Community Benefits Report

Fiscal Year 2021

Beth Israel Lahey Health
Winchester Hospital

Beth Israel Lahey Health

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SECTION I: SUMMARY AND MISSION STATEMENT

Summary and Mission Statement
Winchester Hospital is a member of Beth Israel Lahey Health (BILH). BILH brings together an exceptional array of clinical organizations spanning the full continuum of health care delivery–academic and teaching hospitals, community hospitals, ambulatory and urgent care centers, behavioral health programs, and home care–in a shared mission to expand access to great care and advance the science and practice of medicine through groundbreaking research and education.

At the heart of BILH is the belief that everyone deserves high-quality, affordable health care. This belief is what drives BILH to work with community partners across the region to promote health, expand access, and deliver the best care in the communities BILH serves. BILH Community Benefits staff are committed to working collaboratively with BILH's communities to address leading health issues and create a healthy future for individuals, families, and communities.

Winchester Hospital's mission is to treat patients compassionately and effectively, and to create a healthy future for them and their families. This mission is supported by the hospital's commitment to personalized, excellent care for patients; a workforce committed to individual accountability, mutual respect, and collaboration; and a commitment to maintaining financial health. Winchester Hospital is also committed to being active in the community. Service to community is at the core of Winchester Hospital's mission. The Winchester Hospital founders made a covenant to care for the underserved in the hospital's service area, attend to unmet needs, and address disparities in access to care and health outcomes. Winchester Hospital's commitment to this covenant and the people it serves remains steadfast today.

In 2013, Winchester Hospital's Community Benefits Advisory Committee and Board of Trustees agreed upon our mission: Winchester Hospital is committed to benefit all of the communities we serve by collaborating with community partners to identify health needs, improve the health status of community residents, address health disparities, and educate community members about prevention and self-care.

The following annual report provides specific details on how Winchester Hospital is honoring its commitment and includes information on Winchester Hospital's Community Benefits Service Area (CBSA), community health priorities, target populations, community partners, and detailed descriptions of its Community Benefits programs and their impact.

More broadly, the Winchester Hospital's Community Benefits mission is fulfilled by:

- **Involving** Winchester Hospital's **staff**, including its leadership and dozens of community partners in the community health assessment process, as well as in the development, implementation, and oversight of the hospital's three-year Implementation Strategy;

- **Engaging and learning from residents** throughout Winchester Hospital's service area in all aspects of the Community Benefits process, including assessment, planning, implementation, and evaluation. The hospital pays special attention to engaging those community members who are not patients of Winchester Hospital and those who are often left out of assessment, planning, and program implementation processes;

- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to identify unmet health-related needs and to characterize those in the community who are most vulnerable and face disparities in access and outcomes;

- **Implementing community health programs and services** in Winchester Hospital's CBSA that is geared toward improving the current and future health status of individuals, families, and communities by removing barriers to care, addressing social determinants of health, strengthening the healthcare system, and working to decrease the burden of leading health issues;

- **Promoting health equity** by addressing social and institutional inequities, racism, and bigotry and ensuring that all patients are welcomed and received with respect and have access to culturally responsiveness care; and

- **Facilitating collaboration and partnership** within and across sectors (e.g., public health, health care, social services, business, academic, and community health) to advocate for, support, and implement effective health policies, community programs, and services.

Target Populations

Winchester Hospital's CBSA includes nine cities and towns: Medford, North Reading, Reading, Stoneham, Wakefield, Wilmington, Winchester, Woburn, and Tewksbury. Winchester Hospital's FY19 Community Health Needs Assessment's (CHNA) findings, on which this report is based, clearly show that all geographic, demographic, and socioeconomic segments of the population face challenges that can hinder the ability to access care or maintain good health. The specific populations listed below have been identified and prioritized as the focus for community health efforts:

- Low-Resource Individuals & Families
- Older Adults
- Youth and Adolescents
- Individuals with Chronic Disease

While Winchester Hospital is committed to improving the health status and well-being of those living throughout its entire service area, per the Commonwealth's updated Community Benefits Guidelines, Winchester Hospital's Implementation Strategy (IS) will focus on these most-at-risk priority populations in the hospital's CBSA.

Basis for Selection
In FY19, Winchester Hospital, as a member of Lahey Health at that time, conducted its triennial CHNA in conjunction with all the hospitals in the Lahey Health system. The purpose of the CHNA was to inform and guide the hospital's selection of and commitment to programs and initiatives that address the health needs of the communities it serves. The CHNA was conducted in partnership with John Snow Inc., public health research organization.

Data Collection/Methodology: The CHNA was conducted in three phases, during which data was collected from a number of quantitative and qualitative sources to ensure a comprehensive understanding of the issues.

Quantitative Data Sources:

- MA Community Health Information Profile
- U.S. Census Bureau
- Behavioral Risk Factor Surveillance System
- MA Vital Records
- MA Bureau of Substance Abuse Services
- MA Health Data Consortium
- MA Cancer Registry
- MA Communicable Disease Program
- MA Hospital Emergency Dept. Discharges
- MA Board of Health

Quantitative Data Sources:
To obtain targeted data and understand the current issues facing the community, the following was completed:

- Informant interviews with external stakeholders (28 completed)
- Community surveys (1,022 completed in the Winchester Hospital service area)
- Community listening sessions (two sessions; 100 attendees)

Key Accomplishments for Reporting Year
The accomplishments highlighted in this report are based upon priorities identified and programs contained in Winchester Hospital's FY19 Community Health Needs Assessment (CHNA) and FY20-22 Implementation Strategy (IS):

- ***Community Home Blood Draw Program*** – Winchester Hospital Phlebotomy staff provided home blood draws for 11,398 patients who were homebound due to illness, injury, or transportation issues.

- ***Food Insecurity Relief Initiative*** – In response to the significant increase in food insecurity due to factors associated with the COVID-19 pandemic, Winchester Hospital provided support to help a local food pantry and area senior centers to reduce food insecurity for community residents. In addition to on-site pickup locations, local organizations provided home deliveries of food and essential items to reduce transportation barriers and respond to social distancing concerns.
- ***Metro Housing Boston Co-Location Program*** – Free counseling was provided to 166 low- to moderate-income individuals and families to prevent eviction, increase housing stability and economic self-sufficiency, and improve their overall quality of life. Counselors also helped with housing searches, emergency assistance, rapid rehousing, and benefits maximization, and connected participants to community resources.
- ***Community and Hospital Asthma Management Program (CHAMP)*** – In FY21, 84 children were enrolled in CHAMP, a pediatric asthma management program in which the pediatric asthma nurse specialist works collaboratively with the child, family, doctor, and school personnel to improve each child's management of asthma. This program resulted in fewer missed school days and emergency room visits and improved overall quality of life for participants.
- ***Mobile Mental Health Program*** – The Mystic Valley Elder Services Mobile Mental Health Program provided home-based mental health services to 175 older adults living in Medford, North Reading, Reading, Stoneham, and Wakefield. The program addressed a variety of issues affecting older adults' emotional well-being and quality of life through home-based mental health counseling and direct care services.

- ***Boys & Girls Club – Screening, Brief Intervention, Referral to Treatment*** – In FY21, 321 youth were screened, resulting in referrals to mental health treatment and weekly sessions with mentors.

Plans for Next Reporting Year

In FY19, Winchester Hospital conducted a comprehensive Community Health Needs Assessment (CHNA) that included qualitative and quantitative data collection, robust community engagement activities, and an inclusive prioritization process. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY19. In response to the FY19 CHNA, Winchester Hospital will focus its FY20-22 Implementation Strategy on four priority areas. These priority areas collectively address the broad range of health and social issues facing residents living in Winchester Hospital's CBSA who face the greatest health disparities. These priority areas are:

- Mental Health & Substance Use Disorders
- Chronic Complex Conditions & Risk Factors
- Social Determinants of Health
- Access to Care

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). Winchester Hospital's priorities are also aligned with those identified by the Massachusetts Department of Public Health (DPH), to guide the Community-based Health Initiative (CHI) investments funded by the Determination of Need (DON) process, which underscore the importance of investing in the Social Determinants of Health (i.e., built environment, social environment, housing, violence, education, and employment).

The FY19 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions that are being used to inform and refine Winchester Hospital's efforts. In completing the FY19 CHNA and FY20-22 Implementation Strategy, Winchester Hospital, along with its health, public health, social service, and community partners, is committed to improving the health and well-being of all residents living throughout its CBSA. As discussed above, based on the CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that Winchester Hospital's FY20-22 Implementation Strategy should prioritize certain demographic, socio-economic, and geographic population segments that have complex needs and face barriers to care and service gaps, as well as other adverse social determinants of health. These factors put these segments at greater risk, limit their access to needed services, and can often lead to disparities in health outcomes. More specifically, the FY19 CHNA identified the importance of supporting initiatives that targeted low-income populations, youth, older adults, racially/ethnically diverse populations, emerging bilinguals, and LGBTQ populations.

Winchester Hospital partners with dozens of community-based organizations and service providers to execute its Implementation Strategy, including public agencies, social service providers, community health organizations, academic organizations, and businesses.

Hospital Self-Assessment Form
Working with its Community Benefits leadership team and its Community Benefits Advisory Committee (CBAC), the Winchester Hospital Community Benefits team completed a hospital self-assessment form (Section VII, page 47). The Winchester Hospital Community Benefits team also shared the Community Representative Feedback Form with many CBAC members and community stakeholders who participated in Winchester Hospital's CHNA.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team and Community Benefits Advisory Committee (CBAC)
The membership of Winchester Hospital's Community Benefits Advisory Committee (CBAC) aspires to be representative of the constituencies and priority populations served by

Winchester Hospital's programmatic endeavors, including those from diverse racial and ethnic backgrounds, age, gender, sexual orientation and gender identity, as well as those from corporate and non-profit community organizations. Senior management is actively engaged in the development and implementation of the Community Benefits plan, ensuring that hospital policies and resources are allocated to support planned activities.

It is not only the Board members and senior leadership who are held accountable for fulfilling Winchester Hospital's Community Benefits mission. Among Winchester Hospital's core values is the recognition that the most successful Community Benefits programs are implemented organization-wide and integrated into the very fabric of the hospital's culture, policies, and procedures. A commitment to Community Benefits is a focus and value manifested throughout Winchester Hospital's structure and reflected in how it provides care at the hospital and in affiliated practices.

Winchester Hospital is a member of BILH. While Winchester Hospital oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity, and Inclusion Officer. This structure ensures that Community Benefits efforts, prioritization, planning, and strategy align across the system and are integrated with local and system strategic Diversity, Equity, and Inclusion efforts.

The Winchester Hospital Community Benefits program is spearheaded by LeighAnne Taylor, Regional Manager of Community Benefits and Community Relations. The Regional Manager of Community Benefits and Community Relations has direct access and is accountable to the Winchester Hospital President and the BILH Vice President of Community Benefits and Community Relations, the latter of whom reports directly to the BILH Chief Diversity, Equity, and Inclusion Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of hardly-reached populations are considered every day in discussions on resource allocation, policies, and program development.

This is the structure and methodology employed to ensure that Community Benefits is not the purview of one office alone and to maximize efforts across the organization to fulfill the mission and goals of Community Benefits.

Community Benefits Committee Meetings

- December 10, 2020
- June 24, 2021
- September 30, 2021
- December 15, 2021

Community Partners

Winchester Hospital recognizes its role as a community hospital in a larger health system and knows that to be successful it needs to collaborate with its community partners and those it

serves. Winchester Hospital's Community Health Needs Assessment and the associated Implementation Strategy were completed in close collaboration with Winchester Hospital's staff, its health and social services partners, and the community at large. Winchester Hospital's Community Benefits program exemplifies the spirit of collaboration that is at the core of Winchester Hospital's mission.

Winchester Hospital serves and collaborates with all segments of the population. However, in recognition of the health inequities that exist for these communities, Winchester Hospital focuses its Community Benefits efforts on improving the health status of the low-income, hardly-reached populations living in its CBSA.

Winchester Hospital currently supports dozens of educational, outreach, community health improvement, and health system strengthening initiatives within the Commonwealth. In this work, Winchester Hospital collaborates with many of the area's leading health care, public health, and social services organizations.

These community partners have been a vital part of Winchester Hospital's community health improvement strategy since 1968. Historically, Winchester Hospital has relied heavily on its community partners to implement its Community Benefits initiatives. In this regard, Winchester Hospital has leveraged the expertise and vital connections that these organizations have with the residents and other community-based organizations that operate in the communities within Winchester's CBSA.

Winchester Hospital's Board of Directors, along with its clinical and administrative staff, is committed to improving the health and well-being of residents throughout its service area and beyond. World-class clinical expertise, education, and research, along with an underlying commitment to health equity are the primary tenets of its mission. Winchester Hospital's Community Benefits Department, under the direct oversight of WH's Board of Directors, is dedicated to collaborating with community partners and residents, and will continue to collaborate in order to meet its Community Benefits obligations.

The following is a comprehensive listing of FY21 community partners with which Winchester Hospital joins in assessing community need as well as planning, implementing, and overseeing its Community Benefits Implementation Strategy:

- Boys & Girls Club of Stoneham & Wakefield
- CHNA15
- City of Medford
- City of Woburn
- Council of Social Concern, Woburn
- Metro Housing Boston
- Minuteman Senior Services
- Mystic Valley Elder Services
- Mystic Valley Public Health Coalition
- Stoneham Coalition for a Healthy Community
- Town of Reading
- Town of Stoneham
- Town of Wakefield
- Town of Wilmington
- Town of Winchester
- Winchester Housing Authority
- Winchester SAFER Coalition

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY19 Community Health Needs Assessment (CHNA) along with the associated FY20-22 Implementation Strategy was developed over a ten-month period from October 2018 to August 2019. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and Federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill Winchester Hospital's need to conduct a community health needs assessment, engage the community, identify priority health issues, inventory community assets, assess impact, and develop an Implementation Strategy. However, these activities are driven primarily by Winchester Hospital's dedication to its mission, its covenant to the underserved, and its commitment to community health improvement.

As mentioned above, Winchester Hospital most recent CHNA was completed during FY19. FY21 Community Benefits programming was informed by the FY19 CHNA and aligns with Winchester Hospital's FY20-FY22 Implementation Strategy. The following is a summary description of the FY19 CHNA approach, methods, and key findings.

Approach and Methods

The assessment began in December 2018 and was conducted in three phases, allowing for the collection of an extensive amount of quantitative and qualitative data:

- Phase 1 – Preliminary assessment and engagement
- Phase 2 – Targeted engagement
- Phase 3 – Strategic planning and reporting

Hundreds of individuals from across Winchester Hospital's service area were engaged in the assessment and planning process, including health and social services providers, public health officials, elected officials, public school nurses and administrators, first responders, leaders of faith-based organizations, BILH senior leadership, staff, and board members, and community residents.

Quantitative Data Sources: An extensive amount of demographic and socioeconomic data, health status, utilization rates, and risk survey data was collected from a broad range of sources and analyzed to understand current and emerging health issues:

- U.S. Census Bureau, American Community Survey 5-Year Estimates (2013-2017)
- Massachusetts Department of Elementary and Secondary Education: School and District Profiles
- FBI Uniform Crime Reports (2017)
- Massachusetts Department of Public Health, Registry of Vital Records and Statistics (2015)

- Massachusetts Department of Public Health, Bureau of Substance Abuse Services (2017)
- Massachusetts Department of Public Health, Annual Reports on Births (2016)
- Massachusetts Department of Public Health, Opioid Related EMS Incidents (2018)
- Massachusetts Bureau of Infectious Disease and Laboratory Sciences (2017)
- Massachusetts Center for Health Information Analysis (CHIA) Hospital Profiles (FY 2013-2017)
- Massachusetts Center for Health Information Analysis (CHIA) Hospital Discharges (2017)
- Massachusetts Healthy Aging Collaborative, Community Profiles (2018)
- Middlesex League Youth Risk Behavior Survey (2019)
- Changing Faces of Greater Boston, Boston Foundation (2019)

Qualitative Data Sources:

To obtain targeted data and understand the current issues facing the community, the following was completed:

- 28 internal stakeholder interviews (board members, senior leaders, and service line leaders)
- 20 external stakeholder interviews
- 1,022 community surveys
- Two community listening sessions (100 attendees)

Individuals provided input through interviews, focus groups, community listening sessions, and a widely distributed Community Health Survey. While it was not possible for the CHNA to involve all community stakeholders, every effort was made to be as inclusive as possible and provide a broad range of opportunities for participation. Winchester Hospital's Community Benefits program is centered on partnership and dialogue with its many communities. Winchester Hospital's understanding of these communities' needs is derived from discussions with and observations by healthcare and health-related workers in the neighborhoods, as well as more formal assessments through available public health data, focus groups, surveys, etc. This data was then augmented by demographic and health status information gleaned from a variety of sources including The Massachusetts Department of Public Health, The Boston Public Health Commission, federal resources such as the Institute of Medicine, and Centers for Disease Control and Prevention, and review of literature relevant to a particular community's needs.

The articulation of each specific community's needs (done in partnership between Winchester Hospital and community partners) is used to inform Winchester Hospital's decision-making about priorities for its Community Benefits efforts and community investment decisions. Winchester Hospital works in concert with community residents and leaders to design specific actions to be undertaken each year. Each component of the plan is developed and eventually woven into the annual goals and agenda for the Winchester Hospital's Community Benefits Plan that is adopted by the Board of Trustees.

Summary of FY19 CHNA Key Health-Related Findings
Winchester Hospital's FY20-22 Implementation Strategy focuses on the following three priority areas identified in the CHNA that address the broad range of health and social issues facing residents who have the greatest health disparities:

1) Social Determinants of Health and Access to Care: A key finding was the continued impact that the social determinants of health (e.g., economic stability, transportation, access to care, housing, food security) have on residents of Winchester Hospital's service area, especially those with low to moderate income and those who are frail or homebound, have mental health needs or substance use disorder, or lack a close support system. Despite the fact that people in Winchester Hospital's service area are generally insured and employed, the CHNA indicated concern that families face financial stress because of high out-of-pocket costs for health care services and ineligibility for public benefits. If eligible, families in need often do not enroll because of the stigma of accepting public assistance. In addition, some groups face language and cultural barriers to accessing services.

2) Chronic/Complex Conditions and Risk Factors: The CHNA findings revealed a need to address the many risk factors associated with chronic and complex health conditions, including physical inactivity and poor nutrition/lifestyle, particularly for older adults, people with lower levels of education/health literacy, and those with access issues. Addressing the leading risk factors is the key to many chronic disease prevention and management strategies.

3) Mental Health and Substance Use Disorders: Mental health issues (e.g., depression, anxiety, stress, stigma, and access to treatment) underlie many health and social concerns. Concerns include depression, anxiety/stress, social isolation among older adults, substance dependency (particularly use of e-cigarettes/vaping and alcohol by youth), and the opioid epidemic, which continues to impact individuals, families, and communities.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Area #1: Mental Health & Substance Use Disorders

Priority Health Need: Mental Health & Substance Use Disorders
Program Name: Boys & Girls Club – Screening, Brief Intervention, Referral to Treatment
Health Issue: Mental Health, Substance Use

Brief Description or Objective	This program utilizes an innovative approach to screening, identifying, and providing intervention as early as possible for youth who have, or are at-risk of developing, mental health or substance use disorders. The program is delivered on-site at the Boys & Girls Club by staff members who know the participants. Staff members are the participants' mentors and are highly liked and respected. Administering the program in this non-authoritarian, safe environment results in more open and honest dialogue. The program incorporates three components: 1. Screening: Two screening tools are used based on age (older teens get a combination of the two): • CRAFFT behavioral screening tool – ages 12-17 • QPR – ages 8 and up 2. Interventions (ongoing): • Positive reinforcement: inoculation effects on at-risk youth • Weekly meetings between at-risk youth and an assigned mentor • Group discussions led by social workers and staff, focused on current events and challenges 3. Referral to Treatment: Youth with signs or symptoms of mental health or substance use disorder are referred immediately to mentors and treatment providers. In addition, they receive ongoing support with open dialogue with their parents and help in accessing treatment.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Identify youths who have, or are at-risk of developing, mental health or substance use disorders, deliver immediate intervention and/or referral to treatment to those at risk, and ensure sustainability by training staff to become leaders/mentors who, in turn, train additional staff.

Goal Status	• 60% of staff members were trained in early recognition, basic treatment, and SBIRT methodology.
	• Successfully implemented modified CRAFFT screening tool for elementary age participants for the first time in 2021.
	• 321 youths were screened in FY21, resulting in the following:
	  ○ Three participants were referred to treatment
	  ○ 32 participants were referred to staff mentors
	  ○ 95% of referred participants attended weekly mentoring sessions
	  ○ 74% reported they were less likely to participate in risky behaviors
	  ○ 87% identified an adult to talk to if they felt depressed or had thoughts of self-harm

Program Year: Year 2	Of X Years: Year 3	Goal Type: Outcomes Goal

Priority Health Need: Mental Health & Substance Use Disorders
Program Name: Winchester Interface Referral Service
Health Issue: Mental Health, Substance Use

Brief Description or Objective	According to a 2018 community-wide survey distributed to all Winchester residents, mental health and stress were reported among the top-three health issues for the community. Survey respondents, identified a need for community members to connect with mental health resources in a more convenient and confidential way. In response to this need, Winchester Hospital collaborated with the Winchester SAFER Coalition to support the development of the Interface helpline, launched in January 2020. The program incorporates the William James Interface Referral Service, a confidential service offered for free to all community members. Interface counselors match callers with providers and counselors based on their needs, and follow up with each caller to ensure the match was successful and that the caller has received the help they need. COVID-19 has led to increased mental health challenges and levels of stress for residents. The Interface service was integral in addressing this need by connecting residents to mental health providers and wellness services.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To address mental health challenges of residents and increase access to care by connecting participants to mental health and wellness resources in a timely manner.
Goal Status	In FY21 from December-May, 84 residents were served. As a result of the COVID-19 pandemic, there was an increased demand for the service. Of the 84 residents served in FY21: • 65.5% were female, 32.1% male • Races and ethnic groups served included White, Latinx, Asian, and multiracial • The top presenting issues were anxiety (46%) and depression (27%). Caller's primary requests included referrals to individual therapy and medication evaluation. • The age ranges of those served were: o 6-12 years old – 32.1% o 13-17 years old – 47.6% o 18-24 years old – 6% o 25-59 years old – 10% o 60+ years old – 3.6%

Program Year: Year 2	Of X Years: Year 3	Goal Type: Process Goal

Priority Health Need: Mental Health & Substance Use Disorders
Program Name: Mobile Mental Health
Health Issue: Mental Health, Substance Use

Brief Description or Objective	Winchester Hospital collaborated with Mystic Valley Elder Services (MVES) to support the Mobile Mental Health Program in providing home-based mental health services to older adults in Medford, North Reading, Reading, Stoneham, and Wakefield. The program addresses a variety of issues affecting older adults' emotional well-being and quality of life such as hoarding, depression, anxiety, adjustment to loss, and substance use. A Clinical Caseworker provides participants with ongoing communication and linkages to health care services such as in-home mental health therapy, medication evaluation, and other supports as needed. During the COVID-19 pandemic, treatment was flexibly designed to continue the program despite restrictions. Currently, Clinical Caseworkers and assigned therapists are continuing to rely on telephone and online technology as the primary method of communication with Mobile Mental Health clients.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To address behavioral and mental health concerns in order to improve mental health and emotional well-being of older adults and to increase access to mental health care by providing home-based mental health counseling and direct care services including diagnosis, prescription medication, and therapy in Medford, North Reading, Reading, Stoneham, and Wakefield.
Goal Status	As a result of the COVID-19 pandemic, Clinical Caseworkers and therapists used telephone and online technology as the primary methods of communication with clients. Despite the challenges, the Mobile Mental Health Program provided services to a total of 175 community members. FY21 outcomes achieved include: • 45 consumers averted a mental crisis such as suicide, anger, or abuse • 98 consumers reported reduced loneliness and isolation • 120 consumers saw symptom reduction • 48 consumers achieved medication compliance • 91 consumers reported improved mental health functions • 101 consumers were Stable for 3 months by report of consumer • 15 consumers were supported in avoiding housing loss or eviction as a result of the program Of those served, 97% identified as White, 2% Black, 1% Hispanic, 0.05% Caribbean Islander, and 0.05% Asian. 93% of clients were 65 years of age or older, and 71% were female.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Mental Health & Substance Use Disorders **Program Name:** Stoneham Interface Referral Service **Health Issue:** Mental Health, Substance Use	
Brief Description or Objective	In response to an increased need for connection to mental health services for Stoneham residents, Winchester Hospital collaborated with the Stoneham Coalition to support the establishment of the Interface helpline, launched in May 2021. The service incorporates the William James Interface Referral Service, a confidential service offered for free to all community members. The Interface counselor matches callers with providers and counselors based on their needs, and follows up with each caller to ensure the match was successful and that the caller has received the help they need. COVID-19 has led to increased mental health challenges and levels of stress for residents. The Interface service was integral in addressing this need by connecting residents to mental health providers and wellness services.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To address mental health challenges of residents and increase access to care by connecting participants to mental health and wellness resources in a timely manner.

Goal Status	In the first year of the program, the Stoneham Coalition worked to provide Interface marketing materials to school counselors, the police department, and to key stakeholders. A billboard was also created to raise awareness about Interface. Social media marketing has also been on Facebook to spread awareness of the service. In FY21 (since May), 30 residents were served by Interface. Of the 30 residents served in FY21:
	• 71% were female, 29% male
	• The top presenting issues were anxiety and depression. Callers were primary requests included referrals to individual therapy and medication evaluation.
	• The age ranges of those served were:
	  ○ Under 18 years old – 53%
	  ○ 18-24 years old – 17%
	  ○ Unknown – 30%

Program Year: Year 2	**Of X Years: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Mental Health **Program Name:** North Reading CIT Older Adult Social Isolation Program **Health Issue:** Mental Health, Substance Use	
Brief Description or Objective	The North Reading Community Impact Team (CIT) is a collaborative cross-sector community partnership that emphasizes the use of innovative methods to identify factors that have a negative impact on the quality of life for all and to implement solutions that solve the underlying problems. The Older Adult Social Isolation Program sought to reduce senior isolation and loneliness by providing 4 mental health workshops that included a healthy meal. The target audience was seniors living in subsidized housing and seniors connected to the O'Leary Senior Center. The four workshops covered the topics of mindfulness, decluttering the mind and home, attending to daily living, and grandparents raising grandchildren.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Host 4 mental health workshops to improve older adult mental health and reduce isolation.
Goal Status	All four workshops were well-attended and included a healthy lunch. 42 older adults were served by the program. North Reading CIT received positive reviews of the workshops and plans to host more of these events going forward to help address older adult mental health and reduce isolation in North Reading.
Program Year: Year 1	**Of X Years: Year 1** / **Goal Type: Process Goal**

Priority Health Need: Mental Health **Program Name:** West Medford Community Health Center Youth Mental Health Program **Health Issue:** Mental Health, Substance Use	
Brief Description or Objective	The West Medford Community Center after-school program addresses the need for Medford's youth to have a safe haven during non-school hours and offers activities designed to increase youth connectedness. The after-school program serves children in fourth to eighth grade, ages 9-13. To address increased mental health needs among West Medford Youth, the program team implemented a new youth mental health program. The program is structured as topic-specific workshops based on identified needs that include: conflict resolution, emotion management and positive behavior processing.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Provide topic-specific workshops to address emerging mental health needs of youth served by the West Medford Community Center's after-school program.
Goal Status	16 children enrolled in the mental health program at the West Medford Community Center. Participants self-report increased knowledge of strategies and behaviors to help cope with mental health challenges and staff report positive changes in behavior among the youth who participated in the workshops.

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Mental Health
Program Name: Youth Risk Behavior Survey (YRBS) for the Middlesex League Collaborative
Health Issue: Mental Health, Substance Use

Brief Description or Objective	The Youth Risk Behavior Survey (YRBS) for the Middlesex League Collaborative, includes the towns of Arlington, Wakefield, Belmont, Watertown, Burlington, Wilmington, Melrose, Winchester, Reading, Woburn, and Stoneham. The YRBS can determine the prevalence of health behaviors; assess whether health behaviors increase, decrease, or stay the same over time; examine the co-occurrence of health behaviors; provide comparison data for geographies and subpopulations; and monitor progress toward achieving Healthy People objectives and program indicators. The YRBS allows the schools to better understand the extent to which middle school and high school students in the district engage in risky behaviors. Winchester's BILH peer hospital, LHMC, supports the Middlesex League to create an online, standardized test that allows for the data to be processed in a timely manner and synthesized into a regional report, which covers both Winchester and LHMC hospital service areas.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide funding to support the administration of a regional, comprehensive Youth Risk Behavior Survey. Identify potential health and social impacts to youth from COVID-19. Identify mental health risk factors for youth in the Middlesex League. Identify risk factors and rates of substance use in Middlesex League youth. Identify the risk factors and rates of unintentional injury and violence in youth in the Middlesex League. Identify risk factors for sexual activity in Middlesex League youth. Identify the risk factors for physical health and chronic disease in Middlesex League youth.
Goal Status	At the district-level, survey administration occurred over 1 to 3 day period, during the students' regular class time. Given the COVID-19 public health emergency, the 2021 survey process was typically administered while students were participating in remote learning, although some districts had students take it in the school-setting. The survey was administered to 7,337 middle school students and 8,852 high school students across the Middlesex League towns. Over one-third of HS students and

	about one-fourth of MS students reported that their mental health was not good most of the time or always. Genderqueer students were significantly more likely to report experiencing poor mental health. •While the majority of students did not experience any adverse financial or health-related effects of COVID-19, 11% of HS students and 6% of MS students experienced a family financial problem and 23% of HS students and 22% of MS students had a family member or close friend who died. •More than half of HS and MS students reported experiencing feelings of anger, sadness, worry, numbness, or frustration in reaction to COVID-19. •Just over half of HS and MS students reported feeling close to people in their school (52% and 53%, respectively). •29% of HS and 21% of MS students reported that their mental health was not good most of the time or always. •Genderqueer students were more likely to report experiencing overwhelming stress, depression, and suicidal ideations than male or female students. •School demands and expectations continued to cause students the most negative stress, with keeping up with schoolwork reported as the primary contributing factor. •Suicidal ideation and attempts were reported at similar rates compared to prior YRBS data. Students in 8th grade are at particularly high risk for planning and attempting suicide. •Students most often identified a parent as their support network. •Overall, substance use increased as students increased in grade. •Alcohol was most commonly used by HS and MS students. About one-fifth of HS students report having drank alcohol in the past 30 days. •White and female HS students were more likely to report drinking alcohol. •Hispanic HS students were more likely to report marijuana and electronic vapor product use. •HS students generally accessed substances through friends or family members. •Smoking cigarettes was perceived as the most risky and marijuana use the least among HS students. •Trend data between 2019 and 2021 shows a decline in overall alcohol consumption amongst HS students by 12% and a 3% decline amongst MS students. •Similar trend data across marijuana use was reported, with a 10% decline in usage amongst HS students and a 1% decline amongst MS students. •Hispanic and Multi-Racial students are most likely to report driving under the influence of alcohol or marijuana. •About one-fifth of HS students report that they check their cell phone while driving. •White and female students are most likely to report that they check their cell phone while driving. •Forced sexual behavior was consistent across reporting years. •Genderqueer students were significantly more likely to experience electronic bullying than male or female students. •Trend data shows a 10% decline in experiencing electronic bullying amongst Middlesex MS students from 30% in 2019 to 20% in 2021. •Trend data indicates the number of HS students who reported having been forced to do sexual things they did not want to do as similar to previous years (7-8% across 2017, 2019 and 2021).

	•Overall, 19% of HS students and 2% of MS students reported that they had ever had sexual intercourse •Hispanic, Multi-Racial, and genderqueer students were more likely to report drinking alcohol or using drugs before sexual intercourse. •Trend data indicates an overall decrease in the number of Middlesex HS students who report having had sexual intercourse. This decreased from 28% in 2017 to 26% in 2019 to now 19% in 2021. •HS students reported that condoms were the most common method used to prevent pregnancy. •About 7% of HS students were obese (>= 95th percentile for body mass index, based on sex-and age-specific reference data from the 2000 CDC growth charts) and 14% were overweight (>= 85th percentile but <95th percentile for body mass index). •The percent of HS students who were obese decreased from 8% to 7% while overweight rates increased from 13% to 14% compared from 2019 to 2021. •The majority of MS and HS students report that they are about the right weight. •HS students reporting eating fruit in the past 7 days slightly more often in 2021 compared to 2019 (95% vs 92%) and similar rates of vegetable consumption (94% vs 95%) •The majority of HS students did not drink soda (53%) or an energy/sports drink (69%) in the past 7 days. White students were most likely to have drunk soda or an energy/sports drink in the past 7 days, while Asian students were least likely. •Physical activity per week decreased while average screen time per day increased as students increased in age. •Amongst MS Middlesex Students there was a 5% increase in students who reported "not trying to do anything about my weight" from 31% in 2019 to 36% in 2021.

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Mental Health
Program Name: HART House Tewksbury
Health Issue: Mental Health, Substance Use

Brief Description or Objective	A long-term residential recovery home providing a 24-hour structured rehabilitative environment for pregnant and parenting women recovering from substance use disorder and/or alcohol use disorder. Treatment offered includes individual, family, group therapy and parenting education.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide a 24-hour structured rehabilitative environment for pregnant and parenting women recovering from substance use disorder and/or alcohol use disorder. The program aims to provide women with the skills necessary to maintain their sobriety and the education, skills and guidance to be effective, nurturing parents.

Goal Status	In FY21 the HART House provided 4,434 bed days of care to program participants and served 45 women and 42 children.	
Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Process Goal**

Priority Area #2: Chronic/Complex Conditions

Priority Health Need: Chronic/Complex Conditions **Program Name: CHAMP Pediatric Asthma Program** **Health Issue: Chronic Disease, Asthma, Pediatric Asthma**	
Brief Description or Objective	According to the American Academy of Pediatrics, pediatric asthma continues to be a leading cause of hospital admissions in the U.S., with readmission rates of between 10% and 40%. Asthma is the leading chronic disease in children, affecting about 10% of those under age 18. In addition, it is the No. 1 reason for missed school days. According to the CDC's Vital Signs report on pediatric asthma, action plans can decrease the rate of asthma-related hospitalizations by more than 5%. As a result, Winchester Hospital's Center for Healthy Living developed and launched CHAMP, a model of care that uses a team-approach, proven to help children manage their asthma more effectively. The team consists of family members, caregivers, the child's pediatrician, clinical staff from Winchester Hospital, the child's school nurse, child care personnel, classroom teachers, and anyone else who may be in a position to advise the child and his/her parents about asthma management.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	To reduce emergency department visits for pediatric asthma patients by ensuring effective control of the disease through treatment and through education of patients, families, physicians, and other health professionals.
Goal Status	In FY21, 84 children participated in CHAMP. Participants report significantly fewer asthma-related hospital admissions and emergency department visits. In addition, Winchester Hospital's pediatric asthma nurse specialist provided community outreach in our service area in FY21 via education and training sessions and private consultations and visits to educate students, teachers, and families about pediatric asthma. Efforts included: • 50 home visits and 100 video conference visits • 14 school or camp visits • 10 school education/training sessions held via Zoom • 286 Asthma Action Plans completed and filed with schools and daycare centers, a 75% increase over FY20

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: Outpatient Lactation Program** **Health Issue: Chronic Disease, Maternal/Child Health**	
Brief Description or Objective	According to the American Academy of Pediatrics, there is a critical connection between breastfeeding and an infant's immune system. A mother passes antibodies to her infant through breast milk, which promotes immune-system development, resulting in fewer illnesses and lowers the risk of asthma, allergies, obesity, and sudden infant death syndrome. Breastfeeding mothers also receive numerous health benefits, including lower risk of breast and ovarian cancer, diabetes, and heart disease. Recognizing this connection between breastfeeding and health of the mother and baby, Winchester Hospital launched the Outpatient Lactation Program in 1989. The program offers education and encouragement to new moms before the birth of their baby, during their hospital stay, and after their return home. The program, led by a Certified Lactation Specialist, provides free prenatal breastfeeding classes, along with individual counseling, to give new mothers tools and teach them techniques for successful breastfeeding.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To help mothers meet the breastfeeding goal set during their initial consultation with the Lactation Specialist and successfully breastfeed for at least six months, as recommended by the American Academy of Pediatrics.

Goal Status	The Outpatient Lactation center reinstated in-person office visits in October 2020, with video appointments still available by request. The Nursing Mothers Support Group meets online weekly using Zoom. In FY21, 553 mothers participated in the program. • 80% of the new mothers surveyed after the program reported meeting the breastfeeding goal they set during their initial consultation with the Lactation Specialist. • 79% reported successfully breastfeeding for six months or more.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: Winchester Hospital Meals on Wheels Program** **Health Issue: Chronic Disease, Access to Healthy Foods**	
Brief Description or Objective	For more than three decades, Winchester Hospital has been preparing and delivering freshly cooked, nutritious meals at a discounted rate to Winchester residents of all ages, who are unable to shop for, or prepare, food. Kitchen staff at Winchester Hospital prepare and pack the meals under the direction of staff dietitians, and the meals are delivered by Winchester Hospital volunteers. The meals are tailored to the dietary needs and preferences of the recipient, who can choose to receive meals up to two times per day, five days a week. Although providing healthy meals is the core of the program, the program also helps isolated residents remain safely in their homes by providing a daily check-in and social engagement with a trained and compassionate volunteer.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To help isolated or homebound community members, or those unable to shop for or prepare a meal due to illness or injury, remain independent in their homes by delivering low-cost, healthy meals. To reduce isolation and provide an opportunity for social engagement for residents living alone.
Goal Status	Winchester Hospital's kitchen staff, under the direction of the hospital's team of registered dietitians, prepared and packed 4,772 meals to meet the dietary needs of participants. The meals were delivered by hospital volunteers to homebound residents.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: Oncology Nurse Navigator** **Health Issue: Chronic Disease, Cancer, Senior Health Challenges/Care Coordination**		
Brief Description or Objective	The Oncology Nurse Navigator, an RN with oncology-specific clinical knowledge, offers individualized support to patients and their caregivers to help them make informed care decisions and overcome barriers to optimal care. The Navigator contributes to the hospital's mission by providing cancer patients with holistic care that includes communication and coordination with the patient's family and caregivers and a multidisciplinary team of physicians, clinicians, and social workers. The Navigator works in collaboration with the disease-specific clinical team to develop clinical pathways for appropriate care and acts as the clinical contact person for all patient-related concerns. The Navigator reviews all medical information prior to patient visits, ensures that physicians receive the information, and discusses it with the disease-specific physician prior to patient visits. In addition, the Navigator maintains contact with referring physicians to keep them up-to-date on the patient's care plan.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To guide patients through the complexities of the disease, direct them to healthcare services for timely treatment and survivorship, and identify and address barriers to timely and appropriate treatment. In addition, the Nurse Navigator connects patients with resources, healthcare, and support services in their community and assists them in the transition from active treatment to survivorship.	
Goal Status	In FY21, the Oncology Nurse Navigator dedicated 1,952 hours providing 1,158 new patient consults.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: Breast Cancer Risk Assessment** **Health Issue: Chronic Disease, Breast Cancer**	
Brief Description or Objective	Recognizing that breast cancer risk varies, and some women need screening beyond the standard recommendations, Winchester Hospital implemented a confidential survey to help residents assess their lifetime risk of breast cancer. Assessment, evaluation, and follow-up are all provided at no cost to participants. Results are shared with each participant's physician, who can help her determine whether she might benefit from screening beyond regular checkups and mammograms. In addition, genetic counselors provide information and answer questions about genetic testing.

Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To identify persons who may be at higher lifetime risk of developing breast cancer and to provide screening follow-up to their physicians.
Goal Status	In FY21, Winchester Hospital conducted 4,217 free screenings. Of those screened: • 1123 (26%) had a high-risk mutation. • 866 (20%) had a high lifetime risk of breast cancer. • 31% were between the ages of 40 and 49. • 29% were between the ages of 50 and 59. • 22% were between the ages of 60 and 69. • 11% were between the ages of 70 and 79. • 1.5% were over the age of 80. Follow-up consults were provided after each screening, and results were shared with participants' physicians to discuss recommended follow-up evaluation and care.
Program Year: Year 2	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: Fighting Fatigue Program** **Health Issue: Chronic Disease, Cancer**	
Brief Description or Objective	Studies show that exercise can reduce the chance of cancer recurrence and help survivors reduce disability. At the Reno Center for Cancer Care at Winchester Hospital, more than 500 patients were assessed using the National Comprehensive Cancer Network Distress Thermometer, in which patients are asked to rate their distress over practical, family, emotional, physical, and spiritual problems. Findings from the study indicated fatigue was overwhelmingly the number one concern. As a result, physical therapists from Winchester Hospital developed and launched the Fighting Fatigue Program. Facilitated by a physical therapist and a fitness specialist, the program supports patients before, during, and after cancer treatment. The program includes an initial screening followed by 12 weeks of fitness sessions tailored to each participant's ability. The sessions incorporate relaxation techniques such as breathing and meditation exercises. Without this program, most patients would not be able to exercise independently due to impairment from their illness or side effects from treatment. In FY21, the Fighting Fatigue classes were facilitated virtually. Participants were seen at regular intervals by a Physical Therapist either via virtual visits or in-person visits as needed to re-evaluate individual patient status and goals.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

	☐ Total Population or Community Wide Intervention
Program Goal(s)	To enable cancer patients to gain confidence in self-care independence, establish an exercise program to combat the effects of cancer treatment, and maintain or regain a healthy sense of well-being.
Goal Status	In FY21, 15 virtual classes took place once a week: 2 classes in October 2020 (end of Aug-Oct session); 7 classes from March 12-April 23, 2021 and 6 classes from May 28-July 9, 2021. During the months of November 2020-February 2021, classes did not take place due to limited referrals and reduced interest in participating in a virtual format. 8 out of 11 program participants completed at least one session of the program for a total of 49 visits. Their diagnoses included gynecological, breast, and blood cancers. Participants were given written instructions and accountability charts for performing home exercise program. All participants reported this to be helpful in allowing them to continue exercising independently at home. Due to COVID-19 concerns and changes in medical status among the 11 participants, only 2 participants were able to return to the clinic for re-evaluation and only 1 participant returned the post participation questionnaire making it difficult to evaluate the FY21 program goal status.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: Integrative Therapies for Cancer Patients** **Health Issue: Chronic Disease, Cancer**	
Brief Description or Objective	Winchester Hospital's Center for Healthy Living offers free integrative therapies to help cancer patients reduce stress and anxiety, relieve symptoms and side effects of treatment, and increase their general sense of health and well-being. The therapies include massage and acupuncture which are conducted during infusion treatments or individual appointments, hypnotherapy by individual appointment, and healing yoga classes.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To help cancer patients reduce stress and anxiety, relieve symptoms and side effects from treatment, and increase their general sense of health and well-being.
Goal Status	In FY21 Winchester Hospital provided 613 free integrative therapy sessions to more than 600 patients undergoing cancer treatment. The therapies, which included massage therapy, acupuncture, and hypnotherapy, were conducted during infusion treatments or through individual appointments upon request. In addition, 15 Healing

	Yoga classes were offered to cancer patients in treatment or recovery, reaching approximately 40 participants. According to a survey administered to participants after receiving one Integrative Therapy session, the following reported the treatment to be effective at reducing stress and relieving the side effects of their cancer treatment: ● 100% of massage patients ● 100% of hypnotherapy patients ● 67% of acupuncture patients

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: A Caring Place Wig Donation Program** **Health Issue: Chronic Disease, Cancer**	
Brief Description or Objective	Battling cancer can be a huge physical and emotional burden. While undergoing treatment, many patients experience hair loss, which can have an impact on their self-image and self-esteem. Through generous donations from the Winton Club, a fundraising arm of Winchester Hospital, the professional staff at A Caring Place (located at the Winchester Hospital Center for Cancer Care) provides beautiful and natural-looking wigs free of charge to women experiencing hair loss due to cancer treatment. The professionally trained staff provides a consultation that includes a proper fitting and thorough instructions on how to style and care for the wig.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To provide emotional support for and improve the self-image of women coping with hair loss from cancer treatment by providing wigs at no cost to patients with financial difficulties. Patients unable to afford a wig are provided with this product and the service of a wig stylist.
Goal Status	In FY21, Winchester Hospital provided wigs free of charge to 18 women.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: Mount Vernon House Resident Health Program** **Health Issue: Chronic Disease**	
Brief Description or Objective	Winchester Hospital clinicians provided acupuncture and massage therapy at no cost to residents at the Mount Vernon House and to Winchester residents over the age of 65. Many of the residents who received treatment reported relief of chronic pain for a period of time and improved or maintained their health.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To provide temporary pain relief for older adults with chronic health issues to help them improve or maintain their health.
Goal Status	In FY21, Winchester Hospital provided 725 treatments to Winchester residents. Health issues treated included back weakness, leg stiffness, edema in lower legs, leg numbness, shoulder pain, sinus headaches, hip and knee problems, arthritis of the low back, neck pain, sciatica, carpal tunnel, and balance trouble. Most patients either improve or maintain their health status. Data from a survey completed by participants indicates that: • 67% decreased their pain • 64% improved their flexibility • 53% improved their mood/level of happiness • 39% decreased their level of stress and anxiety • 21% improved their balance
Program Year: Year 2	**Of X Years: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: Center for Healthy Living Health Education Programs** **Health Issue: Chronic Disease, Parenting Skills, CPR, Stress Management**	
Brief Description or Objective	The Center for Healthy Living at Winchester Hospital helps community members take charge of their health and well-being by offering more than 30 programs and services each year, including CPR and first aid training, childbirth education classes, safe babysitting courses, and integrative therapies including massage, acupuncture, and hypnotherapy. In addition, the center offers a variety of specialized fitness classes, led by highly trained educators, targeting people of all ages and fitness levels and those with physical limitations or mobility issues. The classes include Building Bones and Flex and Stretch. Some programs such as yoga, community CPR, First Aid and Babysitting have not resumed due to challenges and risks with COVID restrictions.

Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒ Total Population or Community Wide Intervention
Program Goal(s)	To help people prevent disease and injury, improve health, and enhance quality of life.
Goal Status	In FY21, more than 3,312 community members participated in classes or educational programs.
Program Year: Year 2	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: Winchester Council on Aging Mobile Cholesterol and Anemia Clinic** **Health Issue: Chronic Disease**	
Brief Description or Objective	The Winchester Council on Aging Jenks Center nurse developed a mobile cholesterol and anemia clinic to target households with limited incomes to address these serious health concerns among lower income older adults. Working with the newly acquired Jenks bus, a driver brought the nurse to Winchester Housing Authority sites several times a month and a clinic was stationed at the Jenks Center for persons who did not reside at WHA sites.
Program Type	☐ Direct Clinical Services ☒ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population or Community Wide Intervention
Program Goal(s)	50 unduplicated older adults participated in the clinic to test for hypercholesterolemia and/or anemia. All participants were informed of results and referrals to primary care and further testing as needed.
Goal Status	44 individuals participated between housing sites and Jenks clinic. All participants received results of blood values and were connected with primary care for follow-up. Participants are in communication with the Jenks Center staff. Some have set up appointments with the Jenks Center nurse for 2022.
Program Year: Year 1	**Of X Years: Year 1** / **Goal Type: Process Goal**

Priority Area #3: Social Determinants of Health & Access to Care

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Home Blood Draw Program** **Health Issue: Access to Health Care, Chronic Disease**		
Brief Description or Objective	The Winchester Hospital Home Blood Draw Program was developed to enhance access to phlebotomy services for homebound patients who have difficulty getting to a laboratory or drawing station. Homebound patients are defined as people with a condition due to surgery, illness, or injury that precludes them from accessing medical care outside their home.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to phlebotomy services for homebound patients who have difficulty getting to a laboratory due to illness or injury.	
Goal Status	In FY21, Winchester Hospital Lab Services provided 11,398 free in-home blood draws. In addition to appreciating the convenience of the home blood draw, patients reported reduced feelings of isolation, as the visit with the phlebotomist provided them with a social opportunity.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Winchester Housing Authority Farmers Market** **Health Issue: Access to Healthy Food, Income & Poverty**	
Brief Description or Objective	According to research from the American Diabetes Association, increasing daily intake of fruits and vegetables may help reduce the risk of chronic disease and improve overall health in older adults. Findings from Winchester Hospital's FY19 CHNA indicated that lack of access to healthy foods is a major health issue for segments of the population, specifically low-income individuals and older adults. Interviewees and community forum participants reported that significant numbers of people struggled to buy fresh produce and other nutritional foods, and referred to food insecurity and food scarcity as major concerns. In addition, according to the 2018 Massachusetts Healthy Aging Report, only 28% of adults age 60 or older living in Winchester report getting the recommended five servings of fruits and vegetables per day. Lack of access and information, as well as financial insecurity, play a role in these low figures. To address this need, Winchester Hospital partnered with New Entry Sustainable Farming Project, an organization that grows organic produce locally for Middlesex County, to provide free produce for 20 consecutive weeks to residents living at Winchester Housing Authority sites. To reduce transportation barriers, farmers markets were held at both Winchester Housing locations. Each week, more than six varieties of fresh produce were provided for free, along with a newsletter that included nutrition information and healthy recipes featuring that

	week's produce. In FY21, in order to reduce the spread of COVID-19, Winchester Housing Authority employees bagged each week's produce, and the bags were left in the community room for residents to pick up. Residents were also offered the opportunity to have the bags delivered to their residence.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To help residents of the Winchester Housing Authority increase their daily intake of fruits and vegetables, by reducing barriers to accessing produce and providing information about the benefits of a healthy diet.

Goal Status	The 20-week farmers market at Winchester Housing Authority produced the following outcomes:
	• More than 3,430 pounds of fresh produce, including more than six varieties of fruits and vegetables, were delivered to the two Winchester Housing locations, free for all residents and their families.
	• A weekly newsletter featuring nutritional information and recipes for the fruits and vegetables was created and distributed with the produce.
	• More than 25% of the residents participated in the program.
	• 40% of participants were 76 or older.
	• 60% of the participants were women.
	• A post-program survey, completed by 8 residents, showed that program participants achieved the following results:
	  ○ 86% ate a greater variety of fruits and vegetables.
	  ○ 95% increased their daily intake of fruits and vegetables.
	  ○ 57% learned more about locally grown fruits and vegetables.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health & Access to Care
Program Name: Patient Financial Counseling
Health Issue: Access to Health Care, Income & Poverty

Brief Description or Objective	Winchester Hospital is committed to providing high-quality, affordable health care and strives to promote health, expand access, and deliver the best care in the communities it serves. As part of that commitment, Winchester Hospital dedicates resources to support and strengthen the capacity of its primary care offices throughout the community to help patients connect with and access timely, safe, quality patient care. In addition, Winchester Hospital is committed to providing care for everyone, regardless of their ability to pay, and dedicates representatives from Winchester Hospital's Patient Financial Services Department to assist people with limited financial resources by providing free counseling to help them find options to cover the cost of their care. The financial counselors meet with patients to explore options and help them apply for health coverage, public assistance, and/or the hospital's financial assistance program.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To help individuals with limited financial resources find options to cover the cost of their care and to help them apply for health coverage, public assistance, and/or the hospital's financial assistance program.
Goal Status	In FY21, Patient Financial Services staff at Winchester Hospital dedicated 2,080 hours to providing free counseling for 31,000 patients who had Medicaid coverage, who presented as self-paying and completed an application with a Financial Navigator, or who qualified for upgraded MassHealth coverage. FY21 saw an increase in patients who lost or had job changes due to the COVID-19 pandemic, creating a greater Financial Counseling need for our patients. In addition, more than 700 community members received assistance completing applications for Medicaid. • Of those served, 5,400 were unemployed, 4,770 were employed (full or part time), 835 were self- employed, 515 were disabled, 550 were retired, and 1900 were students. • The ages were: 0-19 (35%), 20-39 (34%), 40-59 (22%), 60-69 (8%), and 71-109 (1%).

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Serving Health Insurance Needs of Everyone (SHINE)** **Health Issue: Access to Health Care, Income & Poverty**

Brief Description or Objective	The Winchester Hospital SHINE collaboration helps address health care costs that Medicare beneficiaries struggle with, by connecting people with health insurance that meets their health care needs, lifestyle, and budget. SHINE counselors help Medicare beneficiaries understand what insurance coverage they need based on

	medical history, current health, prescribed medications, and the costs they incur by not having supplemental insurance. SHINE counselors also screen Medicare beneficiaries for eligibility for MassHealth, the Medicare Savings Program, Prescription Advantage, Health Safety Net, and free care/discounted prescriptions, and they help connect people with fuel assistance, home care, and food. In addition to face-to-face counseling, SHINE counselors conduct presentations to educate people new to Medicare, and those enrolled in Medicare, and a supplemental plan about their health care coverage choices. To help homebound individuals connect with SHINE counselors, information regarding Medicare and SHINE is distributed to anyone receiving Meals on Wheels and is publicized using local cable, social media, and print media. Due to COVID-19 restrictions, all counseling sessions were conducted via phone in FY21.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To provide Medicare beneficiaries and their families with confidential and unbiased health insurance information to address inpatient, outpatient, and prescription drug benefit gaps in coverage. Screen to assess social determinants of health and the need for additional services for clients. The counseling sessions help Medicare beneficiaries and their caregivers: - Navigate the complex health insurance options - Understand the language of the plans and how the components work - Review their current coverage and compare the costs and benefits of available options - Enroll in assistance programs if needed
Goal Status	In FY21, SHINE counselors conducted a total of 211 free confidential, unbiased counseling sessions for community members at two locations: the Jenks Center in Winchester (221 people) and the Winchester Hospital Center for Cancer Care (33 people). This was a 23% decrease, due to COVID-19. As of March, due to COVID restrictions, all counseling sessions were conducted over the phone. Of the 254 participants: - 94% were over the age of 65. - 68% were female; 32% were male. - 43% were below 150% of the federal poverty level, with 83% above and 11% below the low-income subsidy asset limit. This information was not reported for 6% of the participants. The following outcomes were reported by 193 participants who completed a post-program evaluation: - 151 had insurance but were enrolled in a Medigap supplemental plan. - 42 were new to Medicare and benefited from the information/assistance received on the various plans. 193 community members in Winchester were screened using the Social Determinants of Health Screening Tool. Referrals were made for participants to 11 community resources, including MassHealth; Mass College of Pharmacy; Council on Aging, Minuteman Senior Services, Medicare Advocacy Project, Mass Health Connector, SNAP, Fuel Assistance, Legal Services, pharmacies and Prescription Advantage.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Metro Housing Boston Co-Location Program** **Health Issue: Access to Affordable Housing, Income & Poverty**	
Brief Description or Objective	Winchester Hospital financially supported Metro Housing Boston to provide the co-location program in Winchester, Woburn, Stoneham and Medford, which, according to the FY19 CHNA, have significant housing needs. According to U.S. Census Bureau data, over 40% of renters in Woburn and Medford are classified as rent-burdened (devoting over 30% of income towards monthly rent). Approximately one of every four public school students in these communities is classified as economically disadvantaged and relies on governmental assistance programs. This tenuous hold on financial security greatly increases the risk of housing instability, but the services provided by Metro Housing's programs help at-risk families prevent eviction and homelessness. The program provides free counseling services to individuals and families to help them increase housing stability and economic self-sufficiency and improve their overall quality of life. It also helps with housing searches, emergency assistance, rapid rehousing, benefits maximization, and community referrals.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To offer eviction-prevention services and housing-stabilization services to low- and moderate-income families in Winchester Hospital's CBSA.
Goal Status	In FY21, eviction-prevention and housing-stabilization counseling was provided to 166 families in four locations: Medford, Stoneham, Winchester, and Woburn. As a result of COVID-19 restrictions, all counseling sessions were conducted via phone. Of those served: -27% were Black/African American, 64% white/Caucasian, 27% Hispanic of any race, 5% Asian, 1% mixed race, and 3% did not disclose their race. -86% received emergency financial assistance to remain to move to stabilized housing. -166 clients received brief counseling -144 clients submitted emergency rental assistance applications -22 clients received short/long term case management All participants also received referrals to community resources such as workforce development, educational opportunities, income maximization, unemployment assistance, and food stamps.
Program Year: Year 2	**Of X Years: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Woburn Council of Social Concern Food Insecurity Relief** **Health Issue: Access to Healthy Food, Nutrition, Income & Poverty**		
Brief Description or Objective	According to an analysis by Feeding America (https://www.feedingamerica.org/hunger-in-america/massachusetts), Massachusetts has experienced the largest relative increase of food-insecure individuals in the nation due to COVID-19 and the highest increase of food-insecure children (102%). With record unemployment and lost wages and many having little to no savings to protect them from the economic impact of COVID-19, food insecurity has skyrocketed from 8.4% of households pre-pandemic to 17.5% of households in FY20. With funding through the Winchester Hospital Community Health Grant, Council of Social Concern's Food Pantry is working to reduce food insecurity and hunger for individuals and families in need living in the communities of Winchester and Woburn. The Food Pantry Program provides food to individuals and families without adequate resources to meet their basic needs caused by the hardships of reduced wages, job loss and long-term illness. Low-income individuals, older adults and families in our service area find it financially difficult to afford healthy food choices on a low budget. The Food Pantry program provides food assistance to approximately 235 low-income households per month with healthy food choices on a low-income budget. The Food Pantry is open to all households regardless of age, race, ethnicity, or gender. Emergency boxes of food are given out during other agency hours to those who do not have enough food to last until their next eligible appointment.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To support the Woburn Council of Social Concern food bank in reducing hunger and food insecurity, resulting in improved health for food-insecure residents.	
Goal Status	762 individuals were served by the Woburn Council of Social Concern Food Pantry Program. 109,720 pounds of food were distributed in FY21. The percentage of clients served by race in FY21 was: 20% Black, 18% LatinX, 4% Asian, and 74% white. The percentage of clients served by age was: 30% under 18, 55% 18-64, and 13% 65 and over. 92% of households served will report that the food assistance they received from the Food Pantry, along with the food they purchase on their own, was enough for each member of the household to eat at least two complete meals per day over a one-month period. 97% of households served will report that the food assistance and information regarding other community resources that they received from the Food Pantry made it easier for them to meet their other basic monthly financial needs.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Area: Social Determinants of Health & Access to Care **Program Name: Community Based Behavioral Health and Collaborative Care Model** **Health Need: Access to Health Care, Mental Health, Substance Use Disorder**	
Brief Description or Objective	The National Alliance on Mental Illness (NAMI) reports that one-in-four individuals experiences a mental illness each year, underscoring a critical need for mental healthcare access across all patient populations. In the 2019 Winchester Hospital Community Health Needs Assessment, mental health – including depression, anxiety, stress, serious mental illness, and other conditions – was overwhelmingly identified as one of the leading health issues for residents of the service area**.** Further, individuals from across the health service spectrum discussed the burden of mental health issues for all segments of the population, specifically the prevalence of depression and anxiety. In an effort to improve access to behavioral health, Beth Israel Lahey Health has committed to the implementation of the Collaborative Care Model (CoCM) in employed primary care practices over a 5-year period (starting in March 2019). Collaborative Care is a nationally recognized integrated model that specializes in providing behavioral health services in the primary care setting. The services are provided by an embedded licensed behavioral health clinician and they include short-term brief interventions, case review with a consulting psychiatrist, and care coordination. The behavioral health clinician works closely with the primary care provider in an integrative team approach to treating a variety of behavioral health conditions. The primary care provider and the behavioral health clinician develop a treatment plan that is specific to the patient's personal goals. The behavioral health clinician uses therapies that are proven to work within the primary care setting.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To provide a collaborative approach among patients, clinicians, and family members to increase access to behavioral health services in order to identify and address health behaviors that may lead to mental health issues and substance use disorders.
Goal Status	In FY21, success included hiring and training behavioral health clinicians and expanding patient care capacity. Specifically, at Winchester Hospital there was an increase from 3 sites, serving 624 patients in FY20, to 6 sites, serving 1346 patients in FY21.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Transportation** **Health Issue: Access to Health Care, Access to Transportation**		
Brief Description or Objective	Winchester Hospital collaborated with Checker Cab of Woburn to provide free rides to and from medical appointments. Community members who have transportation difficulty due to financial problems, illness, or mobility issues are eligible for the service.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to health services by providing rides to individuals with no means of transportation due to medical or financial issues.	
Goal Status	In FY21, Winchester Hospital provided more than 150 patients, who had no access to public transportation, with free rides via Checker Cab to and from Winchester Hospital locations for appointments.	
Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Wilmington Elder Services Meals and More Program** **Health Issue: Access to Healthy Food, Nutrition, Income & Poverty**		
Brief Description or Objective	The Wilmington Council on Aging Meals and More program provides older adults with free, fresh produce bimonthly in partnership with local grocery stores and farms. This program was created in response to growing food insecurity during the COVID-19 pandemic among older adults in Wilmington.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Serve free, fresh produce to older adults in Wilmington through home deliveries, care giver pickups at the senior center, and directly to senior center program participants.	
Goal Status	308 older adults were served by the Meals and More Program in Wilmington. Of those individuals served, 93 participated in the program via home deliveries, 77 were housing authority deliveries, 12 were caregiver pickups, and 126 were deliver to senior center exercise program participants. 991 bags of produce were served in total in FY21.	
Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Mission of Deeds Kitchen Essentials and Food Access Support Program** **Health Issue: Access to Healthy Food, Nutrition, Income & Poverty**	
Brief Description or Objective	Mission of Deeds (MOD) is a nonprofit volunteer organization that gives purchased beds, donated furniture and basic household items, free of charge, to the previously homeless and others in great need. MOD clients are low-income families and individuals including survivors of domestic abuse, refugees, senior citizens, veterans, single parents, victims of fire and other disasters, and those with physical or mental disabilities. 65% of those served are households with children. MOD Deeds Kitchen Essentials and Food Access Support Program provides clients with the kitchen items they need to cook at home and financial support to purchase groceries at a local supermarket.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	MOD Kitchen Essentials and Food Access Support Program provides clients with the kitchen items they need to cook at home and financial support to purchase groceries at a local supermarket.
Goal Status	48 clients were served by the MOD Deeds Kitchen Essentials and Food Access Support Program. The percentage of clients served by race for FY21 was: 20% Black, 13% LatinX, and 40% White. 42 of the clients were under 18 years of age. 55 $100 grocery store gift cards were distributed to support the purchase of healthy foods.
Program Year: Year 1	**Of X Years: Year 1** / **Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Tewksbury Council on Aging Transportation** **Health Issue: Access to Health Care, Access to Transportation**	
Brief Description or Objective	The Tewksbury Council on Aging provides van rides to medical appointments for older adults in Tewksbury. In the summer and fall of FY21, ride requests for medical appointments increased as the State of Emergency was lifted and older adults, who delayed medical care, were seeking transportation assistance to appointments. To meet this demand, the Tewksbury COA committed additional funding to increase driver hours and increase the travel distance to beyond the 10 mile radius restriction that they had previously operated under.

Program Type	☐ Direct Clinical Services ☒ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population or Community Wide Intervention
Program Goal(s)	Increase Tewksbury COA van driver hours and increase allowable mileage distance of medical appointment van trips beyond 10 miles.
Goal Status	With the added driver hours, Tewksbury COA tripled their ridership in FY21 during the quarter compared to FY20. The COA was able to provide medical appointment trips outside their 10 mile radius. 70 van trips were completed during the grant period. This service continues to increase as Medical Appointments are becoming more available and we are open for more activities in the Senior Center. By employing the van driver for more hours and shifting ride scheduling responsibilities to the driver, the COA's LCSW was able to focus more of her energy to provide other much needed services to the older adults in the community and focus on addressing increasing mental health needs of the older adults served by the COA.

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Woburn Public Schools Backpack Food Program** **Health Issue: Access to Healthy Food, Nutrition, Income & Poverty**	
Brief Description or Objective	To address food insecurity among Woburn students and their families, Woburn Public Schools implemented a Backpack Food Program in partnership with the Woburn Council of Social Concern. This healthy food access initiative served the district's most economically insecure children. The students and families served by this program are identified by Principals and Counseling staff and the backpacks are made available at all 10 Woburn Public School sites.
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒ Total Population or Community Wide Intervention
Program Goal(s)	The program startup funds covered the purchase of 75 gender-neutral backpacks to distribute to students. Once established, this program will serve a minimum of 50 families on a weekly basis through the distribution of a backpack full of free, healthy food.
Goal Status	75 gender neutral backpacks were purchased in FY21 by Woburn Public Schools. Funding has been committed for FY22 to support the Council of Social Concern in filling a minimum of 50 backpacks with healthy food on a weekly basis.

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Medford Food Policy Council Stipends** **Health Issue: Access to Healthy Food, Nutrition**		
Brief Description or Objective	Prior to the COVID-19 pandemic, food insecurity affected at least 11% of Medford community members, with 45% of school-aged children enrolled in the Free or Reduced School Meals program. According to the Greater Boston Food Bank Gaps in Food Access report, these numbers are expected to continue to increase due to the ongoing pandemic. The City of Medford has established a Medford Food Security Task Force, which is taking steps to establish a resident Food Policy Council in pursuit of making Medford Hunger Free by 2028. The work of the council is intend to reach and improve food access for all community members experiencing food insecurity, with a particular focus on Black, Indigenous, and People of Color (BIPOC) community members, who continue to be disproportionately impacted by food insecurity and the effects of the pandemic. The Food Policy council will provide an opportunity for inclusive and equitable participation of residents in addressing food insecurity in their community. The Taskforce recognizes that volunteering is a privilege not afforded to everyone, and that people experiencing food insecurity are likely facing other economic challenges. By including a stipend for community members who contribute to the planning process, we strive to amplify the voices of our marginalized and least served community members and to imbed the interests and needs of all Medford residents within our food systems. With grant funding support, the Medford Food Security Task Force will provide residents with stipends to serve on the Food Policy Council, to support people with lived experience of food insecurity in providing their expertise as council members.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	The Medford Food Security Task Force will establish a resident Food Policy Council and will provide stipends to support people with lived experience of food insecurity in providing their expertise as council members.	
Goal Status	In FY21, the Food Policy Council was established. Municipal staff outlined the membership selection process and began working with residents with lived experience of food insecurity who will lead the membership identification and selection process for the Council.	
Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Medford Family Network Parent Education Program** **Health Issue: Education**		
Brief Description or Objective	The Medford Family Network (MFN) of Medford Public Schools is a free universal parenting education and family support program focusing on the positive impact on the development process of children prenatal to age 8, and supporting the families that care for them. In response to increased mental health needs of Haitian families served by MFN in Medford, in FY21 MFN staff built on their Parenting Journey program to design an 8-week program that focused on mental health to be led by a native-speaking Haitian Creole mental health professional. This 8-week program was conducted virtually via Zoom and families were also given access to individual therapy consultations.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Establish an 8-week virtual mental health program to address emerging needs of Haitian families served by the Medford Family Network.	
Goal Status	12 families were served by this program and a follow-up support group was established to continue the connections between the Haitian families served by the program. Families utilized the individual therapy consultations to connect with ongoing mental health supportive services.	
Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Technology Access for Older Adults** **Health Issue: Education, Access to Health Care**		
Brief Description or Objective	The COVID-19 pandemic precipitated a need in communities across the Commonwealth to increase digital access among older adults to help them stay connected socially, to access telehealth services, and to participate in health-promoting virtual programs. In response to this need, Winchester Hospital provided funding to local Councils on Aging to purchase the equipment necessary to keep older adults connected. The Medford, Stoneham, and Woburn Councils on Aging requested support in purchasing 10 iPads each, and offered training opportunities to teach the older adults who received the devices how to use them effectively.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	Purchase 10 iPads for three participating Councils on Aging in Medford, Stoneham, and Woburn to help older adults stay socially connected, to seek telehealth services, and to participate in virtual programs and services.
Goal Status	The Medford, Stoneham and Woburn Council on Aging purchased and distributed 10 iPads each and hosted training opportunities for older adults to learn how to use the devices for mental, social, and physical health promoting activities.

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Interpreter Services** **Health Issue: Access to Health Care**	
Brief Description or Objective	An extensive body of research illustrates the health disparities and differences in health care access and utilization that exist for diverse populations and immigrants. According to the Centers for Disease Control and Prevention (CDC), non-Hispanic black individuals have higher rates of premature death, infant mortality, and preventable hospitalization than do non-Hispanic whites. LatinX individuals have the highest uninsured rate of any racial or ethnic group in the United States. Asians are at a higher risk for developing diabetes than are those of European ancestry, despite a lower average body mass index (BMI). These disparities show the disproportionate, and often avoidable, inequities that exist within communities and reinforce the importance of understanding the demographic makeup of a community to identify populations more likely to experience adverse health outcomes. The WH service area is quite diverse. While many municipalities are predominantly white, there are significant numbers of Asian and Hispanic/LatinX residents throughout the service area. Language barriers pose significant challenges to providing effective and high-quality health and social services. To address this need, and in recognition that language and cultural obstacles are major barriers to accessing health and social services and navigating the health system, WH offers an extensive Interpreter Services program that provides interpretation and assistance in over 60 languages, including American Sign Language, and hearing augmentation devices for those who are hard of hearing. The Interpreter Services Department also routinely facilitates access to care, helping patients understand their course of treatment, and adherence to discharge instructions and other medical regimens. WH also routinely translates materials such as legal consents for treatment, patient education forms, and discharges, to further reduce barriers to care.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To overcome language barriers and increase access to care by providing free interpreter services via phone, video, or in-person sessions for community members who are emerging bilinguals.

Goal Status	In FY21, Winchester Hospital interpreters assisted 7,086 patients by providing free Interpreter Services sessions remotely. The top three languages requesting interpreter services were: Spanish (1,530), Italian (564), and Portuguese (562).

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Infrastructure
Program Name: Infrastructure to support Community Benefits collaborations across BILH hospitals
Health Issue: Health Professional/Staff Training

Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital have worked together to plan, implement, and evaluate Community Benefits programs. Staff have worked together to plan the FY22 Community Health Needs Assessment, understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH, in partnership with MGB, has developed a Community Benefits (CB) database. This database is part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2021, increase the capacity of BILH Community Benefits staff to understand program evaluation through workshops and case studies.
Goal Status	All 20 BILH Community Benefits staff participated in 6 evaluation workshops on SMART Goals, Logic Models, process and outcome evaluations, and program improvement.

Program Year: Year 2	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

SECTION V: EXPENDITURES

Item/Description	**Amount**	**Subtotal Provided to Outside Organizations (Grant/Other Funding)**

CB Expenditures by Program Type		
Direct Clinical Services	$921,393.00	$0.00
Community-Clinical Linkages	$91,124.00	$36,000.00
Total Population or Community Wide Interventions	$662,252.00	$78,216.00
Access/Coverage Supports	$576,214.00	$24,470.00
Infrastructure to Support CB Collaborations	$10,519.00	$0.00
Total Expenditures by Program Type	$2,265,502.00	$136,686.00
CB Expenditures by Health Need		
Chronic Disease	$653,309.80	
Mental Health/Mental Illness	$339,063.05	
Substance Use Disorders	$147,733.70	
Housing Stability/Homelessness	$20,259.35	
Additional Health Needs Identified by the Community	$1,105,136.10	
Total by Health Need	$2,265,502.00	
Leveraged Resources		
Total CB Programming	$1,859,150.00	
Net Charity Care Expenditures		
HSN Assessment	$2,647,816.00	
Free/Discounted Care	$0.00	
HSN Denied Claims	$764,546.00	
Total Net Charity Care	$3,412,362.00	
Total CB Expenditures	$7,537,014.00	

Additional Information

Net Patient Services Revenue	**$300,834,000.00**
CB Expenditure as % of Net Patient Services Revenue	**2.51%**
Approved CB Budget for FY22 (*Excluding expenditures that cannot be projected at the time of the report)	**$10,277,276.00**
Bad Debt	**$2,438,389**
Bad Debt Certification	**Yes**
Optional Supplement	
Comments	**PILOT payment of $184,000 to the Town of Winchester**

SECTION VI: CONTACT INFORMATION

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SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Update Form – Years 2 and 3

Note: This form is to be completed in the two Fiscal Years following the hospital's completion of its triennial Community Health Needs Assessment

I. Community Benefits Process:

- Has there been any change in composition or leadership of the Community Benefits Advisory Committee in the past year? ☒ Yes ☐ No
    - If so, please list updates:
      CBAC Chair: CBAC Chair: Jane Walsh, Winchester Board of Trustees Chair, and BILH Community Benefits Committee; CBAC Vice Chair: Richard Weiner, President, Winchester Hospital

      CBAC Members: Paul Andrews, Winchester Hospital Board of Trustees; Michael Baldasarre, Assistant Superintendent, Woburn Public Schools; Carla Beaudoin, Director of Development, Metro Housing Boston; Dot Butler, Winchester SAFER Coalition Denise Flynn; Vice President of Philanthropy, Winchester Hospital; LeighAnne Taylor, Regional Manager, Community Benefits and Community Relations Winchester Hospital; Christine Healey, Director of Community Benefits/Community Relations, Beth Israel Lahey Health; Karen Keaney, Associate Chief Nursing Officer, ED and Case Management; Deb McDonough, Winchester Hospital Board of Trustees; Jennifer Murphy, Director of Health, Winchester Health Department; Lauren Reid, Director of Community Programs, Mystic Valley Elder Services Adam Rogers, Executive Director, Boys & Girls Club of Stoneham & Wakefield; Kathy Schuler, Chief Operating Officer, Chief Nursing Officer, Winchester Hospital; Dean Solomon, Executive Director, Council of Social Concern, Woburn; Joseph Tarby, Winchester Hospital Board of Trustees; Matthew Woods, Vice President of Finance, Winchester Hospital; Angeline Brady, Community Health Programs Supervisor, Winchester Hospital Center for Healthy Living.

      This past year Winchester Hospital worked to have municipal leadership, regional planning, and primary care represented on its Community Benefits Advisory Committee. These sectors are represented by new CBAC members who include: Terri Marciello, Director, Wilmington Elderly Services; Sharon Ron, Senior Public Health and Regional Planner, Metropolitan Area Planning Commission; Marie Condon Walsh, Primary Care Physician, Medford Family Practice.

II. Community Engagement:

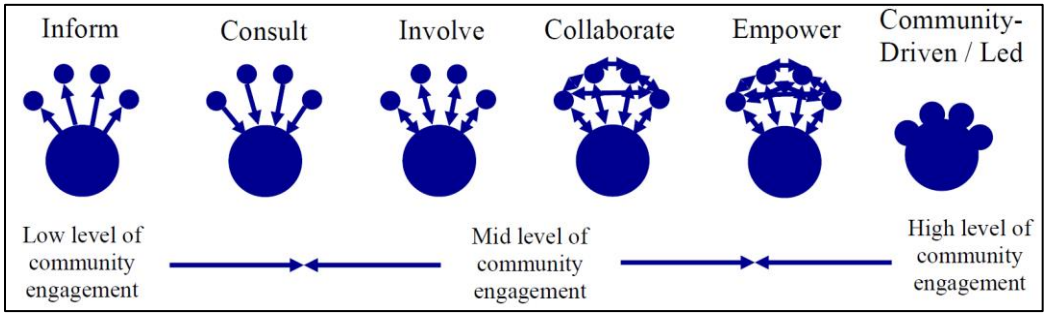
- If there have been any updates to the key partners with whom the hospital collaborates, please indicate in the table below. Please feel free to add rows as needed.

Organization	Name and Title of Key Contact	Organization Focus Area	Brief Description of Engagement
Boys & Girls Club of Stoneham & Wakefield	Adam Rogers, Executive Director	Social service organizations	Adam is a member of the CBAC, and provided input throughout the CHNA process and development of the IS. The BGC works collaboratively with Winchester Hospital in implementing programs that meet the priority needs identified in WH's FY19 CHNA. In addition, the BGC provided programs and services to address the urgent needs in the community in response to COVID-19.
Council of Social Concern, Woburn	Dean Solomon, Executive Director	Social service organizations	As a member of the CBAC, Dean provided input throughout the CHNA process, development of the IS, and provides ongoing input on community benefits programs and services. In addition, Winchester Hospital works collaboratively with the COSC to increase access to food for members of the community.
Woburn Public Schools	Mike Baldassare, Assistant Superintendent	Schools	As a member of the CBAC, Mike provided input throughout the CHNA process. With Winchester support, Woburn Public Schools initiated a Backpack Food Program in partnership with COSC to provide access to food for Woburn students and families who are experiencing food insecurity.
West Medford Community Center	Nathalie Jean, Executive Director	Other	The West Medford Community Center is a new partner for Winchester Hospital. WMCC provided input on our latest CHNA process and will be leading a youth mental health program with Winchester funding support.

- Please use the spectrum below from the Massachusetts Department of Public Health[1] to assess the hospital's level of engagement with the community in implementing its plan to

[1] "Community Engagement Standards for Community Health Planning Guideline," Massachusetts Department of Public Health, *available at*: http://www.mass.gov/eohhs/docs/dph/quality/don/guidelines-community-engagement.pdf. For a full description of the community engagement spectrum, see page 11 of the Attorney General's Community Benefits Guidelines for Non-profit Hospitals.

address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.



Category	**Level of Engagement**	**Did Engagement Meet Hospital's Goals?**	**Goal(s) for Engagement in Upcoming Year(s)**
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Collaborate	Yes	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Collaborate	Yes	Collaborate
Implementing Community Benefits programs	Collaborate	Yes	Collaborate
Evaluating progress in executing Implementation Strategy	Inform	Yes	Inform
Updating Implementation Strategy annually	Consult	Yes	Inform

- For categories where community engagement did not meet the hospital's goal(s), please provide specific examples of planned improvement for next year:

Winchester Hospital dedicated a great deal of time and resources at the local level in response to the COVID-19 global pandemic. Winchester Hospital was intentional when assessing risk factors within our CBSA and worked closely with our local health departments. Winchester Hospital worked to expand community testing access and worked with BILH as a system to develop and distribute written materials (in nine languages) to the communities most impacted by COVID-19, to help slow the spread. Winchester Hospital redeployed staff and procured tangible necessities for both the community at large and hospital staff, such as personal protective equipment (PPE), food, hand sanitizer, and other critical items. While in-person meetings were hindered in the community Winchester Hospital sought creative ways of engaging with our community, including the use of video conferencing for coalition meetings, supporting the purchasing of iPads for older adults who lacked technology access, and organizing a socially-distanced farmer's markets with a housing authority partner. Many of the programs highlighted in this report had to be modified significantly due to COVID-19 and related safety guidelines. In some cases, programs were expanded. In others, programs were cut or significantly reduced because of the pandemic.

- COVID Question: Please describe how the COVID-19 pandemic impacted the hospital's process for engaging its community and developing responsive Community Benefits programming.

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- Did the hospital hold a meeting open to the public (either independently or in conjunction with its CBAC or a community partner) at least once in the last year to solicit community feedback on its Community Benefits programs? If so, please provide the date and location of the event. If not, please explain why not.

Winchester Hospital held a public meeting in conjunction with its CBAC on September 30, 2021. Additionally, Winchester Hospital shared highlights of its Community Benefits program at meetings throughout its CBSA when engaging with the community during the triannual CHNA. The meeting was attended by more than 20 community members and organizations from all nine cities and towns in WH's CBSA. Information about the public meeting was shared with partnering coalitions, in community partner newsletters, and on the Winchester Hospital website and social media.

III. Updates on Regional Collaboration:

1. If the hospital reported on a collaboration in its **Year 1 Hospital Self-Assessment**, please briefly describe any updates to that collaboration, including any progress made and/or challenges encountered in achieving the goals of the collaboration.

Winchester Hospital is part of the Beth Israel Lahey Health (BILH) system community health planning process. In 2019, BILH formed a system-wide Community Benefits Committee (CBC). This Committee provides strategic direction for all 10 BILH hospitals and its affiliates and seeks to ensure that strategies are in place to meet the health care needs of at-risk, underserved, uninsured, and government payer patient populations in the communities. Under the direction of the BILH CBC, we collaborated on specific regionalized initiatives to address housing in stability and food security in our hospital CBSAs. The CBC was also involved in the design and kick-off of our triennial CHNA process this year, and is guiding our systematized approach for all 10 BILH hospital CHNAs.

2. If the hospital entered a regional collaboration in the past year, please provide the information requested of regional collaborations on p. 5 in the **Year 1 Hospital Self-Assessment Form.**
   Click or tap here to enter text.