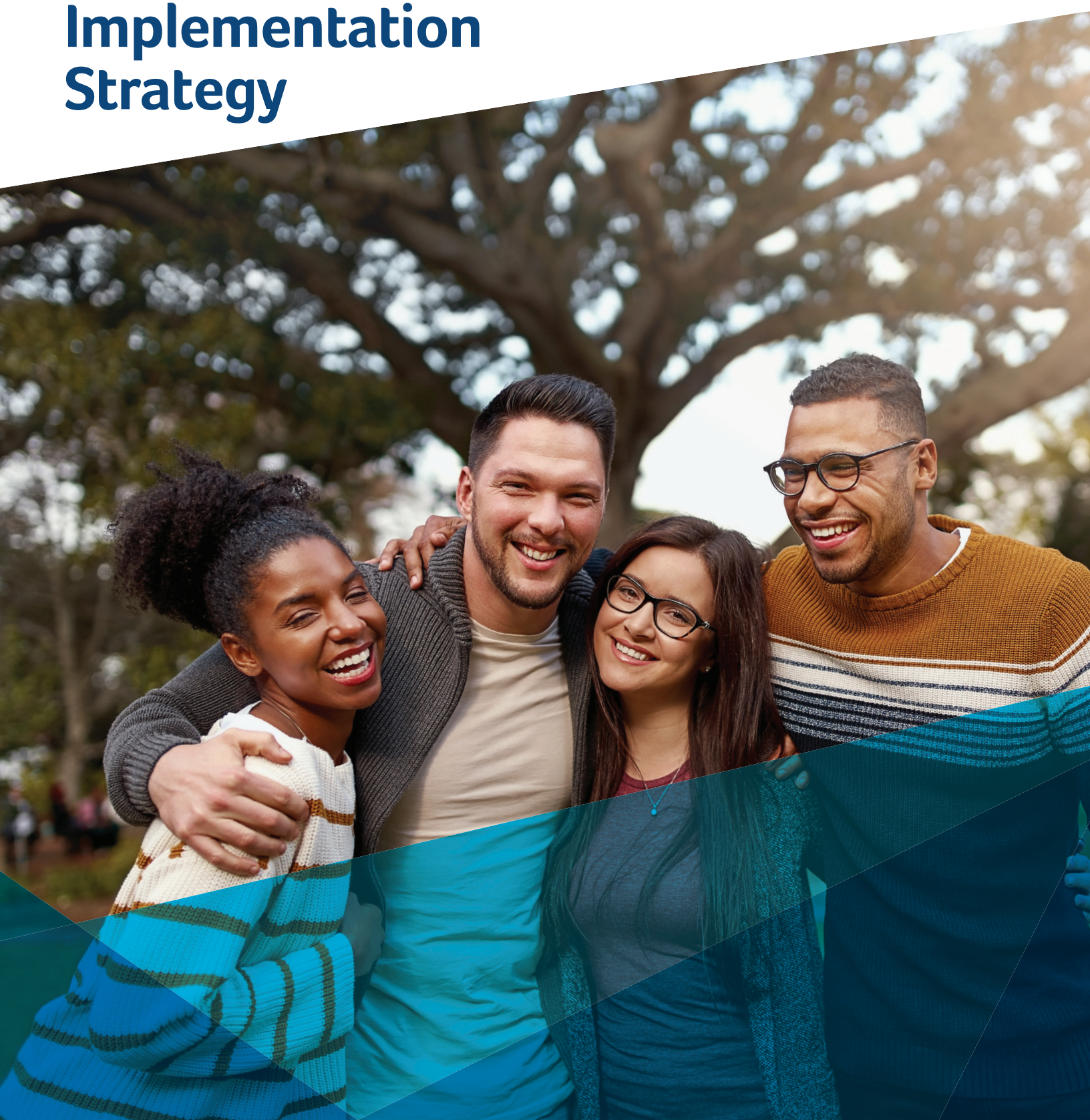
Beth Israel Lahey Health
Winchester Hospital

FY23-FY25 Implementation Strategy



Implementation Strategy

About the 2022 Hospital and Community Health Needs Assessment Process

Winchester Hospital (WH), founded in 1912, is a 229-bed community hospital located in Winchester, Massachusetts, that serves nearly half a million people a year and is one of the leading providers of comprehensive health care services in the area northwest of Boston. In addition to acute-care inpatient services, WH provides an extensive range of primary care, outpatient medical, surgical, and obstetrical services as well as specialized care in bariatrics, cardiology, cardiac surgery, orthopedics, neurology, vascular surgery, and oncology. WH's mission is "To Care. To Heal. To Excel. In Service to Our Community."

The Community Health Needs Assessment (CHNA) and planning work for this 2022 report was conducted between September 2021 and September 2022. In conducting this assessment and planning process, it would be difficult to overstate WH's commitment to community engagement and a comprehensive, data-driven, collaborative, and transparent assessment and planning process. WH's Community Benefits staff and Community Benefits Advisory Committee (CBAC) dedicated hours to ensuring a sound, objective, and inclusive process. This approach involved extensive data collection activities, substantial efforts to engage WH's partners and community residents, and a thoughtful prioritization, planning, and reporting process. Special care was taken to include the voices of community residents who have been historically underserved, such as those who are unstably housed or homeless, individuals who speak a language other than English, those who are in substance use recovery, and those who experience barriers and disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

WH collected a wide range of quantitative data to characterize the communities served across its Community Benefits Service Area (CBSA). The hospital also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data were collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs of specific communities. The data were tested for statistical significance whenever possible and compared against data at the regional, Commonwealth and national level to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments, and other sources. Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing cohorts most at-risk, and crafting a collaborative, evidence-informed IS. Between October 2021 and February 2022, the hospital conducted 21 one-on-one interviews with key collaborators in the community, facilitated three focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 800 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 1,000 community residents, clinical and social service providers, and other key community partners.

Prioritization and Implementation Strategy Process

Federal and Commonwealth community benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its IS. By analyzing assessment data, hospitals can identify the health issues that are particularly problematic and rank these issues in order of priority. Accordingly, using an interactive, anonymous polling software, WH's CBAC and community residents, through the community listening sessions, formally prioritized the community health issues and cohorts that they believed should be the focus of WH's IS. This prioritization process helps to ensure that WH maximizes the impact of its community benefits resources and its efforts to improve health status, address disparities in health outcomes, and promote health equity.

The process of identifying the hospital's community health issues and prioritized cohorts is also informed by a review and careful reflection on the Commonwealth's priorities set by the Massachusetts Department of Public Health's Determination of Need process and the Massachusetts Attorney General's Office.

WH's IS is designed to address the underlying social determinants of health and barriers to accessing care, as well as promote health equity. The content addresses the leading community health priorities, including activities geared toward health education and wellness (primary

prevention), identification, screening, referral (secondary prevention) and disease management and treatment (tertiary prevention).

The following goals and strategies are developed so that they:

- Address the prioritized community health needs and/or populations in the hospital's CBSA.
- Provide approaches across the up-, mid-, and downstream spectrum.
- Are sustainable through hospital or other funding.
- Leverage or enhance community partnerships.
- Have potential for impact.
- Contribute to the systemic, fair and just treatment of all people.
- Could be scaled to other BILH hospitals.
- Are flexible to respond to emerging community needs.

Recognizing that community benefits planning is ongoing and will change with continued community input, WH's IS will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies, and other issues that may arise, which may require a change in the IS or the strategies documented within it. WH is committed to assessing information and updating the plan as needed.

Community Benefits Service Area

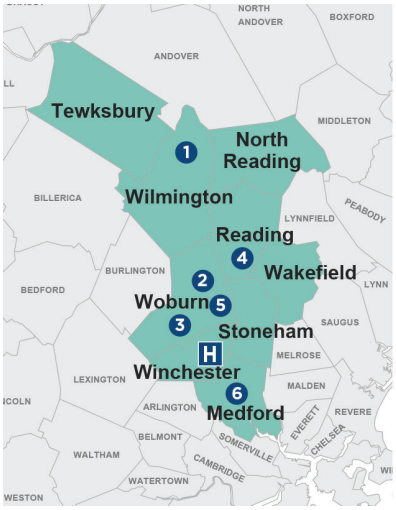
WH's CBSA includes the nine municipalities of Medford, North Reading, Reading, Stoneham, Tewksbury, Wakefield, Wilmington, Winchester, and Woburn located in northwest suburban Boston, Massachusetts. These cities and towns are diverse with respect to demographics (e.g., age, race, and ethnicity), socioeconomics (e.g., income, education, and employment), and geography (e.g., urban, suburban). There is also diversity with respect to community needs.

There are segments of the WH's CBSA population that are healthy and have limited unmet health needs, and other segments that face significant disparities in access, underlying social determinants, and health outcomes. WH is committed to promoting health, enhancing access, and delivering the best care to all who live and/or work in its CBSA, regardless of race, ethnicity, language spoken, national origin, religion, gender identity, sexual orientation, disability status, immigration status, or age. WH is equally committed to serving all patients, regardless of their health, socioeconomic status, insurance status, and/or their ability to pay for services.

WH's CHNA focused on identifying the leading community health needs and priority cohorts living and/or working within its CBSA. In recognition of the health disparities that exist for some residents, WH focuses the bulk of its community benefits resources on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved. By prioritizing these cohorts, WH is able to promote health and well-being, address health disparities, and maximize the impact of its community benefits resources.

Prioritized Community Health Needs and Cohorts

WH is committed to promoting health, enhancing access, and delivering the best care for those in its CBSA. Over the next three years, the hospital will work with its community partners to develop and/or continue programming geared to improving overall well-being and creating a healthy future for all individuals, families, and communities. In recognition of the health disparities that exist for certain segments of the population, investments and resources will focus on improving the health status of the following priority cohorts within the community health priority areas.



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Community Benefits Service Area

- H Winchester Hospital
- 1 Winchester Hospital Family Medical Center
- 2 Winchester Hospital Imaging/Walk-In Urgent Care
- 3 Winchester Hospital Orthopedics Plus at Choate Medical Center
- 4 Imaging at Reading Health Center
- 5 Winchester Hospital Outpatient Center
- 6 Winchester Hospital Community Health Institute Weight Management Program and Diabetes Center

WH Priority Cohorts

Youth

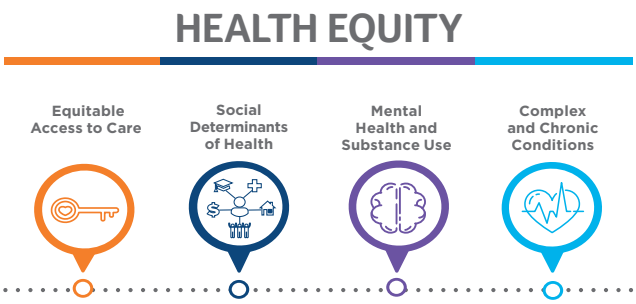
Low-Resourced Populations

Older Adults

Racially, Ethnically and Linguistically Diverse Populations

LGBTQIA+

WH Community Health Priority Areas



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 investment or included in WH's IS. Specifically, supporting education across the lifespan and strengthening the built environment (i.e., improving roads/sidewalks and enhancing access to safe recreational spaces/activities) were identified as community needs but were not included in WH's IS. While these issues are important, WH's CBAC and senior leadership team decided that these issues were outside of the organization's sphere of influence and investments in others areas were both more feasible and likely to have greater impact. As a result, WH recognized that other public and private organizations in its CBSA and the Commonwealth were better positioned to focus on these issues. WH remains open and willing to work with community residents, other hospitals, and other public and private partners to address these issues, particularly as part of a broad, strong collaborative.

Community Health Needs Addressed in WH's IS

The issues that were identified in the WH CHNA and are addressed in some way in the hospital IS are housing issues, transportation, climate change, economic insecurity, build capacity of workforce, navigation of healthcare system, linguistic access barriers, diversify provider workforce, education on domestic violence, diversifying community leadership, cost and insurance barriers, youth mental health, stress, anxiety, depression, isolation, mental health stigma, racism/discrimination, culturally appropriate/competent health and community services, cross sector partnerships/collaboration/responses, linguistic access/barriers to community resources/services, substance use stigma, substance use outreach/education/prevention, services to support long-term recovery, and opioid use/misuse.

Implementation Strategy Details

Priority: Equitable Access to Care

Individuals identified a number of barriers to accessing and navigating the health care system. Many of these barriers are at the system level and stem from the way in which the system does or does not function. System-level issues include providers not accepting new patients, long wait lists, and an inherently complicated health care system that is difficult for many to navigate.

There are also individual-level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forgo or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.

Resources/Financial Investment: WH expends substantial resources on its community benefits program to achieve the goals and objectives of its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by WH and/or its partners to improve the health of those living in its CBSA. Additionally, WH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, WH supports residents in its CBSA by providing "charity" care to individuals who are low-resourced and are unable to pay for care and services. Moving forward, WH will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

Goal: Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic, and economic barriers.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Promote access to health care, health insurance, patient financial counselors, and needed medical services for patients who are uninsured or underinsured.	• Low-resourced populations • Racially, ethnically, and linguistically diverse populations	• Patient financial counselors • Home Blood Draw program • Serving the Health Insurance Needs of Everyone (SHINE) Program • Primary Care Support	• # patients and clients assisted and their demographics • # referrals to services • participant responses to Social Determinants of Health Screening tool	• Minuteman Senior Services • BILH Primary Care	Economic stability
Promote equitable care, health equity, health literacy for patients, especially those who face cultural and linguistic barriers.	• Racially, ethnically, and linguistically diverse populations • LGBTQIA+	• Interpreter Services	• # of patients assisted • # of languages provided	WH Interpreter Services Department	Not Applicable

Goal: Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic, and economic barriers.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Reduce barriers to care by providing/ supporting free or reduced cost transportation for homebound residents needing care.	• Low-resourced populations • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	• Medical appointment transportation voucher program • Jenks Center transportation program	• # patients assisted • # rides provided	• Woburn Checker Cab • Jenks Center	Transportation
Provide and promote career support services and career mobility programs to hospital employees.	WH employees	• Career and academic advising • Hospital-sponsored community college courses • Hospital-sponsored English Speakers of Other Languages (ESOL) classes	• # of employees who participated	BILH Workforce Development	Economic stability

Priority: Social Determinants of Health

The social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions influence and define the quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to housing, food insecurity, economic insecurity, education, and other important social factors.

There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, listening sessions, and the BID Needham Community Health Survey reinforced that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, food insecurity/nutrition, transportation, and economic instability.

Resources/Financial Investment: WH expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by WH and/or its partners to improve the health of those living in its CBSA. Additionally, WH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, WH supports residents in its CBSA by providing "charity" care to individuals who are low-resourced who are unable to pay for care and services. Moving forward, WH will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

Goal: Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Support education, systems, programs, and environmental changes to increase healthy eating and access to affordable, healthy foods.	• Youth • Low-resourced populations • Racially, ethnically, and linguistically diverse populations	• Council of Social Concern food pantry program • Woburn Public Schools Backpack Food Program • Winchester Housing Authority free farmer's market • Farmer's market SNAP Gap matching funds and programs • Winchester Hospital Meals on Wheels Program	• # clients assisted and their demographics • # pounds of food served • # of residents reached • # of meals prepared	• Council of Social Concern • Woburn Public School System • Winchester Housing Authority • Area Farmer's Markets • City of Medford • Jenks Center • Local Councils on Aging • New Entry Sustainable Farming Project	Chronic & Complex Conditions
Support impactful programs that stabilize or create access to affordable housing.	Low-resourced populations	Metro Housing Boston housing security and stability program	• # clients assisted and their demographics • # of referrals made • # of Families prevented from homelessness	Metro Housing Boston	Not Applicable

Goal: Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Support impactful programs that address issues associated with the social determinants of health.	• Youth • Low-resourced populations • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	• Provide community grants to address emerging needs	• # of grantees • Length of grant period • # of new partnerships established • $ amount invested • Grant outcomes	To be identified	Not Applicable
Participate in multi-sector community coalitions to convene stakeholders to identify and advocate for policy, systems, and environmental changes to address the social determinants of health.	• Youth • Low-resourced populations • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	• Network for Social Justice Housing Coalition • Medford Food Policy Council • Middlesex Regional Food Security Coalition	• Hospital representation on community coalitions • Support of coalition-sponsored policy, system, and environmental changes • # of policies considered • # of policies adopted	• Network for Social Justice • City of Medford • Local and regional elected officials	Not Applicable

Priority: Mental Health and Substance Use

Anxiety, chronic stress, depression, and social isolation were leading community health concerns. There were specific concerns about the impact of mental health issues on youth and young adults, and social isolation among older adults. These difficulties were exacerbated by COVID-19.

In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services. Interviewees, focus group, and community listening session participants also discussed the stigma, shame, and isolation that those with mental health challenges face that limit their ability to access care and cope with their illness.

Substance use continued to have a major impact on the CBSA; the opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities, including mental health, housing, and homelessness. Interviewees, focus groups, and community listening session participants engaged in the assessment identified stigma as a barrier to treatment and reported a need for programs that address common co-occurring issues (e.g., mental health issues, homelessness). Those participating in interviews, focus groups, listening sessions, and other meetings also reflected on the need for transitional housing and other recovery support services.

Resources/Financial Investment: WH expends substantial resources on its community benefits program to achieve the goals and objectives of its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by WH and/or its partners to improve the health of those living in its CBSA. Additionally, WH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, WH supports residents in its CBSA by providing "charity" care to individuals who are low-resourced who are unable to pay for care and services. Moving forward, WH will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Support impactful programs that promote healthy development, support children, youth, and their families, and increase their resiliency, coping, and prevention skills.	• Youth • Low-resourced populations • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	School-based mental health and substance use prevention programs and after school youth programs	• # participating students • Self-reported changes in knowledge and behaviors	Public school systems	Equitable access to care
Build the capacity of the community to understand the importance of mental health and availability of services, and reduce negative stereotypes, bias, and stigma around mental illness and substance use.	• Youth • Low-resourced populations • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	Screening, Brief Intervention, Referral to Treatment (SBIRT) & Question, Persuade, Refer (QPR) programs at Boys and Girls Club of Stoneham & Wakefield	• # staff trained • # referrals made • # youth matched to treatment • # youth matched to mentors	Boys and Girls Club of Stoneham & Wakefield	Equitable access to care

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Provide access to high-quality and culturally and linguistically appropriate mental health and substance use services through screening, monitoring, counseling, navigation, and treatment.	• Low-resourced populations • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	• Centralized Bed Management • Detoxification Services • Behavioral Health Emergency Department technicians • BILH Collaborative Care Model • Mobile Mental Health Clinic • Mystic Valley Elder Services (MVES) •	• # of patients served • # of therapy sessions • # of integrated behavioral health consultations • # of practices	• Winchester affiliated primary care practices • Winchester Emergency Department • BILH Behavioral Health Services • Mystic Valley Elder Services	Equitable access to care
Support a model that spans the continuum of care from inpatient to outpatient and community initiatives that identify and address mental health needs and substance use disorders.	• Youth • Low-resourced populations • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	• Healing and Recovering Together (HART) House Tewksbury • Transitional Support Services - Tewksbury • Town of Winchester social worker • Council on Aging programs for older adults mental health promotion and substance use prevention • Interface Referral Service – Winchester and Stoneham • Provide community health grants to address this need	• # participants and their demographics • # of referrals made • Self-reported changes in mood and behavior • # of police officers who complete 40-hour Crisis Intervention Training • Top reasons for referral • Caller demographics • Amount awarded • # of grantees • Length of grant period • # of new partnerships established	• HART House • Local Councils on Aging • Town of Winchester • Town of Stoneham	Equitable access to care

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Participate in multi-sector community coalitions to identify and advocate for policy, systems, and environmental changes that reduce and prevent substance use and promote mental health.	• Youth • Low-resourced populations • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	• Mystic Valley Public Health Committee • Mystic Valley Behavioral Health Coalition • Middlesex District Attorney (DA) Opioid Task Force • Local substance use prevention coalitions	• Hospital participation in coalition meetings • Support of coalition-sponsored policy, system, and environmental changes • # of new partnerships established • # of policies considered • # of policies adopted • Programs offered	• Mystic Valley Public Health Committee staff lead, based in Medford Public Health Department • Tufts Medicine • Melrose Wakefield Hospital • Middlesex DA	Not Applicable

Priority: Chronic and Complex Conditions

Chronic conditions such as cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease contribute to 56% of all mortality in Massachusetts and over 53% of all health care expenditures ($30.9 billion a year). Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

Resources/Financial Investment: WH expends substantial resources on its community benefits program to achieve the goals and objectives in its IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by WH and/or its partners to improve the health of those living in its CBSA. Additionally, WH works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, WH supports residents in its CBSA by providing "charity" care to individuals who are low-resourced and are unable to pay for care and services. Moving forward, WH will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

Goal: Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications, and other resources.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Provide preventive health information, services, and support for those at risk for complex and/or chronic conditions and support evidence-based chronic disease treatment and self-management programs.	• Low-resourced population • Racially, ethnically, and linguistically diverse populations • LGBTQIA+ • Youth	• Breast Cancer Risk Assessment • Oncology Nurse Navigator • Center for Healthy Living Health Education Programs • CHAMP Pediatric Asthma program • Fighting Fatigue Program • A Caring Place wig donation program • Mount Vernon House Resident Health Program • Patient support groups	• # clients assisted and their demographics • changes in health status • self-reported changes in knowledge and behavior • # of support group meetings • # of support group participants • Staff time	• Winchester Hospital Center for Healthy Living • Mount Vernon House • Winchester Center for Cancer Care	Equitable Access to Care
Support community-based programs that increase access to free or low-cost health-promoting supports to prevent chronic disease.	• Youth • Low-resourced populations • Racially, ethnically, and linguistically diverse populations • LGBTQIA+	• Integrative Therapies for Cancer Patients • Outpatient Lactation Program • Diabetes Management Program monthly clinic	• # clients assisted and their demographics • Changes in health status • Self-reported changes in knowledge and behavior	• Winchester Hospital Center for Healthy Living • Mount Vernon House	Equitable Access to Care

General Regulatory Information

Contact Person:	LeighAnne Taylor, Regional Manager, Community Benefits & Community Relations
Date of written plan:	June 30, 2022
Date written plan was adopted by authorized governing body:	September 13, 2022
Date written plan was required to be adopted	February 15, 2023
Authorized governing body that adopted the written plan:	Winchester Hospital Board of Trustees
Was the written plan adopted by the authorized governing body on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed?	☑ Yes ☐ No
Date facility's prior written plan was adopted by organization's governing body:	September 17, 2019
Name and EIN of hospital organization operating hospital facility:	Winchester Hospital 04-2104434
Address of hospital organization:	41 Highland Ave, Winchester, MA 01890