MW MelroseWakefield Healthcare

COMMUNITY HEALTH IMPLEMENTATION PLAN 2020-2022

Prepared in collaboration with MelroseWakefield Healthcare by the Institute for Community Health

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INSTITUTE FOR COMMUNITY HEALTH

ABOUT MELROSEWAKEFIELD HEALTHCARE

> **[MelroseWakefield Healthcare's] involvement with the community is their strength. Every time we go to a community meeting, they have their representatives there. So they are collaborating, or attempting to connect the dots for services."**
>
> *-Community Stakeholder*

MelroseWakefield Healthcare, Inc., (MWHC) formerly known as Hallmark Health System, is a comprehensive system of community hospitals, outpatient centers, primary care and specialty physicians, and visiting nurse and hospice programs serving north suburban Boston. MelroseWakefield Healthcare is committed to its mission to provide quality care for its communities and achieve clinical excellence for the patients it serves.

On January 1, 2017, **MelroseWakefield Healthcare became the third founding member of Wellforce**, a collaboration of academic, medical, and community health care providers in Massachusetts that also includes Circle Health in Lowell, Tufts Medical Center in Boston, and the Home Health Foundation.

Today, MelroseWakefield Healthcare encompasses **MelroseWakefield Hospital** in Melrose, **Lawrence Memorial Hospital** of Medford, urgent care locations in Reading and Medford, **Breast Health Center** in Stoneham, **Center for Radiation Oncology** in Stoneham, a **Medical Center** in Reading, **Tufts Medical Center Community Care**, **Hallmark Health Visiting Nurse Association and Hospice**, the **Lawrence Memorial/Regis College Nursing and Radiography Programs**, and a **variety of community-based programs and services**. The Massachusetts Department of Public Health (DPH) has designated MelroseWakefield Hospital as a Primary Stroke Service hospital.

MelroseWakefield Hospital is also designated a “Baby Friendly” hospital, a program of the World Health Organization (WHO) and United Nations Children’s Fund (UNICEF). Baby-Friendly birthing facilities create environments for parents and infants to get the best start in life from the very beginning, supporting breastfeeding and best practice infant care strategies.

MWHC’s Community Services division oversees programs that impact both medical and social determinants of health, supported by a mix of federal, state, and private funding. These include:

- Aging in Balance Elder Outreach
- Community Health Education
- Healthy Families Program and Massachusetts Home Visiting Initiative
- North Suburban Child and Family Resource Network
- North Suburban Women, Infants, and Children (WIC) Nutrition Program

MELROSEWAKEFIELD HEALTHCARE COMMUNITY BENEFITS

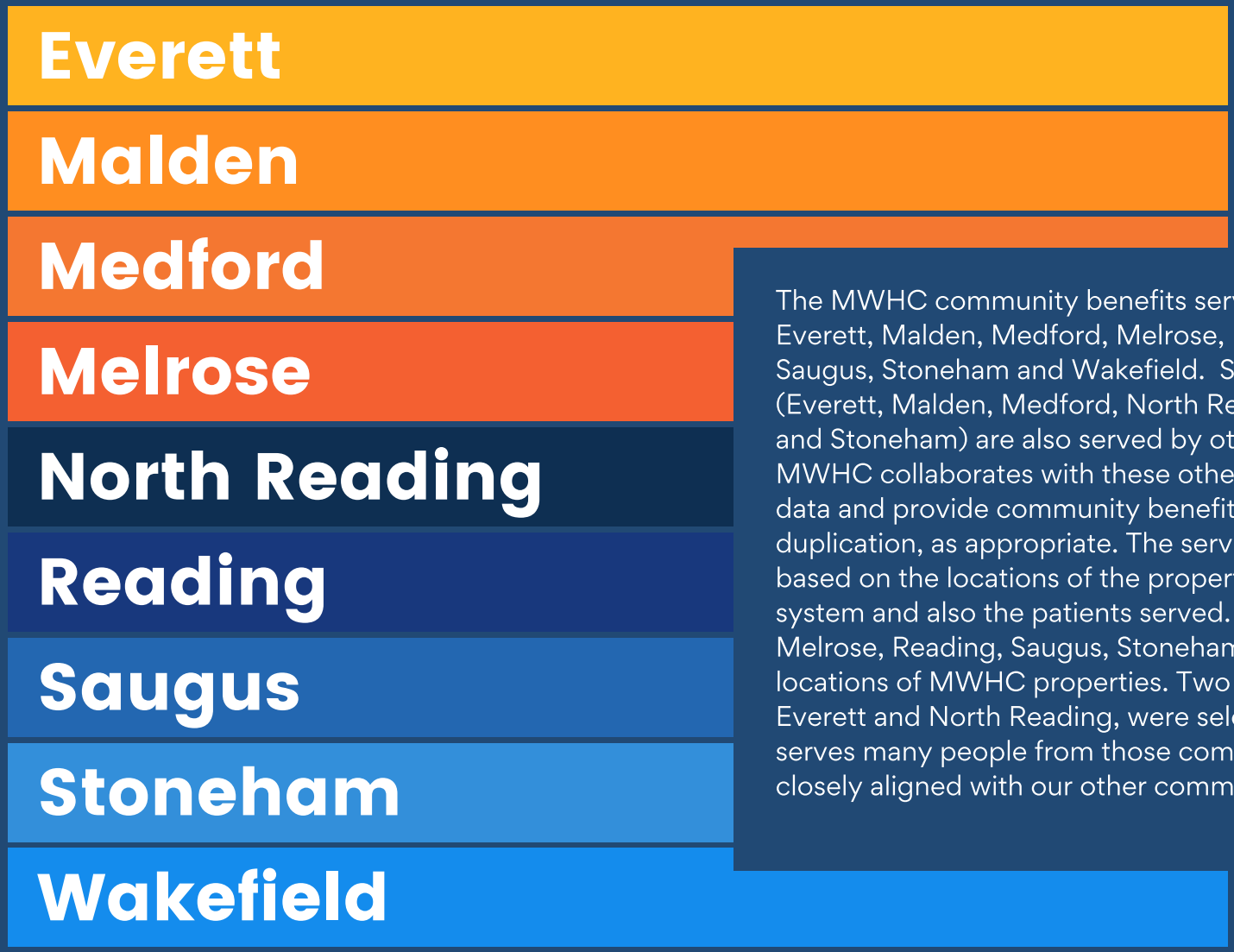
Community Benefits Mission

MelroseWakefield Healthcare's community benefits program is committed to building and sustaining a strong, vibrant and healthy community. MelroseWakefield Healthcare dedicates its resources to supporting collaborations with community partners and utilizing community members' input toward improving health services. MelroseWakefield Healthcare employees act as resources and work with the community during emergencies to improve access to care. The system identifies, monitors, and addresses the unique healthcare needs within its core communities and promotes healthier lifestyles for residents through health education and prevention activities.

Much of the community work MelroseWakefield Healthcare performs is through engaged, long-term partnerships in which ideas and resources are shared to improve the health of our communities in the most efficient and advantageous framework. We work to identify individuals in the community who are in need, and partner with community service agencies to reach out to those individuals with direct services. We also attend community events to provide health education and free medical screenings. Additionally, we work at the state level to advocate for public heath policy change, and partner with local and regional agencies to improve health equity and community resiliency.

Data is collected to understand and identify the needs of our communities. We report our findings and develop a formal community health needs assessment every three years. This assessment advises the development of our community health implementation plan (as required by state and federal law).

MELROSEWAKEFIELD HEALTHCARE COMMUNITY BENEFITS SERVICE AREA



The MWHC community benefits service area consists of Everett, Malden, Medford, Melrose, North Reading, Reading, Saugus, Stoneham and Wakefield. Six of these communities (Everett, Malden, Medford, North Reading, Reading, Saugus, and Stoneham) are also served by other healthcare systems. MWHC collaborates with these other health systems to share data and provide community benefits programming without duplication, as appropriate. The service area was determined based on the locations of the properties operated by the health system and also the patients served. Malden, Medford, Melrose, Reading, Saugus, Stoneham, and Wakefield are all locations of MWHC properties. Two other cities and towns, Everett and North Reading, were selected because MWHC serves many people from those communities, and they are also closely aligned with our other communities.

COMMUNITY HEALTH NEEDS ASSESSMENT 2019

As a not-for-profit healthcare system, MelroseWakefield Healthcare is **required to complete a Community Health Needs Assessment (CHNA) every three years**. MWHC completed its third formal CHNA process in August 2019 in collaboration with the Institute for Community Health (ICH), a nonprofit consulting organization in Malden, Massachusetts.

The MelroseWakefield Healthcare Community Benefits Advisory Council, comprised of community representatives, stakeholders, and MWHC leadership, gave input throughout the CHNA process. Various groups, individuals, and advisors, including those with public health expertise and local community knowledge, also had input into the process.

The **CHNA was conducted using a mixed-methods approach** in order to shape a robust understanding of the needs and patterns in the communities served. The methods used included: key stakeholder surveys and interviews conducted with community stakeholders; a community survey; and the collection and analysis of secondary quantitative data.

The **findings were then used to prioritize the health concerns**. Preliminary concerns were shared at six community listening sessions in order to gather public input. The complete assessment is available at https://www.melrosewakefield.org/wp-content/uploads/2017/07/2019-MWHC-CHNA-report.pdf and in hard copy at nine locations--one in each community.

Through the CHNA process, eleven priorities were identified:

COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP)2020 – 2022

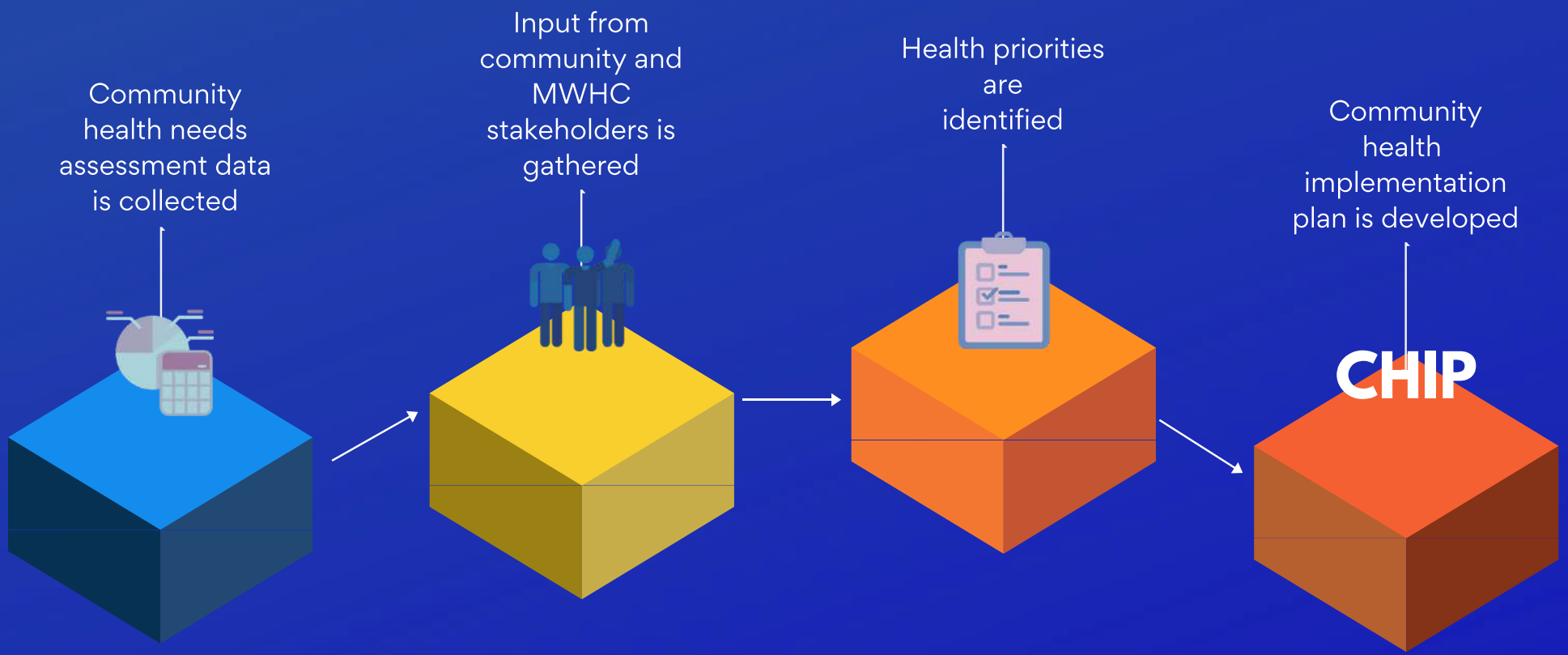
After the 2019 Community Needs Health Assessment was completed, the Community Benefits Advisory Council and leaders from the health system **reviewed the information gathered, sought community input, and made decisions** about how the health system will utilize the available resources to address the needs identified.

In 2020, the resources available for community programming are limited; however, MWHC will make every effort to **use the funds available to continue to support upstream health impacts and programs with demonstrated success** such as those funded by state grants and serving vulnerable populations. **Other programming will be implemented through partnerships with other like-minded organizations, and as donations, grants, and other funds are secured to ensure their sustainability**.

While the system will touch on most of the health and social priorities identified in the 2019 CHNA, the CHIP will be limited in the breadth of programming and will not be fully funded to address all aspects of the identified needs. In each year of the three year CHIP the resources available will be reevaluated and allocated as needed.

COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) 2020 - 2022

Overview of CHNA and CHIP process



HEALTH PRIORITIES

- Access to Healthcare
- Chronic Disease
- Disaster Readiness and Emergency Preparation
- Housing Stability and Homelesness
- Infectious Disease
- Mental Illness and Mental Health
- Preventable Injuries and Poisonings
- Social Determinants of Health
- Substance Use Disorders
- Violence and Trauma
- Vulnerable Populations*

* Vulnerable populations are prioritized for services in each of the other ten priorities.

ACCESS TO HEALTH CARE

GOAL

Increase access to healthcare, especially for uninsured and vulnerable populations, through provision of programs that address barriers to care, offer assistance with healthcare coverage applications, and provide education to increase the diverse healthcare workforce. Healthcare will be defined as access to equitable care and services needed to become healthy and maintain health over the lifespan.

LONG TERM OUTCOMES

Increased number of people with health insurance, an increased diverse health care workforce, and decreased number of people experiencing barriers to care

KEY STRATEGIES

- Assist families with **access to family assistance programs** such as those through WIC and Healthy Families Program and Massachusetts Home Visiting Initiative (HF/MHVI)
- Assist several thousand residents annually with **applications or re-applications for health insurance**, as well as consultations related to health coverage and other related social issues impacting health
- Continue to work with local schools and colleges to **promote the education and training of professional health care workers, especially diverse candidates**
- Ensure programs and services **address and increase access to the social factors that impact health**
- Host a **Mobile Food Market** monthly in partnership with the Greater Boston Food Bank and area volunteers
- **Participate on local boards of directors** for agencies serving the underserved

COMMUNITY PARTNERS

Action for Boston Community Development (ABCD); Asian American Civic Association; Beth Israel Lahey Health; Bread of Life, Malden is Moving; Cambridge Health Alliance; Cross Cultural Communications; East Boston Neighborhood Health Center; Elder Services of Merrimack Valley; Greater Boston Food Bank; Health Care for All; Immigrant Learning Center of Malden; Jewish Family and Children's Service; Joint Committee for Children's Health Care in Everett; local schools and colleges; Lowell Community Health Center; MA Department of Transitional Assistance; Massachusetts General Hospital; Medford Food Security Task Force; Medford Health Matters; Melrose Birth to Five; MelroseWakefield Mass in Motion; Mystic Valley Elder Services; Philips Lifeline; Sharewood Project; South Cove Community Health Center; The Community Family; Tufts Medical Center; Zonta Clubs of Malden and Medford

CHRONIC DISEASE

GOAL

Reduce incidence and long term impacts of chronic disease (especially cancer, cardiovascular disease, diabetes and respiratory disease) through prevention, screenings, education and support.

LONG TERM OUTCOMES

Reduced incidence of chronic disease, improved morbidity and mortality associated with chronic disease

KEY STRATEGIES TO REDUCE CANCER

- Continue to promote the **ongoing health of patients in recovery**
- Continue to promote **vaccines as a prevention strategy for human papillomavirus (HPV)**
- Offer **Baby Cafes** in three local sites as a prevention tool
- Offer opportunities for cancer patients and their families to receive **support to address the challenges of living with the disease**
- Promote **healthy living and green technology** such as low energy lights and electric car plug-in stations as root cause prevention measures
- Provide a variety of **screenings according to the American Cancer Association standards**; screening will be done in partnership with Tufts Medical Center
- Through a collaborative effort, provide **chronic disease self-management programming,** and resources and referrals to Live Strong Programs at local YMCAs

KEY STRATEGIES TO REDUCE CARDIOVASCULAR DISEASE

- Continue to offer **cardiac maintenance programs** in partnership with the Melrose YMCA
- Continue to **train the community to recognize and respond quickly to the signs of stroke**
- Offer **heart healthy education** to community residents
- Provide **Emergency Medical Technician (EMT) training focused on stroke and cardiovascular disease education**
- **Train high school students in a train-the-trainer CPR model**, preparing them to train their families and friends

CHRONIC DISEASE

KEY STRATEGIES TO REDUCE DIABETES

- Offer monthly **support groups** to area residents with diabetes
- Offer **Overeaters Anonymous groups space** for their local meetings
- Provide diabetes education throughout the region, including **comprehensive diabetes education for newly diagnosed and long term diabetics** and their families and friends
- Through a collaborative effort, provide **chronic disease self-management programs,** and resources and referrals to pre-diabetes prevention programs at local YMCAs

KEY STRATEGIES TO REDUCE RESPIRATORY DISEASE

- Continue to **promote vaccines as a prevention strategy** for adults, elders, and children
- Provide **programs to address COPD, chronic asthma and bronchitis**
- Provide **resources for long-term smokers to be able to successfully quit**
- Support the **regional tobacco coalitions to address vaping, e-cigarettes, and other tobacco products at a policy level**

COMMUNITY PARTNERS

American Cancer Society; American Diabetes Association; American Heart Association; American Lung Association; American Red Cross; Baby Café USA; Baby Friendly America; local EMT companies; local Mass in Motions; local schools, VNAs and YMCAs; Merrimack Valley Elder Services; Mystic Valley Elder Services; Overeaters Anonymous local and regional organizations; Tufts Medical Center

DISASTER READINESS AND EMERGENCY PREPARATION

GOAL

Support community preparation for cataclysmic events, including natural disasters, pandemic illness, heat and cold emergencies, and terrorism threats, and ensure access to healthcare in case of such event.

LONG TERM OUTCOMES

Develop and maintain community resilience after cataclysmic events

KEY STRATEGIES

- **Act as a resource to the community** during emergencies or acts of terror
- Continue to oversee regional **support for local EMS**
- **Offer blood drives** in partnership with the American Red Cross to ensure local blood supply is available during emergencies and for regular needs
- **Plan for heat and cold emergencies** with local health departments and EMS
- Provide support to MelroseWakefield Healthcare communities **preparing for seasonal flu**
- **Sponsor seven community teams** to provide support to local communities and bring back information from stakeholders/residents on emerging community needs
- **Support the Malden Warming Center** with supplies and materials

COMMUNITY PARTNERS

American Red Cross; local boards of health and municipal leaders; local police, fire and EMS; Malden Warming Center; The Salvation Army and other partners focused on serving vulnerable populations such as local religious organizations and those serving immigrant families

HOUSING STABILITY AND HOMELESSNESS

GOAL

Provide needed resources to local residents who are homeless or at risk of homelessness, and support community efforts to increase housing stability and prevent homelessness.

KEY STRATEGIES

- **Convene annual necessities drives** for veterans, children, and low-income residents
- **Provide lightly-used children's clothing and equipment, parenting education, and resources and referrals to families in need** through the Mothers Helping Mothers Closet
- **Support equitable housing advocacy** in the MWHC service area and across the state
- **Support local initiatives addressing housing stability and homelessness** through task force participation such as through Bread of Life and the Hunger, Housing, and Homelessness Task Force
- **Support the Malden Warming Center** with supplies and materials

LONG TERM OUTCOMES

Increased resources available to service area residents vulnerable to housing instability, increased housing stability in service area communities

COMMUNITY PARTNERS

Action for Boston Community Development (ABCD); Centerboard: Melrose; Eliot Community Human Services Inc.; Housing Families; Inc., Housing, Health and Hunger Advocates; local housing authorities both federal and state; Malden Warming Center; Malden YWCA Willcox Hall Residency Program; Medford Family Life

Lack of affordable housing, and rent burden are issues in the MWHC area. For example, In Malden and Everett many residents pay more than 30% of income in rent. That is not sustainable. The cost of living is beyond what many people can afford"

-Community Stakeholder

INFECTIOUS DISEASE

GOAL

Prevent the spread of infectious disease through education, awareness strategies, and provision of vaccination programs. Improve outcomes related to infectious disease through screening, education and treatment.

KEY STRATEGIES

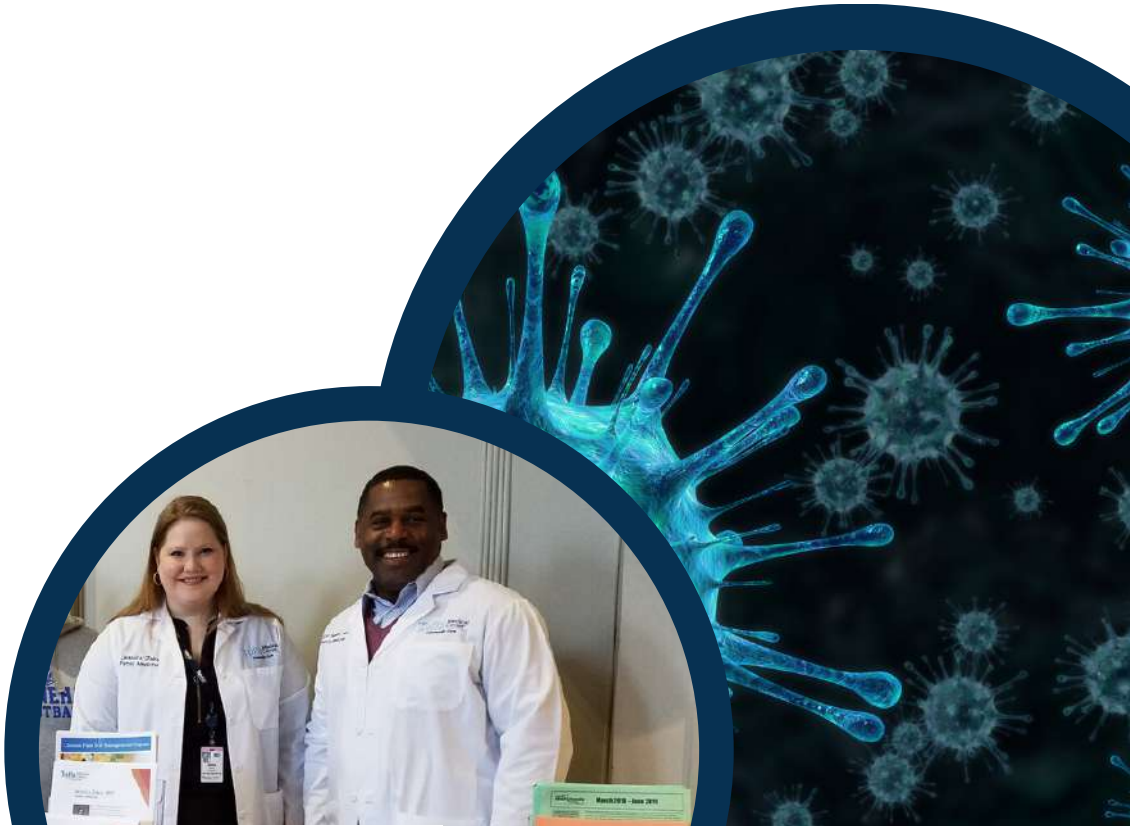
- Conduct ongoing **medical education programs**, available for community members to participate in free of charge
- Continue to **address emerging diseases** through disaster readiness and emergency planning efforts
- **Produce Health Minute YouTube videos** in collaboration with Wakefield Cable Access TV
- **Promote handwashing** for community members and emplyees across the system
- Promote **screening. education and vaccination for Hepatitis B and HPV** through employed physician offices
- **Provide support to local flu clinics**
- Refer patients/residents to the Cambridge Health Alliance for **screening, education and treatment for TB, HIV and AIDS**

LONG TERM OUTCOMES

Reduced incidence of newly acquired infectious disease, improved morbidity and mortality associated with infectious disease

COMMUNITY PARTNERS

Cambridge Health Alliance (HIV/AIDS and Cambridge TB clinics); local boards of health; MA Department of Public Health; Wakefield Cable Access TV



MENTAL HEALTH AND MENTAL ILLNESS

GOAL

Reduce stigma and increase access to mental health care through programs and infrastructure changes that offer education and support to individuals with mental illness and their families, and make it easier to obtain mental health care in existing medical and community settings.

KEY STRATEGIES

- Continue to **integrate behavioral health needs into primary and chronic disease models of care**, including MWHC community-based programming and coalition efforts (HF/MHVI, North Suburban Child and Family Resource Network) as well as with external partners, to support individuals and families impacted by behavioral health challenges
- Continue to work with partners on **court diversion programs**
- **Convene a community coalition** to address community behavioral health needs
- Offer programming to **reduce elder isolation**
- Offer **school-based strategies to reduce anxiety and toxic stress** and build resilience in youth
- Offer **sliding scale supplemental support for individuals unable to afford mental health services**
- Offer the "**Savvy Caregiver Program**"
- Provide a variety of **support programs for elders, children, and adults suffering after the loss of a family member or friend** in partnership with the Home Health Foundation
- **Reduce the stigma of mental illness through education, advocacy, and support** to families and the community at large

LONG TERM OUTCOMES

Increased access to mental health treatment, improved awareness of mental illness in the community, reduction of stigma on this topic, and improvement in mental health outcomes for local residents in treatment

COMMUNITY PARTNERS

ABCD (housing); Arbour Counseling Services Medford; Children's Trust; Column Health; Eliot Community Human Services; Inc.; Greater Boston Food Bank; Home Health Foundation; Housing Families; Learn to Cope; local courts; local fire, police and EMS; local public schools and senior centers; local veterans' organizations; MA Department of Mental Health Everett, Malden; Malden Overcoming Addictions; Malden Warming Center; Medford Health Matters; Medford Hub; Medford YMCA; Middlesex County District Attorney's Office; Mystic Valley Elder Services; Mystic Valley Opioid Abuse Prevention Coalition; National Alliance on Mental Illness; Portal to Hope (DV); Reading Prevention Coalition; RESPOND Inc. (DV); Riverside Community Care; Samaritans; South Bay Community Services; Substance Abuse Prevention Collaborative; Wakefield Unified Prevention Council; Wayside Youth and Family Support Network; YouthHarbors at JRI

PREVENTABLE INJURIES AND POISONINGS

GOAL

Decrease preventable injuries and poisonings through education and training.

KEY STRATEGIES

- Continue to offer the **Concussive Injury Prevention Program for school-age children**
- Maintain **sports medicine trainers in local high schools** at a reduced fee to help reduce sports injuries
- Offer a new **falls prevention program** such as “A Matter of Balance” for elders
- Promote **CPR, First Aid, and Safe Sitter babysitting training programs** in the community
- Provide **education and training for residents with chronic back problems** and risk of further injury

LONG TERM OUTCOMES

Deceased incidence of preventable injuries and poisonings

COMMUNITY PARTNERS

American Heart Association; American Red Cross; local adult day health providers; local public and private schools; local VNAs; Mass 211; Merrimack Valley Elder Services; Mystic Valley Elder Services; Philips Lifeline; Poison Control; Safe Sitter

SOCIAL DETERMINANTS OF HEALTH

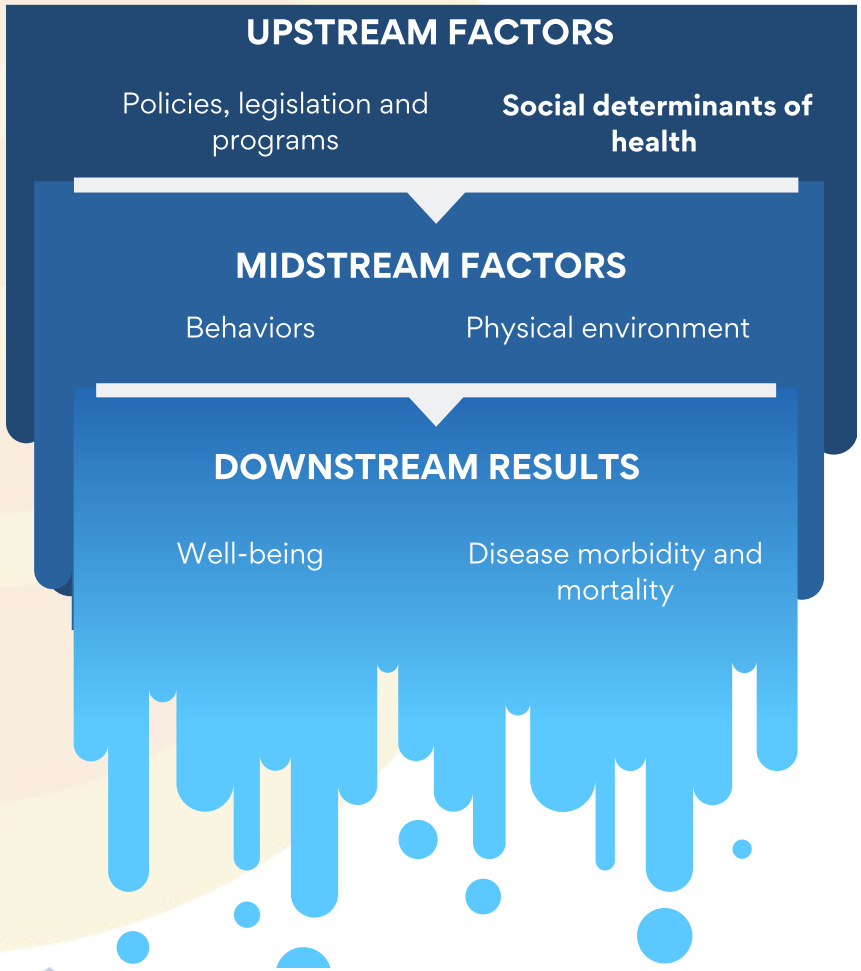
GOAL

Impact the social determinants of health, especially poverty, education, employment and food access, through upstream efforts such as advocacy and policy change, and downstream efforts such as education, training, provision of supplies and food, and access to safety net programs.

LONG TERM OUTCOMES

Improved well-being, improved health outcomes, increased health equity

UPSTREAM FACTORS AND DOWNSTREAM RESULTS



KEY STRATEGIES

- **Increase enrollment in government programs** such as WIC Nutrition Program, Child and Adult Care Food Program, School Meals, Summer Meals, and commodity distribution
- **Maintain the standards for a Baby Friendly designation** at MWH, the birthing facility of MWHC
- Mentor colleagues on **food distribution strategies**
- Participate as members on the **Food Security Task Force of the Greater Boston Food Bank** (GBFB)
- **Participate on local boards of directors** for agencies serving the underserved
- Partner with Tufts Medical Center Community Care and the Wellforce Accountable Care Organization in addressing systems change through "Mobilizing Healthcare for a Hunger Free MA", allowing MWHC to build an **electronic medical record (EMR) tool to screen for food insecurity in patients and develop ways to enhance food access**
- **Promote policy development** through partnerships such as Food is Medicine Massachusetts which is striving for a hunger-free MA in 2028
- Promote **registration in government sponsored food programs** through Mass in Motion local food plans to address the SNAP GAP
- Support the GBFB, Malden YMCA, the Hunger Network and Malden Bread of Life to raise funds and develop strategies such as school and college food pantries, a food pantry with a workforce development component in Medford, and Breakfast after the Bell program to **build a more extensive infrastructure for food access in Everett, Malden, and Medford**

SOCIAL DETERMINANTS OF HEALTH

KEY STRATEGIES TO ADDRESS POVERTY

- **Assist families with access to family assistance programs** such as those through WIC, HF/MHVI, the Wellforce Accountable Care Organization (ACO), and the New England Quality Alliance (NEQA)- funded Behavioral Health Integration Program (BHIP)
- **Assist residents with applications or re-applications for health insurance**, as well as consultations related to health coverage and related financial challenges and issues
- **Convene annual necessities drives for veterans, children, and low-income residents**
- Provide lightly-used **children's clothing and equipment, parenting education, and resources and referrals to families** in need at the Mothers Helping Mothers Closet. This should allow families additional resources for food and other necessities
- Provide **nutrition education and vouchers to low-income eligible recipients** through the WIC program

KEY STRATEGIES TO ADDRESS EMPLOYMENT

- Continue to **support the workforce development program** through the Asian American Civic Association
- Post **open positions on diverse websites and through diverse groups** such as the Malden Immigrant Learning Center
- **Support the new jobs program** offered through ABCD

KEY STRATEGIES TO ADDRESS FOOD ACCESS

- **Host a Mobile Food Market monthly** in partnership with the Greater Boston Food Bank (GBFB) and area volunteers
- **Support the development of a food access program** for students on the Lawrence Memorial Hospital/Regis campus
- Work with the Everett, Malden and Medford YMCA and the GBFB to **bring a new type of food pantry to this area**

KEY STRATEGIES TO ADDRESS EDUCATION

- Continue to work with local schools and colleges to **promote the education and training of professional health care workers,** especially diverse candidates
- **Mentor high school students** to expose them to and encourage interest in the health professions
- Support **programming** through the North Suburban Child and Family Resource Network **focused on literacy and family engagement prior to school-age**

COMMUNITY PARTNERS

Asian American Civic Association; Bread of Life; Department of Transitional Assistance; Food is Medicine Task Force; Greater Boston Food Bank; Harvard Law School; Immigrant Learning Center of Malden; local congregate meal sites; local food pantries; local private and public schools; local transportation agencies; The Career Place

SUBSTANCE USE DISORDERS

GOAL

Build increased community awareness of substance use disorders and provide education to decrease stigma. Reduce the impact of substance use disorders through provision of support to efforts around primary prevention, overdose reduction, and recovery-based interventions.

KEY STRATEGIES

- **Continue to offer programming** such as HF/MHVI and Grandparents Raising Grandchildren in Harmony
- **Focus on advocacy and policy changes** across local and state networks
- **Host the Middlesex County District Attorney's regional Eastern Middlesex Opioid Task Force**
- **Provide medication assisted treatment (MAT) in primary care** through both a one-to-one and group model
- **Provide space to an Alcoholics Anonymous (AA) support group** in a handicapped accessible location
- Provide **support to local and regional substance abuse prevention coalitions** and support programs
- Support **Malden Court programs for decriminalization**
- **Support regional tobacco prevention efforts**

LONG TERM OUTCOMES

Increased access to substance use treatment, reduction in people who have substance use disorder, decreased morbidity and mortality related to substance use

COMMUNITY PARTNERS

Club 24 Malden; District Attorney's Eastern Middlesex Opioid Task Force; Eliot Community Human Services, Inc.; local substance abuse prevention coalitions in Malden, Reading, Stoneham and Wakefield; Malden Overcoming Addiction; Massachusetts Opioid Abuse Prevention Collaborative; Middlesex Recovery; Mystic Valley Tobacco and Alcohol Program; Project NESST at Jewish Family and Children's Service; Substance Abuse Prevention Collaborative; Tufts Medical Center Community Care

VIOLENCE AND TRAUMA

GOAL

Improve support for survivors of domestic violence and sexual assault by providing assistance to local organizations focused on addressing interpersonal violence.

LONG TERM OUTCOMES

Decreased incidence of domestic violence (DV) and sexual assault (SA), improved outcomes for survivors of DV and SA

KEY STRATEGIES

- **Facilitate bi-annual round table on domestic violence and intimate partner violence** and provide other trainings to employees and community members
- **Offer office space in-kind to Portal to Hope**
- **Provide space to Melrose Alliance Against Violence** for a monthly group for domestic violence survivors
- **Support local initiatives addressing domestic violence** through board and task force participation

COMMUNITY PARTNERS

Alliances against violence in Melrose, Stoneham and Wakefield; local police; Middlesex County District Attorney's Office; Portal to Hope; RESPOND, Inc.

> **We could not do our work without MWHC's partnership, support and leadership; we thank MWHC for continuing to support our mission in the cause to end domestic violence."**

-Community Stakeholder

VULNERABLE POPULATIONS

GOAL

Increase health equity by providing concrete supports, resources and referrals to individuals and families within vulnerable target populations, with a particular focus on older adults, immigrants, people living in poverty, children and families, and people with substance use disorder.

LONG TERM OUTCOMES

Reduced heath disparities, increased health equity across all residents in MWHC community benefits service area

VULNERABLE POPULATIONS IN THE MWHC COMMUNITY BENEFITS SERVICE AREA IDENTIFIED AS BEING AT HIGHEST RISK FOR EXPERIENCING DISPARITIES

- Older adults
- Immigrants (especially those who are recently arrived and/or have undocumented status)
- People living in poverty
- Children and families (especially very low income families, adolescents, homeless youth and working families not eligible for benefits)
- People with substance use disorder
- People who have disabilities
- Young adults
- People affected by domestic violence and sexual assault
- People who identify as LGBTQ
- Veterans

KEY STRATEGIES

Working to mitigate disparities for vulnerable populations is an important focus for MWHC. Providing support to vulnerable populations is prioritized in all of MWHC's community benefits work. Therefore, there are not specific strategies for this priority area; strategies targeted at vulnerable populations are interwoven throughout each of the other ten priority areas.

VISION OF THE FUTURE

MelroseWakefield Healthcare (MWHC) is changing the way it delivers health care by keeping more healthcare and services local. Though a collaboration with value-driven academic medical and community health care providers in Massachusetts, there are tremendous opportunities for collaboration, and for developing and exploring best practice strategies to most effectively serve our collective communities.

For their 2019 Community Health Needs Assessments (CHNAs), Wellforce members **Tufts Medical Center and MWHC had the opportunity to share resources and information with other health systems and hospitals to impact the overall health of the community.** Through the Conference of Boston Teaching Hospitals (COBTH) a coalition of twelve Boston-area teaching hospitals, and the North Suffolk and Malden/Everett CHNAs, our health systems were able to think about upstream impacts and the value of addressing the social determinants of health. MelroseWakefield Healthcare was instrumental in convening this collaborative approach in Malden and Everett. This added value will inform our community benefits strategies and programs in the years to come.

APPENDIX A: OVERVIEW OF MWHC PROGRAMS AND INITIATIVES ADDRESSING COMMUNITY HEALTH PRIORITIES

	ACCESS TO HEALTHCARE	CHRONIC DISEASE	DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SOCIAL DETERMINANTS OF HEALTH*	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	VULNERABLE POPULATIONS
ALLIED HEALTH/NURSING CLINICAL TRAINING											
LABORATORY SCIENCE AND PHLEBOTOMY	✓	✓			✓			✓	✓		✓
PHYSICAL THERAPY AND OCCUPATIONAL THERAPY	✓	✓					✓	✓			✓
PHARMACY AND GRADUATE PHARMACIST RESIDENCY	✓	✓				✓		✓			✓
PHARMACY TECHNICIAN TRAINING AND SCHOLARSHIPS	✓	✓						✓	✓		✓
MEDICAL ASSISTANT TRAINING AND SCHOLARSHIPS	✓	✓		✓		✓	✓	✓	✓	✓	✓
ENVIRONMENTAL SCIENCES AND PHYSICAL PLANT	✓							✓			✓
NURSING STUDENT CLINICAL PLACEMENTS	✓	✓			✓	✓	✓	✓	✓	✓	✓

*Targeted social determinants of health include built environment, social environment, housing, violence, education and employment
** Indicates a program serviced by our clinical partner Tufts Medical Center
***Indicates a program serviced by our clinical partner Home Health Foundation

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ONE ON ONE NURSING PRECEPTORSHIPS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
VOCATIONAL HIGH SCHOOL PLACEMENTS (PERIODIC)	✓							✓			✓
AGING IN BALANCE SENIOR HEALTH PROGRAM											
COMMUNITY BLOOD PRESSURE MONITORING CLINICS	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
CHRONIC DISEASE/PAIN SELF MANAGEMENT PROGRAMS		✓				✓	✓	✓	✓		✓
ELDERCARE AND CAREGIVER LECTURES	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
COMMUNITY HEALTH EDUCATION											
FIRST AID/CPR CLASSES			✓				✓		✓	✓	✓

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APPENDIX A: OVERVIEW OF MWHC PROGRAMS AND INITIATIVES ADDRESSING COMMUNITY HEALTH PRIORITIES

	ACCESS TO HEALTHCARE	CHRONIC DISEASE	DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SOCIAL DETERMINANTS OF HEALTH*	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	VULNERABLE POPULATIONS
BONE AND JOINT EDUCATION		✓					✓	✓			
SAVE A LIFE, PASS IT ON! HIGH SCHOOL CPR TRAINING		✓	✓				✓	✓	✓	✓	✓
SAFESITTER BABYSITTING CURRICULUM		✓					✓	✓		✓	✓
NUTRITION EDUCATION		✓						✓			✓
OSTEOPOROSIS AND FALL PREVENTION TALKS	✓						✓	✓	✓		✓
COMMUNITY LECTURES ON VARIOUS HEALTH TOPICS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CONTINUING MEDICAL EDUCATION (OPEN TO PUBLIC)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

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COMMUNITY SERVICES	ACCESS TO HEALTHCARE	CHRONIC DISEASE	DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SOCIAL DETERMINANTS OF HEALTH*	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	VULNERABLE POPULATIONS
SUPPORT TO SUBSTANCE ABUSE PREVENTION COALITIONS		✓				✓		✓	✓		✓
SUPPORT TO COMMUNITY HEALTH NETWORK AREAS 15 AND 16	✓	✓						✓			✓
FREE/SUBSIDIZED TRANSPORTATION SERVICES	✓							✓			✓
PATIENT FINANCIAL NAVIGATION SERVICES	✓	✓						✓			✓
IN-KIND SPACE FOR 12-STEP GROUPS (NA/AA/OA)	✓	✓				✓		✓	✓		✓
SUPPORT TO MALDEN'S PROMISE COALITION						✓		✓	✓		✓
COMMUNITY-BASED DOMESTIC VIOLENCE SUPPORT	✓					✓	✓	✓	✓	✓	✓

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	ACCESS TO HEALTHCARE	CHRONIC DISEASE	DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SOCIAL DETERMINANTS OF HEALTH*	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	VULNERABLE POPULATIONS
IN-KIND SPACE FOR PORTAL TO HOPE DV SERVICES	✓			✓		✓	✓	✓	✓	✓	✓
SUPPORT TO LOCAL MASS IN MOTION PROGRAMS	✓	✓				✓		✓	✓		✓
CREATIVE COPING FOR NEW MOTHERS GROUP	✓	✓			✓	✓	✓	✓	✓		✓
COMMUNITY TEAM ACTIVITIES											
BLOOD DRIVES WITH THE AMERICAN RED CROSS		✓	✓							✓	
SEASONAL TOY, BOOK AND NECESSITIES DRIVES	✓					✓		✓			✓
SENIOR CITIZEN LUNCHES/ COMMUNITY SUPPERS	✓	✓				✓		✓			✓
COMMUNITY HEALTH FAIRS AND HEALTH-RELATED EVENTS	✓	✓			✓	✓	✓	✓			

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	ACCESS TO HEALTHCARE	CHRONIC DISEASE	DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESSNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SOCIAL DETERMINANTS OF HEALTH*	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	VULNERABLE POPULATIONS
EMERGENCY PLANNING AND PREPAREDNESS											
MEDICAL DIRECTION FOR LOCAL AREA BLS SERVICES			✓					✓	✓		
MEDICAL OVERSIGHT OF MELROSE ALS/BLS SERVICES			✓					✓	✓		
CONTINUING EDUCATION FOR AREA FIRST RESPONDERS	✓	✓	✓			✓	✓	✓	✓	✓	
LEADERSHIP WITHIN MA EMS-REGION III	✓		✓					✓			✓
HEALTHY FAMILIES/MA HOME VISITING INITIATIVE											
HOME VISITING FOR FIRST TIME PARENTS AGE 24 AND UNDER	✓			✓	✓	✓	✓	✓	✓	✓	✓

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NORTH SUBURBAN CHILD & FAMILY RESOURCE NETWORK											
GRANDPARENTS RAISING GRANDCHILDREN IN HARMONY	✓					✓		✓	✓		✓
MIDDLESEX FELLS STORYBOOK WALKS								✓			✓
AGES AND STAGES SCREENINGS	✓					✓	✓	✓			✓
NORTH SUBURBAN WIC PROGRAM											
WOMEN, INFANTS AND CHILDREN'S NUTRITION	✓	✓			✓	✓		✓			✓
FARMERS MARKET PROGRAM	✓	✓						✓			✓
MOBILE FOOD MARKET	✓	✓	✓		✓	✓		✓	✓	✓	✓

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	ACCESS TO HEALTHCARE	CHRONIC DISEASE	DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SOCIAL DETERMINANTS OF HEALTH*	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	VULNERABLE POPULATIONS
MOTHERS HELPING MOTHERS STORE	✓	✓				✓		✓	✓	✓	✓
WIC BABY CAFES IN MALDEN AND EVERETT	✓	✓			✓	✓		✓	✓	✓	✓
SUPPORT FOR TRI-CITY HUNGER NETWORK	✓	✓				✓		✓	✓	✓	✓
WIC FAMILY SUPPORT NETWORK	✓			✓	✓	✓	✓	✓	✓	✓	✓
INTEGRATED BREASTFEEDING SERVICES	✓	✓			✓	✓		✓			✓
SCREENING, EDUCATION AND SUPPORT GROUPS											
YOUTH CONCUSSION INJURY SCREENING PROGRAM	✓					✓		✓			✓
DIABETES SELF MANAGEMENT PROGRAM	✓	✓				✓		✓			✓

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	ACCESS TO HEALTHCARE	CHRONIC DISEASE	DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SOCIAL DETERMINANTS OF HEALTH*	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	VULNERABLE POPULATIONS
CANCER CENTER SUPPORT GROUPS**	✓	✓				✓		✓			✓
COLORECTAL CANCER EDUCATION**	✓	✓						✓			✓
SKIN CANCER SCREENING AND EDUCATION**	✓	✓						✓			✓
ORAL/HEAD/NECK CANCER SCREENING**	✓	✓						✓			✓
BREAST CANCER SCREENING AND EDUCATION	✓	✓						✓			✓
BEREAVEMENT AND GRIEF SUPPORT GROUPS FOR CHILDREN, ADULTS AND SENIORS***	✓					✓		✓			✓
OTHER PROGRAMS											
BABY CAFE IN MELROSE	✓							✓	✓		✓

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HEALTH MINUTES VIDEO SERIES		✓			✓	✓		✓	✓		
TUMOR REGISTRY		✓									
MEDICATION ASSISTED TREATMENT PROGRAM	✓	✓				✓	✓	✓	✓		✓
REGIONAL MENTAL HEALTH COLLABORATIVE	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
ADDRESSING FOOD INSECURITY AT LMH/REGIS COLLEGE								✓			✓
SCREENING FOR FOOD INSECURITY AND OTHER SDOH	✓			✓				✓			✓
COLLABORATIVE WORK WITH MGH AND CHA	✓							✓			✓

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APPENDIX B: GLOSSARY

AA= Alcoholics Anonymous

ABCD= Action for Boston Community Development

ALS= Advanced life support

BLS= Basic life support

CHA= Cambridge Health Alliance

CHIP= Community health implementation plan

CHNA= Community health needs assessment

COPD= Chronic obstructive pulmonary disease

CPR= Cardiopulmonary resuscitation

DV= Domestic violence

EMR= Electronic medical record

EMS= Emergency medical services

EMT= Emergency medical technician

GBFB= Greater Boston Food Bank

HF/MHVI= Healthy Families Program and Massachusetts Home Visiting Initiative

HPV= Human papillomavirus

LMH= Lawrence Memorial Hospital

MA= Massachusetts

MAT= Medication assisted treatment

MGH= Massachusetts General Hospital

MWH= MelroseWakefield Hospital

MWHC= MelroseWakefield Healthcare

NA= Narcotics Anonymous

OA= Oveareaters Anonymous

SA= Sexual assault

SDoH= Social determinants of health

TB=Tuberculosis

VNA= Visiting Nurses Association

WIC= Women, Infants and Children Nutrition Program

MelroseWakefield Healthcare
Community Health Improvement Plan (CHIP)
Approved Amendment FY20

The MelroseWakefield Healthcare (MWHC) CHIP has been in operation since it was approved by the MWHC Board of Trustees in February 2020. As required by the IRS and the state of Massachusetts through the Attorney General's Office, the comprehensive plan identifies the programs and services the system expects to provide to the community as community benefits during a three year period comprised of fiscal years 2020 through 2022. Community benefits at MWHC has historically been a system-wide approach to addressing community health needs with services and programs provided in a de-centralized model of care integrated across many clinical, ambulatory, and community departments.

Due to the COVID-19 global pandemic, many of the community benefits programming have been paused or are running in a different capacity, such as remote, as of the end of March 2020. These programs will begin again once the pandemic has ended and it is safe to resume in-person activities. MWHC is currently running the programs listed on our website.

Despite the changes in services, the system will touch on the majority of the health and social priorities identified in the 2019 CHNA.

The Community Benefits Advisory Council (CBAC) understands and approves the changes to the CHIP. The CBAC voted to amend the CHIP on August 20, 2020.