	**Timeline (Y1, Y2, Y3)**	**Hospital Contribution**	**Other Recommended External Funding Sources**
7. Continue the **ModivCare** program (a Lyft platform) and explore how that program could be modified/expanded to cover patient needs and expanded to include community partnerships.	Community Health NWH Case Management	Y1, Y2, Y3	Funding Staff Time	

Priority Area 4: Transportation Goal 4: Eliminate barriers to, and expand accessible, affordable, and flexible transportation to essential services.
Monitoring/Evaluation Approach
• Completion of inventory and dissemination to community partners and NWH providers • An established approach for sustainability of the transportation inventory • NWH CHW Dashboard • NWH Modivcare data • Transportation data from COAs and other transportation providers • Program pre- & post-evaluations/surveys
Potential Partners
• Chambers of Commerce • CHWs and Patient Navigators • Councils on Aging (COA)/Senior Centers) • Disability Organizations • Healthcare Providers • Higher Education Institutions • Libraries • Non-Profit Organizations servicing clients with transportation needs • Town Administrators/Officials • Transportation Providers

Appendices

Appendix A: 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 B: Community Benefits Committee Expanded 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 C: CBC+ Planning Participants

Priority 1: Affordable Housing	Priority 2: Mental Health & Substance Use	Priority 3: Access to Quality Healthcare	Priority 4: Transportation
Genoveva Tavera Josephine McNeil Shin-Yi Lao Sue Ross	Josephine Pang Katie Sugarman Kaytie Dowcett Liz Booma Tiffany Zike	Alejandro Bracamontes Deanna Bruno Gihan Suliman Kim Gerard Maria DiMaggio Regina Wu Sara DeMedeiros	Donlyn Canella Mignonne Murray Lauren Lele

Appendix D: Acronyms

BARCC	Boston Area Rape Crisis Center
BIPOC	Black, Indigenous, and People of Color
BRFSS	Behavioral Risk Factor Surveillance System
CBC	Community Benefits Committee
CBC+	Community Benefits Committee with expanded membership
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CDC	Community Development Corporation
CHF&C	The Newton-Wellesley Collaborative for Healthy Families and Communities
CHNA	Community Health Needs Assessment
CHW	Community Health Worker
COA	Council on Aging
COVID-19	Coronavirus Disease of 2019
DON	Determination of Need
DSV	Domestic and Sexual Violence
LGBTQIA+	Gay, Lesbian, Bisexual, Transgender, Queer, Intersex, and Asexual people
MGB	Mass General-Brigham Hospital System
MH	Mental Health
MH/SU	Mental Health and Substance Use
NWH	Newton-Wellesley Hospital
QPR	Question, Persuade, Refer (Suicide Prevention Training)
SDOH	Social Determinants of Health
SIP	Strategic Implementation Plan
SOAR	Supporting Outreach and Addiction Recovery
SU	Substance Use
TBD	To Be Determined
WATCH CDC	Waltham Alliance for Teaching, Community Organizing and Housing – Community Development Corporation
WFD	Workforce Development
YRBS	Youth Risk Behavior Survey

Appendix E: Glossary of Terms

Essential Services: All wrap-around and support services required for maintaining optimal physical and mental health.

Outcome Indicator: Measures used to track the progress/success/impact of a series of strategies on improving population health.

Potential Partners: Individuals and agencies/organizations who can implement and/or support strategies identified in the SIP.

Vulnerable Populations: Groups and communities at a higher risk for poor health as a result of the barriers they experience to social, economic, political, and environmental resources, as well as limitations due to illness or disability.