TuftsMedicine
MelroseWakefield Hospital

2022-2025 Community Health Implementation Plan

Prepared by Institute for Community Health for Tufts Medicine MelroseWakefield Hospital and Lawrence Memorial Hospital

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About Tufts Medicine Melrose Wakefield Hospital and Lawrence Memorial Hospital

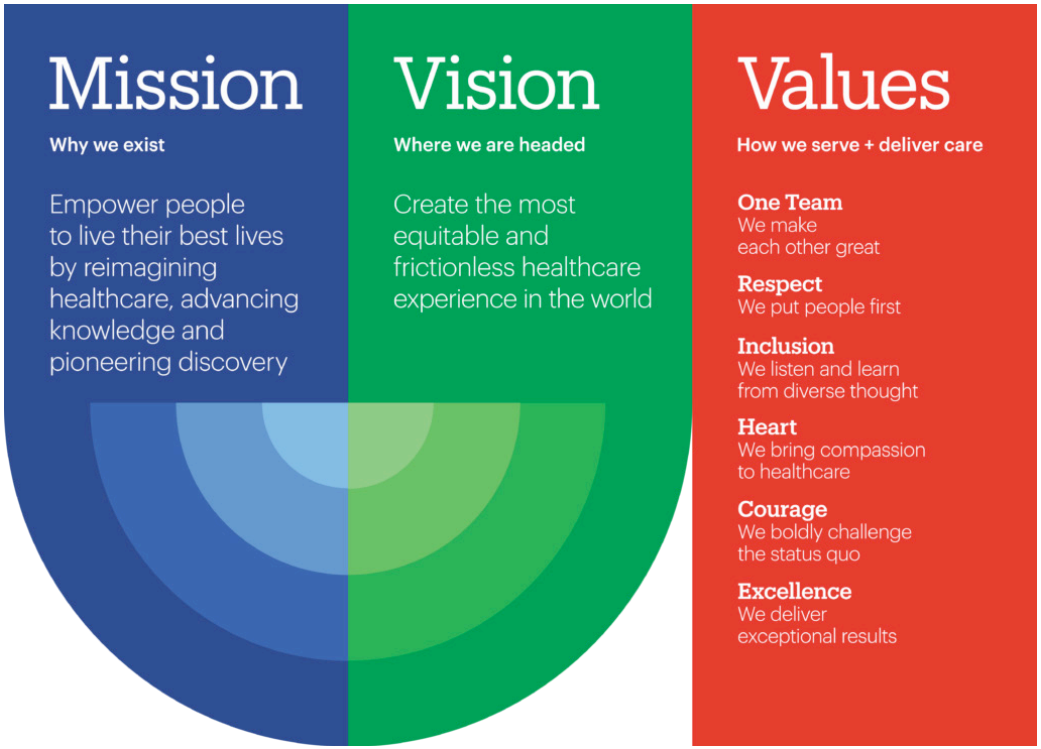
Tufts Medicine Melrose Wakefield Hospital and Lawrence Memorial Hosptial

Tufts Medicine MelroseWakefield Hospital and Lawrence Memorial Hospital (MWH and LMH) is a comprehensive system of community hospitals, outpatient centers, primary care and specialty physicians, community serving programs, and visiting nurse and hospice programs serving north suburban Boston. MWH and LMH is committed to its mission to empower people to live their best lives by reimagining healthcare, advancing knowledge and pioneering discovery.

In March 2022, MelroseWakefield Healthcare's parent organization, Wellforce, Inc., changed its name to Tufts Medicine. MelroseWakefield Healthcare will be known as Tufts Medicine MelroseWakefield Hospital and Lawrence Memorial Hospital. The Tufts Medicine name was selected to better reflect the system's shared identity, its close relationship with Tufts University and its School of Medicine, and its commitment to unite the best of both academic and community health care and deliver a complete connected care experience when, where and how consumers want it.

Tufts Medicine is a not-for-profit health system leveraging the strengths of academic and community medicine. Our integrated system includes three Massachusetts-based hospitals: Tufts Medical Center, Lowell General Hospital, and MelroseWakefield Hospital and Lawrence Memorial Hospital; Care at Home, which provides home health and hospice care; and our patient-centered Integrated Network of physicians. While each entity serves diverse communities with unique needs, we share a mission, vision, and deep commitment to health equity.

Mission, Vision and Values



Tufts Medicine Melrose Wakefield Hospital and Lawrence Memorial Hosptial

Today, MWH and LMH encompasses MelroseWakefield Hospital in Melrose, Lawrence Memorial Hospital of Medford, urgent care in Medford, Breast Health Center in Stoneham, Center for Radiation Oncology in Stoneham, a Medical Center in Reading, Tufts Medical Center Community Care, 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 an acute stroke ready 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.

MWH and LMH'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: Older Adult Outreach, Community Health Education, Healthy Families Program and Massachusetts Home Visiting Initiative, North Suburban Child and Family Resource Network, and North Suburban Women, Infants, and Children (WIC) Nutrition Program.

Melrose Wakefield Hospital and Lawrence Memorial Hospital Community Benefits

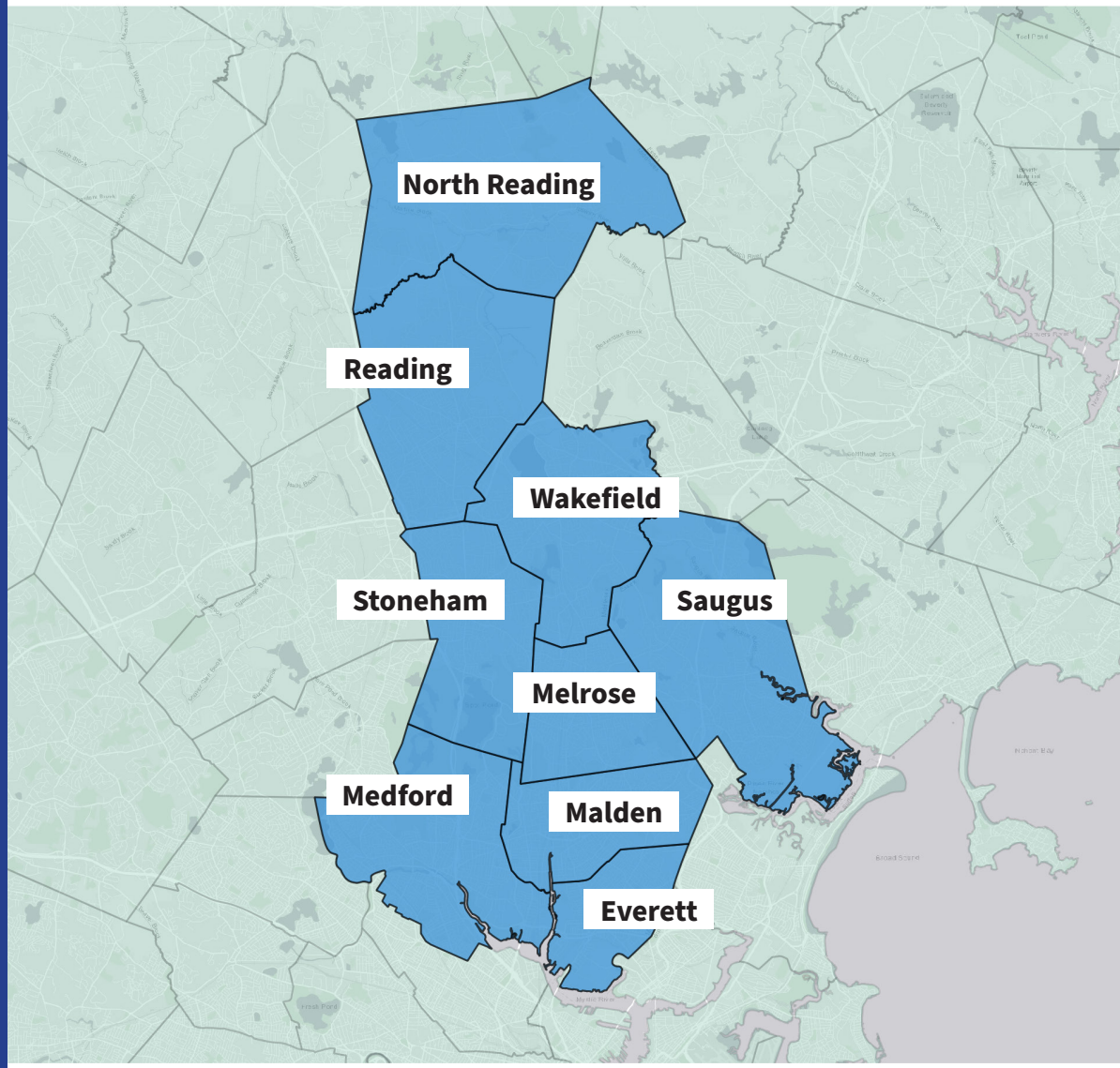
MelroseWakefield Hospital and Lawrence Memorial Hospital's community benefits program is committed to building and sustaining a strong, vibrant and healthy community. MWH and LMH dedicates its resources to supporting collaborations with community partners and utilizing community members' input toward improving health services. Our employees act as resources and work with the community during emergencies and to improve access to care. We identify, monitor, and address the unique healthcare needs within its core communities and promote healthier lifestyles for residents through health education and prevention activities. Much of the community work at MWH and LMH is performed through engaged, long-term partnerships in which we share resources and ideas to improve the health of our communities together in the most efficient and advantageous framework.

We work to identify individuals in the community who are in need. Our community benefits programs promote the health and well-being of our communities. We partner with community service agencies to reach out to those in need with direct services and to attend community events to provide health education and free medical screenings. We also work at the state level to advocate for public health 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. MWH and LMH 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 Hospital and Lawrence Memorial Hospital Community Benefits Service Area

The Melrose Wakefield Hospital and Lawrence Memorial Hospital community benefits service area consists of Everett, Malden, Medford, Melrose, North Reading, Reading, Saugus, Stoneham and Wakefield. Everett, Malden, Medford, North Reading, Reading, Saugus, Stoneham, and Wakefield also have other healthcare systems serving their communities. MW collaborates with other health systems to share data and to provide community benefits programming without duplication, as appropriate.

The community benefits service area has remained the same since 2013. The service area was determined based on the locations of the properties operated by the health system and the patients served. Malden, Medford, Melrose, Reading, Stoneiham, and Wakefield are all locations of MWH and LMH properties. Three other cities and towns closely aligned with the properties, Everett, North Reading, and Saugus, were also included in the service area.



Source: https://felix.rohrba.ch/en/2016/awesome-basemap-layer-for-your-qgis-project/
MassGIS (2022). MassGIS Data: Municipalities. https://www.mass.gov/

About the 2023-2025 Community Health Implementation Plan (CHIP)

2022 Community Health Needs Assessment

As a not-for-profit healthcare system, MelroseWakefield Hospital and Lawrence Memorial Hospital is required to complete a Community Health Needs Assessment (CHNA) every three years. MWH and LMH completed its third formal CHNA process in September 2022 in collaboration with the Institute for Community Health (ICH), a nonprofit consulting organization in Malden, Massachusetts. The Community Benefits Advisory Council, composed of community representatives, stakeholders, and system leadership, gave input throughout the CHNA process. Various groups, individuals, and advisors, including those with public health expertise and local community knowledge, also gave input into the process.

The CHNA was conducted using a mixed-methods approach in order to shape a robust understanding of the needs and trends in the communities served. In addition to a systematic review of available secondary data, focus groups were conducted with elders and adults from a variety of backgrounds, ages, and races and ethnicities. Surveys were conducted both broadly with community members who live and work in the community benefits service area, and with a targeted group of stakeholders who work for organizations that serve medically underserved, low income, and minority populations. Two listening sessions were held to share the data collected and solicit community input on the health priorities and inform the Community Health Implementation Plan (CHIP). In order to allow as many people as possible to attend, the sessions were held remotely via Zoom, one during the day and one in the evening. Interpreters and a gift card raffle were offered to participants.

Health priorities in the 2022 CHNA:

- **Access to healthcare**
- **Chronic disease**
- **Disaster readiness and emergency preparation**
- **Housing stability and homelessness**
- **Infectious disease**
- **Mental health and mental illness**
- **Preventable injuries and poisonings**
- **Substance use disorders**
- **Violence and trauma**

2023-2025 Community Health Implementation Plan

After the 2022 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 2022, the resources available for community programming are limited; however, MelroseWakefield Hospital and Lawrence Memorial Hospital 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 MWH and LMH will touch on most of the health and social priorities identified in the 2022 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.

Overview of the CHNA and CHIP process

Data collection

Community health needs assessment data is collected

Community input

Input from the community and MelroseWakefield Hospital and Lawrence Memorial Hospital stakeholders is gathered

Health priorities

Health priorities are identified

CHIP development

Community health implementation plan is developed

Strategies to Address 2023-2025 Health Priorities

2023-2025 Health Priorities:

Access to healthcare

Chronic disease

Disaster readiness & emergency

Housing stability & homelessness

Infectious disease

Mental health & mental illness

Preventable injuries & poisonings

Subsance use disorders

Violence and trauma

Understanding Social Determinants of Health and Supporting Vulnerable Popoulations

Data collected throughout the CHNA process has consistently emphasized the importance of addressing social determinants of health, such as poverty, housing, education, food security, and employment, and supporting vulnerable populations. Community survey respondents and key stakeholders identified housing and housing instability, social isolation, and education as top social concerns affecting the community benefits service area. Key stakeholders also mentioned housing stability and homelessness as a top social concern, as well as poverty and employment, and identified Black, Indigenous, and People of Color (BIPOC), low-income populations, and new immigrants as vulnerable populations of focus for the system. Secondary data reviewed for the CHNA also shows that poverty, food insecurity and housing cost burden are persistent issues affecting community health in the service area. Finally, the COVID-19 pandemic has also exacerbated existing health inequities; contributed to social isolation; and disproportionately impacted the wellbeing of BIPOC and low-income communities in the community benefits service area.

MelroseWakefield Hospital and Lawrence Memorial Hospital focuses on these social determinants of health and vulnerable populations in the community benefits service area throughout the 2022 CHNA health priorities, and the strategies developed to address them. MWH and LMH aims to provide support to its communities and strengthen its commitment to advancing health equity and anti-racism across the communities it serves.

Addressing Social Determinants of Health:
Goals, Partners and Long-term Outcomes

Goals

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

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.

Addressing Social Determinants of Health:
Key Strategies

Food Insecurity

- Mentor colleagues on food distribution strategies
- Participate as members on the Health Research 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 MWH and LMH to build an electronic medical record (EMR) tool to screen for food insecurity in patients and develop ways to enhance 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 Mystic Valley YMCAs and the GBFB to bring a new type of food pantry to this area
- 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 advocate for free school lunch in MA through Project Bread.

Education & Employment

- 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 readiness; this includes new parent/child+ program for home visits of most vulnerable families
- Promote educational attainment and job skills training through the Massachusetts Maternal, Infant, & Early Childhood Home Visiting Program (MA MIECHV)

Supporting Vulnerable Populations

Working to mitigate disparities for vulnerable populations is an important focus for MelroseWakefield Hospital and Lawrence Memorial Hospital. Providing support to vulnerable populations is prioritized in all of MWH and LMH'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 9 priority areas.

Vulnerable Populations in the Community Benefits Service Area

MWH and LMH identified groups of vulnerable populations in their community benefits service area that are at highest risk for experiencing health disparities, including:

- 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 disorders
- People who have disabilities
- Young adults
- People affected by domestic violence and sexual assault
- People who identify as LGBTQ+
- Veterans

Goals

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 MWH and LMH community benefits service area

Access to Healthcare

Goals

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.

Key Strategies

- **Assist families with access to family assistance programs** such as those through WIC and MA MIECHV
- 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.**
- **Athletic training** in high schools
- Provide GI and Breast Navigators
- **Develop strategies locally and systemwide through DEI Center** at Tufts Medicine.

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

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; Language Line; the DCF Family Resource Center in Everett, 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 Health Matters; 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, and local Boards of Health.

Chronic Disease

Goals

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

Key Strategies to Reduce Cardiovascular Disease

- **Re-energize Cardiac Rehab Programming.**
- 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.

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, bronchitis
- **Provide resources for long-term smokers** to successfully quit
- Support the **regional tobacco coalitions** to address vaping, e-cigarettes, and other tobacco and nicotine products at a policy level

Key Strategies to Reduce Diabetes

- Offer **monthly support groups** to area residents with diabetes
- 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

Chronic Disease

Key Strategies to Reduce Cancer

- Continue to promote the **ongoing health of patients in cancer 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** as root cause prevention measures
- **Provide a variety of navigated screenings** such as mammography and colon cancer screening 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
- Partner with the cities of Malden and Medford to create **additional green space** in the location of the former Malden Hospital
- Offer **GI Navigators**
- Offer **Breast Navigators**
- Offer **support groups**
- **Early detection screening**
- **Offer at home testing** through Cologuard

Long-term Outcomes

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

Community Partners

Acadia Health; American Cancer Society; American Diabetes Association; American Heart Association; American Lung Association; American Red Cross; Baby Café USA; Baby Friendly America; Friends of Fellsmere Heights; local EMT companies; local Boards of health,; local schools, VNAs and YMCAs; Merrimack Valley Elder Services; Mystic Valley Elder Services; local and regional organizations; Tufts Medical Center

Disaster Readiness & Emergency Preparation

Goals

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 events.

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**
- **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 communities preparing for seasonal flu and ongoing COVID 19 response**
- **Sponsor hospital employee volunteerism 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

Local boards of health and municipal leaders; local police, fire and EMS; Malden Cares, Tri-City Hunger Coalition, 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 & Homelessness

Goals

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.

Long-term Outcomes

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

Key Strategies

- **Convene annual necessities drives** for 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.** This should allow families additional resources for food and other necessities
- **Support local initiatives addressing housing stability and homelessness** through task force participation such as through Bread of Life, Action for Boston Community Development, and Eliot Human Services
- Support the **Malden Warming Center** with supplies
- Through Tufts Medicine Government Affairs, support **equitable housing advocacy** in the MW service area and across the state
- Convene **annual necessities drives** for veterans, children, and low-income residents
- **Provide nutrition education and vouchers** to low-income eligible recipients through the WIC program
- **Assist families with access to family assistance programs** such as those through WIC, MA MIECHV, the Wellforce Accountable Care Organization (ACO), and the New England Quality Alliance (NEQA)- funded Behavioral Health Integration

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; MA Department of Housing and Community Development; Malden Warming Center; Malden YWCA Willcox Hall Residency Program; Medford Family Life

Infectious Disease

Goals

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 **educational materials** in collaboration with Wakefield Cable Access TV
- Promote **screening, education and immunization**
- Refer patients/residents to the **Cambridge Health Alliance for screening, education and treatment for TB, HIV and AIDS**
- Provide **support to local flu clinics**
- Support community wide efforts for **education and vaccination for COVID 19**

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, Tufts Medical School

Mental Health and Mental Illness

Goals

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. A new joint venture with Acadia Health will bring a new mental health hospital to the grounds of the former Malden Hospital site.

Key Strategies

- Continue to integrate **behavioral health needs into primary and chronic disease models of care**, including MW community-based programming and coalition efforts (MA MIECHV, North Suburban Child and Family Resource Network) as well as with external partners, to support individuals and families impacted by behavioral health challenges
- Continue work with partners on **court diversion programs**
- Continue to convene Mystic Valley Regional Behavioral Health **community coalition** to to improve cross-agency collaborations and educate providers and the community to address community behavioral health needs
- Offer programming to **reduce elder isolation**
- Offer **school-based and community-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"**

Key Strategies

- 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
- Continue to develop plans for a **new Behavioral Health hospital in Malden**
- Reduce health disparities through **identifying and addressing barriers to care for diverse community members**
- Promote the new **Community Behavioral Health Center a**s a model to increase access to care
- Promote new **behavioral health state phone line**
- Fund programs offering **Mental Health First Aid Training** to **Police in Malden, Melrose and Saugus** trough DoN CHI grants
- Offer **Mental Health First Aid training** in partnership with the **City of Melrose**

Mental Health and Mental Illness

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; Acadia Health; 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 Cares, the Malden Opioid Task Force, the Malden Warming Center; Medford Health Matters; Medford Hub; Mystic Valley 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 & Poisonings

Goals

Decrease preventable injuries and poisonings through education and training.

Long-term Outcomes

Decreased incidence of preventable injuries and poisonings

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 **falls prevention program** such as "A Matter of Balance" for elders
- Work closely with the **Emergency Department** to address trauma such as falls, sports injuries, and pedestrian and motor vehicle accidents
- Promote **CPR, First Aid, Safe at Home, and Safe Sitter** babysitting training programs in the community
- Provide **education and training for residents** with chronic back problems and risk of further injury

Community Partners

American Heart Association; 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, and the Tufts Medical Center Trauma Team

Substance Use Disorders

Goals

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.

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

Key Strategies

- Continue to offer **programming** such as MA MIECHV and Grandparents Raising Grandchildren in Harmony
- Focus on **advocacy and policy changes** across local and state networks
- Provide **medication assisted treatment (MAT)** in primary care
- Provide support to local and regional substance use **prevention coalitions and support programs**
- Support Malden Court programs for **decriminalization**
- Support **regional tobacco prevention efforts**
- Participate on the **Community Advisory Group of the Bridge Recovery Center** in Malden
- Participate on the **Malden Opioid Task Force**

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, Opioid Task Force, Malden Overcoming Addiction; Malden Cares, Massachusetts Opioid Abuse Prevention Collaborative; Middlesex Recovery; Mystic Valley Tobacco and Alcohol Program; Bridge Recovery Center, Substance Abuse Prevention Collaborative; Tufts Medical Center Community Care

Violence & Trauma

Goals

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**
- Support **local initiatives addressing domestic violence** through board and task force participation, such as Melrose Alliance Againste Violence (MAAV), Stoneham Alliance Against Violence (SAAV), and Wakefield Alliance Against Violence (WAAV)
- Continue to work on **active shooter trainings**
- Offer **LGBTQ+ Affinity Group** for employees

Community Partners

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

Vision for the Future

Tufts Medicine MelroseWakefield Hospital and Lawrence Memorial Hospital, similar to many community health systems, is changing in the way it delivers health care in the hospital, through ambulatory services, and in the community. Through this collaboration of value-driven academic medical and community health care providers in Massachusetts, there are tremendous opportunities for collaboration and exploring best practice strategies to most effectively serve our collective communities. For the 2022 Community Health Needs Assessments (CHNA), both Tufts Medicine members at Tufts Medical Center and MWH had the opportunity and privilege 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, the North Suffolk and MWH and LMH CHNAs, and the sharing of information with Cambridge Health Alliance and Beth Israel Lahey Health, our health systems were able to think about upstream impacts and the value of addressing the social determinants of health. This added value will inform our community benefits strategies and programs in the years to come.

Appendices

Appendix A: Overview of programs to address health priorities

	ACCESS TO HEALTHCARE	CHRONIC DISEASE	COVID-19, DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESSNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	SOCIAL DETERMINANTS OF HEALTH	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	✓	✓			✓	✓	✓	✓	✓	✓	✓

Appendix A: Overview of programs to address health priorities

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	ACCESS TO HEALTHCARE	CHRONIC DISEASE	COIVD-19, DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESSNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	SOCIAL DETERMINANTS OF HEALTH	VULNERABLE POPULATIONS
GRANDPARENTS RAISING GRANDCHILDREN IN HARMONY	✓					✓		✓		✓	✓
FALLS PREVENTION CLASSES	✓						✓	✓		✓	✓
AUTO SAFETY CLASSES							✓	✓			✓
PEDESTRIAN SAFETY CLASSES							✓	✓		✓	✓
COMMUNITY HEALTH EDUCATION											
FIRST AID/CPR CLASSES	✓		✓				✓	✓	✓		✓
BONE AND JOINT EDUCATION		✓					✓			✓	
SAVE A LIFE, PASS IT ON! HIGH SCHOOL CPR TRAINING	✓	✓	✓				✓	✓	✓	✓	✓

Appendix A: Overview of programs to address health priorities

	ACCESS TO HEALTHCARE	CHRONIC DISEASE	COVID-19, DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESSNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	SOCIAL DETERMINANTS OF HEALTH	VULNERABLE POPULATIONS
SAFESITTER BABYSITTING CURRICULUM		✓					✓		✓	✓	✓
NUTRITION EDUCATION		✓								✓	✓
OSTEOPOROSIS AND FALL PREVENTION TALKS		✓					✓	✓		✓	✓
COMMUNITY LECTURES ON VARIOUS HEALTH TOPICS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CONTINUING MEDICAL EDUCATION (OPEN TO PUBLIC)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MENOPAUSE WORKSHOPS		✓				✓		✓		✓	
SAFE AT HOME PROGRAM							✓			✓	✓
STRESS MANAGEMENT CLASSES	✓					✓				✓	✓

Appendix A: Overview of programs to address health priorities

	ACCESS TO HEALTHCARE	CHRONIC DISEASE	COVID-19, DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	SOCIAL DETERMINANTS OF HEALTH	VULNERABLE POPULATIONS
BEHAVIORAL HEALTH EDUCATION	✓	✓				✓		✓		✓	✓
CREATIVE COPING FOR NEW MOTHERS GROUP	✓	✓			✓	✓	✓	✓		✓	✓
BREASTFEEDING EDUCATION	✓	✓			✓	✓				✓	✓
BABY CARE BASICS						✓	✓			✓	✓
BABY'S FIRST YEAR						✓	✓			✓	✓
COMMUNITY SERVICES											
SUPPORT TO SUBSTANCE ABUSE PREVENTION COALITIONS		✓				✓		✓		✓	✓
SUPPORT TO COMMUNITY HEALTH NETWORK AREAS 15 AND 16	✓	✓								✓	✓

Appendix A: Overview of programs to address health priorities

	ACCESS TO HEALTHCARE	CHRONIC DISEASE	COVID-19, DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	SOCIAL DETERMINANTS OF HEALTH	VULNERABLE POPULATIONS
FREE/SUBSIDIZED TRANSPORTATION SERVICES	✓									✓	✓
PATIENT FINANCIAL NAVIGATION SERVICES	✓	✓								✓	✓
IN-KIND SPACE FOR 12 STEP GROUPS (NA/AA/OA)	✓	✓				✓		✓		✓	✓
GI NAVIGATORS	✓	✓								✓	✓
BREAST NAVIGATORS	✓	✓								✓	✓
COMMUNITY-BASED DOMESTIC VIOLENCE SUPPORT	✓					✓	✓	✓	✓	✓	✓
IN-KIND SPACE FOR PORTAL TO HOPE DV SERVICES	✓			✓		✓	✓	✓	✓	✓	✓
SUPPORT TO LOCAL MASS IN MOTION PROGRAMS	✓	✓				✓		✓		✓	✓

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	ACCESS TO HEALTHCARE	CHRONIC DISEASE	COVID-19, DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	SOCIAL DETERMINANTS OF HEALTH	VULNERABLE POPULATIONS
SUPPORT SERVICES	✓					✓					
NORTH SUBURBAN CHILD AND FAMILY RESOURCE NETWORK											
CHILDCARE RESOURCES	✓									✓	✓
PARENTING SUPPORT	✓		✓	✓		✓				✓	✓
PARENT/CHILD LEARNING GROUPS										✓	✓
MIDDLESEX FELLS STORYBOOK WALKS										✓	✓
PARENTCHILD+ HOME VISITING PROGRAM	✓					✓	✓			✓	✓
NORTH SUBURBAN WIC PROGRAM											

Appendix A: Overview of programs to address health priorities

	ACCESS TO HEALTHCARE	CHRONIC DISEASE	COVID-19, DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESSNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	SOCIAL DETERMINANTS OF HEALTH	VULNERABLE POPULATIONS
WOMEN, INFANTS, AND CHILDREN'S NUTRITION	✓	✓				✓				✓	✓
FARMER'S MARKET PROGRAM	✓	✓								✓	✓
MOBILE FOOD MARKET	✓	✓	✓		✓	✓		✓		✓	✓
MOTHERS HELPING MOTHERS STORE	✓	✓				✓		✓		✓	✓
WIC BABY CAFES IN MALDEN AND EVERETT	✓	✓				✓		✓		✓	✓
SUPPORT FOR TRI-CITY HUNGER NETWORK	✓	✓				✓		✓		✓	✓
WIC FAMILY SUPPORT NETWORK	✓			✓	✓	✓	✓	✓	✓	✓	✓
INTEGRATED BREASTFEEDING SERVICES	✓	✓				✓				✓	✓

Appendix A: Overview of programs to address health priorities

SCREENING, EDUCATION, AND SUPPORT GROUPS	ACCESS TO HEALTHCARE	CHRONIC DISEASE	COVID-19, DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	SOCIAL DETERMINANTS OF HEALTH	VULNERABLE POPULATIONS
YOUNG CONCUSSION INJURY SCREENING PROGRAM	✓	✓				✓	✓			✓	✓
DIABETES SELF MANAGEMENT PROGRAM	✓	✓				✓				✓	✓
CANCER CENTER SUPPORT GROUPS	✓	✓				✓				✓	✓
COLORECTAL CANCER EDUCATION	✓	✓								✓	✓
SKIN CANCER SCREENING AND EDUCATION	✓	✓								✓	✓
ORAL/HEAD/NECK CANCER SCREENING	✓	✓								✓	✓
BREAST CANCER SCREENING AND EDUCATION	✓	✓								✓	✓

Appendix A: Overview of programs to address health priorities

	ACCESS TO HEALTHCARE	CHRONIC DISEASE	COVID-19, DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESSNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	SOCIAL DETERMINANTS OF HEALTH	VULNERABLE POPULATIONS
BEREAVMENT AND GRIEF SUPPORT FOR CHILDREN, ADULTS, AND SENIORS	✓					✓				✓	✓
OTHER PROGRAMS											
BABY CAFES IN MELROSE	✓					✓				✓	✓
HEALTH MINUTES VIDEOS SERIES	✓	✓	✓		✓	✓	✓	✓		✓	✓
TUMOR REGISTRY		✓									✓
MEDICATION ASSISTED TREATMENT PROGRAM	✓	✓				✓	✓	✓		✓	✓
MYSTIC VALLEY REGIONAL BEHAVIORAL HEALTH COALITION	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
ADDRESSING FOOD INSECURITY AT LMH AND REGIS COLLEGE						✓				✓	✓

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	ACCESS TO HEALTHCARE	CHRONIC DISEASE	COVID-19, DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESSNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	SOCIAL DETERMINANTS OF HEALTH	VULNERABLE POPULATIONS
SCREENING FOR FOOD INSECURITY AND OTHER SDOH	✓	✓		✓						✓	✓
COLLABORATIVE WORK WITH BI/LAHEY, MGH, AND CHA	✓					✓				✓	✓
MASS HOSPITAL ASSOCIATION DEI COMMITTEE	✓									✓	✓
MALDEN OVERCOMING ADDICTION BOARD MEMBER	✓							✓		✓	✓
CITY OF MALDEN OPIOID TASK FORCE	✓							✓		✓	✓
BRIDGE RECOVERY CENTER COMMUNITY COALITION	✓							✓		✓	✓
BURBANK YMCA BOARD OF ADVISORS MEMBER	✓					✓				✓	✓
JCCHCE FUNDRAISING COMMITTEE	✓									✓	✓

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	ACCESS TO HEALTHCARE	CHRONIC DISEASE	COVID-19, DISASTER READINESS AND EMERGENCY PREPARATION	HOUSING STABILITY AND HOMELESSNESS	INFECTIOUS DISEASE	MENTAL ILLNESS AND MENTAL HEALTH	PREVENTABLE INJURIES AND POISONINGS	SUBSTANCE USE DISORDERS	VIOLENCE AND TRAUMA	SOCIAL DETERMINANTS OF HEALTH	VULNERABLE POPULATIONS
AREA WELLNESS COMMITTEES	✓	✓		✓	✓	✓		✓		✓	✓
SUPPORT LOCAL BOARDS OF HEALTH	✓	✓	✓		✓	✓		✓		✓	✓
GREATER BOSTON FOOD BANK HEALTH AND RESEARCH COMMITTEE	✓	✓								✓	✓
DA'S SAFE BABY/SAFE CHILD TASK FORCE	✓	✓				✓	✓			✓	✓
DA'S MIDDLESEX OPIOID TASK FORCE	✓							✓		✓	✓
SUPPORT TO MALDEN CARES COALITION	✓					✓		✓		✓	✓

Appendix B: Glossary of terms

ABCD=Action for Boston Community Development

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

HPV=Human papillomavirus

MA=Massachusetts

JCCHE=Joint Committee for Children's Health Everett

MAAV=Melrose Alliance Against Violence

MA MIECHV=Massachusetts Maternal, Infant, & Early Childhood Home Visiting Program

MAT=Medication assisted treatment

MWH and LMH=MelroseWakefield Hospital and Lawrence Memorial Hospital

SA=Sexual assault

SAAV=Stoneham Alliance Against Violence

TB=Tuberculosis

VNA=Visiting Nurses Association

WIC= Women, Infants and Children Nutrition Program

WAAV=Wakefield Alliance Against Violence

TuftsMedicine
MelroseWakefield Hospital

TuftsMedicine
Lawrence Memorial Hospital