Winchester Hospital
Implementation Strategy 2020 - 2022

Between November 2018 and August 2019, Winchester Hospital (WH) conducted a comprehensive Community Health Needs Assessment (CHNA) that included an extensive review of existing quantitative data as well as the collection of qualitative information through interviews, focus groups, community listening sessions, and a community health survey. A resource inventory was also completed to identify existing health-related assets and service gaps. This extensive array of assessment and community engagement activities allowed WH to collaborate with key health system partners across the region. During the CHNA process, WH also made substantial efforts to engage their own administrative and clinical staff, including senior leadership. A detailed review of the CHNA approach, data collection methods, and community engagement activities are included in WH's 2019 Community Health Needs Assessment report.

Throughout the CHNA process, WH's Community Relations staff worked with the hospital's Community Benefits Advisory Committee (CBAC), composed of senior leadership from the hospital and community stakeholders/service providers to:

- Present quantitative and qualitative findings
- Prioritize community health issues and vulnerable populations
- Review existing community benefits programming
- Develop WH's 2020 – 2022 Implementation Strategy

The authorized body of Winchester Hospital – the Board of Trustees – approved this Community Benefits Needs Assessment and adopted the Implementation Strategy on September 17, 2019.

IMPLEMENTATION STRATEGY PLANNING PRINCIPLES AND STATE PRIORITIES

In developing the Implementation Strategy, care was taken to ensure that WH's community health priorities were aligned with priority areas determined by the Massachusetts Department of Public Health (MDPH) and the Massachusetts Attorney General's Office (MA AGO). In addition to the four priority areas, MDPH identified six health priorities to guide investments funded through Determination of Need processes. The MDPH and the MA AGO encourage hospitals to consider these priorities during the community benefits planning process.

Table 1: Massachusetts Department of Health and Attorney General Priority Areas

Community Benefits Priorities	Determination of Need Priority Areas
Chronic disease with a Focus on Cancer, Heart Disease, and Diabetes	Built Environment
Housing Stability/Homelessness	Social Environment
Mental Illness and Mental Health	Housing
Substance Use Disorders	Violence
	Education
	Employment

The following are a range of programmatic ideas and principles that are critical to community health improvement and have been applied in the development of the Implementation Strategy provided below.

- **Social Determinants of Health:** With respect to community health improvement, especially for low income and disadvantaged populations, there is growing appreciation for the importance of addressing the underlying social determinants of health. These social determinants have been defined as "the conditions in which people are born, grow, live, work and age that may limit access, lead to poor health outcomes, and are at the heart of health inequities between and within communities."[1] The leading social determinants of health include issues such as poverty, housing, food access, violence, racism/bigotry, and transportation. It is important that hospital Implementation Strategies include collaborative, cross-sector initiatives that address these issues.

- **Health Education and Prevention:** Primary prevention aims to prevent disease or injury before it ever occurs by reducing risks, preventing exposures to hazards, or altering unhealthy behaviors that can lead to disease or injury. Secondary and tertiary prevention aims to reduce the impact of chronic disease or health conditions through early detection as well as behavior change and chronic disease management geared to

[1] O. Solar and A. Irwin, World Health Organization, "A Conceptual Framework for Action on the Social Determinants of Health," Social Determinants of Health Discussion Paper 2 (Policy and Practice), 2010, available at http://www.who.int/social_ determinants/corner/SDHDP2.pdf.

helping people to manage health conditions, lessen a condition's impact, or slow its progress. Targeted efforts across the continuum to raise awareness about a particular condition, educate people about risk factors and protective factors, change unhealthy behaviors, and manage illness are critical to improving health status.

- **Screening and Referral:** Early identification of those with chronic and complex conditions following by efforts to ensure that those in need of education, further assessment, counseling, and treatment are critical to preventing illness before it takes hold or managing illness so as to lessen or slow its impacts. A critical component of screening and referral efforts is taking steps to ensure that people are fully engaged in treatment, including linkages to a primary care provider.

- **Chronic Disease Management:** Learning how to manage an illness or condition, change unhealthy behaviors, and make informed decisions about health allow individuals to lead healthier lives. Evidence-based chronic disease management or self-management education programs, implemented in community-based setting by clinical and non-clinical organizations, can help people learn skills to manage their health conditions, improve eating and sleeping habits, reduce stress, maintain a healthy lifestyle.

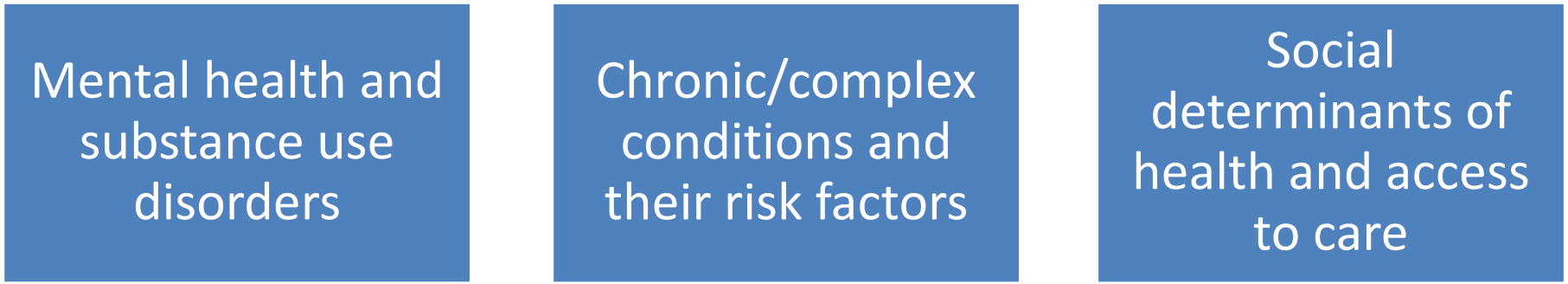
- **Care Coordination and Service Integration:** Efforts to coordinate care and integrate services across the health care continuum are critical to community health improvement. These efforts involve bringing together providers and information systems to coordinate health services, patient needs, and information. This helps better achieve the goals of treatment and care.

- **Patient Navigation and Access to Health Insurance:** One of the most significant challenges that people face in caring for themselves or their families is finding the services they need and navigating the health care system. Having health insurance that can help people to pay for needed services is a critical first step. The availability of health coverage/insurance enrollment support, patient navigation, and resource inventories are important aspects of community health improvement.

- **Cross-Sector Collaboration and Partnership:** When it comes to complex social challenges, such as community health improvement, there is a clear consensus that success will only be achieved through collective action, partnership, and collaboration across organizations and health-related sectors. No one organization or even type of organization can have a sustained impact on these types of issues on their own. Hospital Implementation Strategies must be collaborative and include partnerships with service providers across multiple sectors (e.g., health, public health, education, public safety).

COMMUNITY HEALTH PRIORITY AREAS

WH's CHNA and strategic planning process provided many opportunities to vet the quantitative and qualitative data compiled during the assessment. Based on this process, the WH's CBAC and Community Relations staff identified three community health priority areas, which together embody the leading health issues and barriers to care for residents of WH's service area:



Community Health Needs Not Prioritized by WH

It is important to note that there are community health needs that were identified by WH's assessment that were not prioritized for inclusion in the implementation strategy for a number of reasons:

- Feasibility of WH having an impact in the short- or long-term
- Limited burden on residents of service area
- The issue is currently being addressed by community partners in a way that does not warrant additional support

Namely, walkability of streets was identified as a community health issue, but this issue was deemed by the CBAC to be outside of WH's primary sphere of influence. This is not to say that WH will not support efforts in this area; the hospital remains open and willing to work with hospitals across Beth Israel Lahey Health's network and with other public and private partners, such as town administrators, to address this issue collaboratively.

PRIORITY POPULATIONS

WH is committed to improving the health status and well-being of all residents living throughout its service area. However, in recognition of the considerable health disparities that exist in some communities, WH focuses the bulk of its community benefits resources on improving the health status of underserved populations. The CBAC voted to prioritize the populations listed below:

IMPLEMENTATION STRATEGY DETAILS

The grid below provides details on WH's goals, priority populations, objectives, activities, and sample measures to track progress and outcomes, and potential partners. It is also noted when WH objectives align with state community health priorities. WH looks forward to working towards these goals in collaboration with community partners in the years to come.

PRIORITY AREA 1: MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Description: As it is throughout the Commonwealth and the nation, the burden of mental and substance use on individuals, families, communities and service providers in WH's community benefit service area is overwhelming. Nearly every key informant interview, focus group, and listening session included discussions on these topics. From a review of the quantitative and qualitative information, depression, anxiety/stress, and social isolation were the leading issues around mental health. There were particular concerns regarding the impact of depression and anxiety for youth and social isolation amongst older adults. Despite increased community awareness and sensitivity about the underlying issues and origins of mental health issues, there is still a great deal of stigma related to these conditions.

Substance use disorder, often co-morbid condition with mental health, has impacts on individuals, families, and communities. The opioid epidemic continues to be an area of focus, even as the number of opioid deaths across the Commonwealth declines. Beyond opioids, key informants were also

concerned with alcohol misuse, changing community norms in light of the legalization of recreational marijuana use, and e-cigarette/vaping amongst adolescents. Many individuals characterized e-cigarette and vaping as an epidemic, with a need for education, prevention, and treatment services.

WH is committed to promoting education and prevention efforts, increasing the number of individuals who are screened and referred to appropriate services, reducing structural barriers to treatment, and maintaining the high-quality treatment services that it provides. Hospital staff and leadership will continue to be leaders and conveners in promoting collaboration and sharing knowledge with community-based partners. The hospital is also committed to improving access to treatment and support services through their Community Benefit activities.

Resources/Financial Investment: WH will commit direct community health program investments and in-kind resources of staff time and materials. WH will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services, as well as on behalf of its community partners.

Goal #1: Address the prevalence and impact, stigma, risk/protective factors, and access issues associated with mental health and substance use disorder					
Target Population(s)	**Objective(s)**	**Activities**	**Sample Measure(s)**	**Potential Partner(s)**	**State Priority Area**
• Older adults • Individuals with chronic/complex conditions • Low-resource individuals and families • Youth and adolescents	Reduce isolation and depression	Organize and/or support initiatives that increase opportunities for social engagement (e.g. Senior Outreach Initiative, Senior Volunteer Opportunities, etc.)	# of participants # of individuals served/reached # of events/programs held # of staff trained # of task forces/organizations involved with # of meetings attended # of linkages and/or referrals made Pre/post tests to measure changes in knowledge, behaviors,	Elder services providers Local councils on aging Local boards of health Volunteer Services	Mental Illness and Mental Health Social Environment
	Reduce environmental risk factors associated with developing mental health issues	Organize and/or support initiatives that reduce environmental risk factors associated with developing mental health issues such as hoarding, etc. (e.g. Safe Home Initiative)		Elder services providers Local councils on aging Local boards of health Local police/fire	Mental Illness and Mental Health Built Environment Social Environment
	Promote collaboration, share knowledge, and coordinate activities with internal colleagues and external partners	Support and/or participate in task forces and community collaboratives that discuss strategies to address mental health/substance use issues		Regional/local SUD task forces Middlesex DA Office Local public health coalitions	Mental Illness and Mental Health Substance Use Disorder

Goal #1: Address the prevalence and impact, stigma, risk/protective factors, and access issues associated with mental health and substance use disorder					
Target Population(s)	**Objective(s)**	**Activities**	**Sample Measure(s)**	**Potential Partner(s)**	**State Priority Area**
	Increase awareness of the impacts and risk factors for developing substance use disorders	Organize and/or support community based initiatives that increase awareness, prevent, and/or identify individuals at risk for developing substance use disorders, including vaping. (e.g. Boys & Girls Club SBIRT)	feelings and/or motivation level.	Regional/local SUD task forces Elder services providers Local boards of health Local youth organizations Local police/fire/schools	Substance Use Disorders
	Increase awareness of the signs, symptoms, risks, and stigma of developing mental health issues and promote access to treatment	Organize and/or support initiatives in clinical and community based settings that reduce stigma, increase awareness about the signs and symptoms of mental health issues and/or identify individuals at risk for developing mental health issues and refer to treatment (e.g. Boys & Girls Club SBIRT, Mobile Mental Health Program)		Local public health coalitions Elder services providers Local boards of health Local youth organizations local police/fire Local schools	Mental Illness and Mental Health
	Increase access to appropriate mental health and substance use treatment and support services	1. Enhance access to integrated behavioral health services 2. Provide support/referrals to individuals with mental health and/or substance use issues within the Emergency Department		Primary Care Practices Emergency Department Lahey Health Behavioral Services	Mental Illness and Mental Health Substance Use Disorders

PRIORITY AREA 2: CHRONIC/COMPLEX CONDITIONS AND RISK FACTORS

Description: Heart disease, stroke and cancer continue to be the leading causes of death in the nation and the Commonwealth, and produce a significant burden on communities. Approximately six in ten deaths can be attributed to these three conditions combined. If you include respiratory disease (e.g., asthma, COPD) and diabetes, which are in the top 10 leading causes across all geographies, then one can account for the vast majority of causes of death.

Many of the risk factors for these conditions are the same – physical inactivity, poor nutrition, obesity, and tobacco/alcohol use. WH has a long history of working with community partners to create awareness and education of these risk factors and their link to chronic and complex health conditions. The hospital will continue to support programs that provide opportunities for people to access low-cost healthy foods opportunities for safe and affordable

physical activity. Beyond addressing the risk factors, WH is also committed to supporting individuals and caregivers throughout the service area to engage in chronic disease management programs, supportive services (e.g., integrative therapies, support groups), and providing linkages to care.

Resources / Financial Investment: WH will commit direct community health program investments and in-kind resources of staff time and materials. WH will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services, as well as on behalf of its community partners.

Goal #1: Prevent, detect and manage chronic disease and complex conditions and enhance access to treatment and support services					
Target Population(s)	**Objective(s)**	**Activities**	**Sample Measure(s)**	**Potential Partner(s)**	**State Priority Area**
• Older adults • Individuals with chronic/complex conditions • Low-resource individuals and families • Youth and Adolescents	Create awareness of/educate community members about the preventable risk factors associated with chronic and complex health conditions	Organize and/or support programs and activities in clinical or community based settings to provide education (e.g. Breast Cancer Education & Outreach, Stroke Awareness, Back to School event)	# of participants # of individuals or families served/reached # of events/programs held # of linkages and/or referrals made # of consultations # of items provided # of treatments provided Pre/post tests of knowledge, ability to manage condition, quality of life Pre/post tests of ability to perform daily activities, energy level, mood, pain, stress	American Cancer Society Breast Care Center Center for Healthy Living Local boards of health Local councils on aging	Chronic Disease
	Help community members detect chronic disease and provide linkages to associated services	Organize and/or support health screenings in clinical or non-clinical settings to detect chronic/complex conditions and refer to and/or coordinate care (e.g. Breast Cancer Risk Assessment, Home Blood Draw Program)		WH Breast Care Center American Cancer Society Lab Services Department	Chronic Disease
	Engage individuals in evidence-based/evidence-informed programs that help them better manage their chronic disease	Organize and/or support programs and activities that refer, educate and support individuals in better managing their chronic/complex conditions (e.g. Chronic Disease Management Program, CHAMP Pediatric Asthma Program, Fighting Fatigue, etc.)		Center for Healthy Living Local schools Elder services providers	Chronic Disease

Goal #1: Prevent, detect and manage chronic disease and complex conditions and enhance access to treatment and support services					
Target Population(s)	**Objective(s)**	**Activities**	**Sample Measure(s)**	**Potential Partner(s)**	**State Priority Area**
	Educate individuals about achieving a healthy diet	Organize and/or support programs in clinical and non-clinical settings that educate on how to choose and/or prepare healthy foods (e.g. Nutrition Community Education, HMR Weight Management Program, Healthy State website)		Center for Healthy Living Local boards of health Local councils on aging Local schools Local food assistance programs Elder services providers	Chronic Disease
	Increase access to supportive services that reduce the stress and anxiety associated with chronic illness	Provide or support programs and services that help individuals and family members alleviate the burden(s) associated with chronic/complex conditions (e.g. Support Groups, A Caring Place wig donation, , Heidbreder Comfort Fund, Mount Vernon Lifeline Program, Mount Vernon Resident Health Program, Integrative Therapies for Cancer Patients, Patient Navigators, etc.)		Center for Healthy Living Mount Vernon House Philips Lifeline Local councils on aging Elder services providers Oncology Department American Cancer Society	Chronic Disease

PRIORITY AREA 3: SOCIAL DETERMINANTS OF HEALTH AND ACCESS TO CARE

Description: A dominant theme from the assessment was the tremendous impact that the social determinants of health, particularly financial insecurity, adequate health insurance coverage, housing, transportation, and access to healthy foods have on residents within WH's CBSA. The social determinants of health are often the drivers or underlying factors that create or exacerbate mental health issues, substance misuse, and chronic/complex conditions. These social determinants of health, particular financial insecurity, also underlie many of the access to care issues that were prioritized in the assessment: navigating the health system (including health insurance), chronic disease management, and affording care.

WH is committed to addressing social determinants and breaking down barriers to care. The hospital will continue to collaborate with community-based organizations to engage individuals in services, reduce financial burdens, increase access to appropriate prevention and primary care services, and support

healthy families and communities. WH is also committed to developing relationships with community partners and organizations that address issues associated with housing instability.

Resources / Financial Investment: WH will commit direct community health program investments and in-kind resources of staff time and materials. WH will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services, as well as on behalf of its community partners.

Goal #1: Address social determinants of health and barriers to care					
Target Population(s)	***Objective(s)***	***Activities***	***Sample Measure(s)***	***Potential Partner(s)***	***State Priority Area***
• Older adults • Individuals with chronic/complex conditions • Low-resource individuals and families • Youth and adolescents	Increase access to affordable and safe transportation options	Provide support for programs/initiatives that address issues associated with transportation (e.g. Transportation Program, Jenks Senior Center Van, etc.)	# of participants # of individuals served/reached # of meals provided # of sessions held # of individuals enrolled in health insurance # of consultations provided # of volunteers trained Assistance provided ($ amount) Pre/post tests of mobility, flexibility, pain, stress Pre/post tests of knowledge, confidence, ability to care for child # of community events where community resources were shared/distributed # of community partners/staff members resources was distributed to	Local councils on aging Elder services providers Regional/local task forces Checker Cab Woburn	Built Environment
	Educate providers and community members about hospital and/or public assistance programs that can help them identify and enroll in appropriate health insurance plans and/or reduce their financial burden	Provide counseling, support, and referral services to community members to enroll and remain in appropriate programs (e.g. financial counseling, SHINE program)		WH Financial Services Elder services providers Primary care physicians	Access to Care
	Enhance awareness about hospital/community resources that address health issues and social determinants of health	Distribute information at community events and to physicians, clinical staff, and community partners.		Elder services providers Physicians, case managers, and clinical staff Faith based organizations Local schools Food assistance programs ACOs	Access to Care Built Environment Social Environment Mental Illness and Mental Health Substance Use

Goal #1: Address social determinants of health and barriers to care					
Target Population(s)	***Objective(s)***	***Activities***	***Sample Measure(s)***	***Potential Partner(s)***	***State Priority Area***
	Explore ways to reduce/address housing instability	Develop relationships with community partners and organizations that address issues associated with housing instability (e.g. Co-location Program)		Metro Housing Boston Faith based organizations Local housing authorities	Housing Stability
	Increase access to clinical services for homebound patients	Provide or support programs/initiatives that enhance access to clinical services (e.g. Home Blood Draw Program)		WH Lab Services	Chronic Disease
	Increase access to affordable and nutritious foods and affordable physical activity	Organize and/or support programs that provide access to free or low-cost healthy foods and physical activity (e.g. Food Insecurity Relief Initiative, Farmers Markets, Meals on Wheels, Chair Yoga for Seniors)		Metro Housing Boston Local food assistance programs Faith based organizations	Chronic Disease Social Environment
	Increase awareness about how to create a healthy and safe environment for babies and families, and promote healthy child development	Organize and/or support programs that promote a healthy and safe environment and/or foster healthy growth and development for infants and babies (e.g. Lactation Consultation Program, Safe Sleep Initiative, Read to Me Program, Cuddler Program, etc.)		WH Maternal Health Middlesex District Attorney	Social Environment Built Environment