Established by the state legislature through Chapter 224 of the Acts of 2012, PWTF received $60 million over four years, through funding from an assessment of health insurers and large hospital systems. The Southeastern Health Initiative for Transformation (SHIFT), coordinated by City of New Bedford Health Department, received $5 million as one of nine partnerships across the Commonwealth.

THE NEED
Preventable and chronic health conditions continue to climb. Furthermore, health care inequities based on race, income, and geography, are a persistent challenge. New Bedford is home to some of Massachusetts’ most ethnically and culturally diverse, vulnerable, and in-need individuals and families.

Prior to the PWTF program, no coordinated clinical-community approach existed that could address common health challenges and inequities affecting neighborhoods in New Bedford. PWTF leverages a network of health care providers, community-based organizations, residents, leaders, and existing initiatives to bring a comprehensive approach to the prevention and management of pediatric asthma, hypertension, falls in older adults, and substance use.

CLINICAL PARTNERS
- Greater New Bedford Community Health Center, Inc.
- Hawthorn Medical Associates

COMMUNITY PARTNERS
- Community Nurse Home Care
- YMCA Southcoast
- Immigrants’ Assistance Center
- Seven Hills Behavioral Health
- New Bedford Parks Recreation and Beaches
- New Bedford Housing Authority

NEW BEDFORD SNAPSHOT
95,000 residents
Health Equity: 32.8% of patients at the clinical sites are Hispanic/Latino and 15.9% are Black; 1 in 5 lives below the Federal Poverty Level

Pediatric Asthma: 15.8% of children were told they have asthma vs. 13.7% statewide
Hypertension: 34.8% of adults have been told they have hypertension vs. 28.8% statewide
Falls in Older Adults: 12.2% of adults over age 65 experienced a fall with an injury in the last 12 months vs. 10.1% statewide

Pediatric patient diagnosed with asthma meets with a Community Health Worker to learn about using an inhaler.

Learn more at www.mass.gov/pwtf
THE PARTNERSHIPS
PWTF supports a partnership that shares leadership among clinical, municipal, and community organizations. The coordinating partner (City of New Bedford Health Department) is responsible for building, monitoring, and maintaining a robust infrastructure of working relationships that focuses on referral management, training, data collection and evaluation, and quality improvement.

THE LOCAL IMPACT
Since implementing the program, SHIFT made over 1,000 referrals from clinical sites to community organizations. PWTF is proving to be an essential component in the mission to improve health outcomes and combat health inequities in our communities.

A COORDINATED APPROACH
The PWTF model implements evidence-based prevention approaches at a systemic level, which complements existing health care services and ongoing health care transformation efforts. PWTF focuses on extending care into the community through clinical-community linkages, while developing stronger evidence of effective prevention programming.

CLINICAL
Identify high risk patients, treat them according to clinical guidelines, and refer them to prevention-based programming outside of the clinical setting.

LINKAGE
Bridge services through warm hand-offs by Community Health Workers (CHWs) and electronic systems; build strong partnerships among clinical and community leaders.

COMMUNITY
Evidence-based interventions at community-based and social service organizations, i.e., Chronic Disease Self-Management, Asthma Home Visiting, Tai Chi, etc.

1. US Census, American FactFinder. 2010 data. Prepared by MDPH.

Learn more at www.mass.gov/pwtf