Community Benefits Report

Fiscal Year 2024

Beth Israel Lahey Health
Winchester Hospital

TABLE OF CONTENTS

SECTION I: SUMMARY AND MISSION STATEMENT 1

Priority Cohorts 3

Basis for Selection 4

Key Accomplishments for Reporting Year 4

Plans for Next Reporting Year 5

SECTION II: COMMUNITY BENEFITS PROCESS 7

Community Benefits Leadership/Team 7

Community Benefits Advisory Committee (CBAC) 8

Community Partners 8

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT 10

Approach and Methods 10

Summary of FY 2022 CHNA Key Health-Related Findings 11

SECTION IV: COMMUNITY BENEFITS PROGRAMS 13

SECTION V: EXPENDITURES 40

SECTION VI: CONTACT INFORMATION 41

SECTION VII: HOSPITAL SELF-ASSESSMENT FORM 42

SECTION I: SUMMARY AND MISSION STATEMENT

Winchester Hospital is a member of Beth Israel Lahey Health (BILH). The BILH network of affiliates is an integrated health care system committed to expanding access to extraordinary patient care across Eastern Massachusetts and advancing the science and practice of medicine through groundbreaking research and education. The BILH system is comprised of academic and teaching hospitals, a premier orthopedics hospital, primary care and specialty care providers, ambulatory surgery centers, urgent care centers, community hospitals, homecare services, outpatient behavioral health centers, and addiction treatment programs. BILH's community of clinicians, caregivers and staff includes approximately 4,000 physicians and 35,000 employees.

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. Winchester Hospital's Community Benefits staff are committed to working collaboratively with its communities to address the leading health issues and create a healthy future for individuals, families and communities.

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 makes sure that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WE CARE:*

- ***W****ellbeing - We provide a health-focused workplace and support a healthy work-life balance*
- ***E****mpathy - We do our best to understand others' feelings, needs and perspectives*
- ***C****ollaboration - We work together to achieve extraordinary results*
- ***A****ccountability - We hold ourselves and each other to behaviors necessary to achieve our collective goals*
- ***R****espect - We value diversity and treat all members of our community with dignity and inclusiveness*
- ***E****quity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.*

Winchester Hospital's mission is "To Care. To Heal. To Excel. In Service to Our Community." 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 agreed upon its 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, priority populations, community partners, and detailed descriptions of its Community Benefits programs and their impact.

More broadly, 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 Needs Assessment (CHNA) process as well as in the development, implementation, and oversight of the hospital's three-year Implementation Strategy (IS);

- **Engaging and learning from residents** throughout Winchester Hospital's Community Benefits Service Area (CBSA) in all aspects of the Community Benefits process, with special attention focused on engaging diverse perspectives, from those, patients and non-patients alike, who are often left out of similar assessment, planning and program implementation processes;

- **Assessing unmet community need** by collecting primary and secondary data (both quantitative and qualitative) to understand unmet health-related needs and identify communities and population segments disproportionately impacted by health issues and other social, economic and systemic factors;

- **Implementing community health programs and services** in Winchester Hospital's CBSA that address the underlying social determinants of health, barriers to accessing care, as well as promote equity to improve the health status of those who are often disadvantaged, face disparities in health-related outcomes, experience poverty, and have been historically underserved;

- **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., state/local public health agencies, health care providers, social service organizations, businesses, academic institutions, community health collaboratives, and other

community health organizations) to advocate for, support, and implement effective health policies, community programs, and services.

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

Priority Cohorts

Winchester Hospital's CBSA includes nine cities and towns: Medford, North Reading, Reading, Stoneham, Wakefield, Wilmington, Winchester, Woburn, and Tewksbury. In FY 2022, Winchester Hospital conducted a comprehensive and inclusive Community Health Needs Assessment (CHNA) that included extensive data collection activities, substantial efforts to engage Winchester Hospital's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. While Winchester Hospital is committed to improving the health status and well-being of those living throughout its entire CBSA, per the Commonwealth's updated community benefits guidelines, Winchester Hospital's FY 2023 - 2025 Implementation Strategy (IS) is focusing its Community Benefits resources on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved living in its CBSA.

Based upon Winchester Hospital's FY 2022 CHNA, the community characteristics that were thought to have the greatest impact on health status and access to care in its CBSA were issues related to age, race/ethnicity, language, gender identity and sexual orientation, and economic security. There was consensus among interviewees, focus groups, and community listening session participants that people of color, low-resource individuals, and non-English speakers were more likely to have poor health status and face systemic challenges accessing needed services than white, English speakers who were born in the United States. These segments of the population are impacted by language and cultural barriers that limit access to appropriate services, pose health literacy challenges, exacerbate isolation, and may lead to discrimination and disparities in access and health outcomes.

For its FY 2023 – 2025 IS, Winchester Hospital will work with its community partners in the nine cities and towns comprising our CBSA to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, Winchester Hospital's Community Benefits investments and resources will focus on the improving the health status of the following priority cohorts:

- Youth
- Low-Resourced Populations
- Older Adults
- Racially, Ethnically and Linguistically Diverse Populations; and
- LGBTQIA+

Basis for Selection
Community health needs assessments; public health data available from government (public school districts, Massachusetts Department of Public Health, federal agencies) and private resources (foundations, advocacy groups); and Winchester Hospital's areas of expertise.

Key Accomplishments for Reporting Year
The accomplishments and activities highlighted in this report are based upon priorities identified and programs contained in Winchester Hospital's FY 2022 Community Health Needs Assessment (CHNA) and FY 2023-2025 Implementation Strategy (IS):

Program accomplishments include:

- ***Community Home Blood Draw Program*** – Winchester Hospital Phlebotomy staff provided 1,341 home blood draws for patients who were homebound due to illness, injury, or transportation issues.
- ***Metro Housing Boston Co-Location Program*** – Free counseling was provided to 18 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)*** – 109 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.
- ***Mystic Valley Elder Services Mobile Mental Health Program*** – The Mystic Valley Elder Services Mobile Mental Health Program provided home-based mental health services to 259 older adults and people with disabilities 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*** –105 students were paired with mentors for a longitudinal mentorship program.
- ***Social Capital Inc and Network for Social Justice – Leaders for an Equitable Tomorrow Internship Program*** – This program provides an internship opportunity for 13 youth participants to raise awareness of mental health and intersectional issues of class and gender and its impacts on youth in both Winchester and Woburn. The internship includes design and maintenance of an intern-developed mental health website Middlesexforyouth.org, which received 622 website users and 1099 website views to the mental health event and resources listings on the site.

Plans for Next Reporting Year

In FY 2022, Winchester Hospital conducted a comprehensive and inclusive CHNA that included extensive data collection activities, substantial efforts to engage Winchester Hospital's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. In response to the FY 2022 CHNA, Winchester Hospital will focus its FY 2023 - 2025 IS 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 four priority areas are:

- Equitable Access to Care
- Social Determinants of Health
- Mental Health and Substance Use
- Complex and Chronic Conditions.

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 the priorities 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 FY 2022 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions being used to inform and refine Winchester Hospital's efforts. In completing the FY 2022 CHNA and FY 2023 - 2025 IS, Winchester Hospital, along with its other health, public health, social service, and community partners, 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 identify, sexual orientation, disability status, immigration status, or age. As discussed above, based on the FY 2022 CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that for [insert name of hospital's FY 2023 - 2025 IS, it should work with its community partners to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, Winchester Hospital's Community Benefits investments and resources will continue to focus on improving the health status, addressing disparities in health outcomes, and promoting health equity for its priority cohorts, which include youth; low-resourced populations; older adults; racially, ethnically and diverse populations; and LGBTQIA+.

Winchester Hospital partners with clinical and social service providers, community-based organizations, public health officials, elected/appointed officials, hospital leadership and other key collaborators throughout its CBSA to execute its FY 2023 – 2025 IS.

- **Equitable Access to Care**
  - Winchester Hospital will continue to work with Minuteman Senior Services to provide free health insurance information and counseling to Massachusetts Medicare beneficiaries and their caregivers via certified counselors at Winchester Hospital Center for Cancer Care.

- **Social Determinants of Health**
  - Winchester Hospital will continue to work with Metro Housing Boston to provide free counseling to low-resource individuals and families to prevent eviction and increase housing stability and economic self-sufficiency.

- **Mental Health and Substance Use**
  - Winchester Hospital will continue to work with the Boys and Girls Club of Stoneham Wakefield and the Burbank YMCA to support evidence-based programs to address youth mental health.

- **Complex and Chronic Conditions**
  - The Winchester Hospital Center for Healthy Living will continue to offer programs and services to support individuals of all ages living with chronic conditions, such as asthma and cancer.

Hospital Self-Assessment Form
Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), the Winchester Hospital Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 38 The Winchester Hospital Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members who participated in Winchester Hospital's CHNA and asked them to submit the form to the AGO website.

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership/Team
Winchester Hospital's Board of Trustees along with its clinical and administrative staff is committed to improving the health and well-being of residents throughout its CBSA and beyond. Winchester Hospital's Community Benefits Department, under the direct oversight of Winchester Hospital's Board of Trustees, is dedicated to collaborating with community partners and residents and will continue to do so in order to meet its Community Benefits obligations. Hospital senior leadership is actively engaged in the development and implementation of the Winchester Hospital's Implementation Strategy, ensuring that hospital policies and resources are allocated to support planned activities.

It is not only the Winchester Hospital's Board of Trustee members and senior leadership who are held accountable for fulfilling Winchester Hospital's Community Benefits mission. Among Winchester Hospital's core values are 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 BILH and Winchester Hospital's structure and reflected in how care is provided at the hospital and in affiliated practices.

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 makes sure that Community Benefits efforts, prioritization, planning, and strategy focus on equity and align and are integrated with local and system strategic and regulatory priorities to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WE CARE:*

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- ***E****quity - Everyone has the opportunity to attain their full potential in our workplace and through the care we provide.*

The Winchester Hospital Community Benefits program is spearheaded by LeighAnne Taylor, the 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 cohorts who have been historically underserved are considered every day in discussions on resource allocation, policies, and program development.

This structure and methodology are 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 BILH and Winchester Hospital's Community Benefits program.

Community Benefits Advisory Committee (CBAC)
The Winchester Hospital Community Benefits Advisory Committee (CBAC) works in collaboration with Winchester Hospital's leadership, including the hospital's governing board and senior management to support Winchester Hospital's Community Benefits mission: 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 CBAC provides input into the development and implementation of Winchester Hospital's Community Benefits programs in furtherance of Winchester Hospital's Community Benefits mission. The membership of Winchester Hospital's CBAC aspires to be representative of the constituencies and priority cohorts 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.

The Winchester Hospital CBAC met on the following dates:

- December 13, 2023
- March 20, 2024
- June 26, 2024
- September 18, 2024 (public meeting)

Community Partners
Winchester Hospital recognizes its role as an acute care, independent 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 (CHNA) and the associated Implementation Strategy (IS) were completed in close collaboration with Winchester Hospital's staff, community residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, hospital leadership and other key collaborators from throughout its CBSA. Winchester Hospital's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of Winchester Hospital's mission.

Winchester Hospital currently supports numerous educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA. In this work, Winchester Hospital collaborates with many of its local community-based organizations, public health departments, municipalities and clinical and social service organizations. The

following is a comprehensive listing of the community partners with which Winchester Hospital joins in assessing community need as well as planning, implementing, and overseeing its Community Benefits Implementation Strategy. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment (Section VII, page 38).

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

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY 2022 Community Health Needs Assessment (CHNA) along with the associated FY 2023-2025 Implementation Strategy was developed over a twelve-month period from September 2021 to September 2022. 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 the 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 cohorts who have been historically underserved, and its commitment to community health improvement.

As mentioned above, Winchester Hospital's most recent CHNA was completed during FY 2022. FY 2023 Community Benefits programming was informed by the FY 2022 CHNA and aligns with Winchester Hospital's FY 2023 – FY 2025 Implementation Strategy. The following is a summary description of the FY 2022 CHNA approach, methods, and key findings.

Approach and Methods
The FY 2022 assessment and planning process was conducted in three phases between September 2021 and September 2022, which allowed Winchester Hospital to:

- assess community health, defined broadly to include health status, social determinants, environmental factors and service system strengths/weaknesses;
- engage members of the community including local health departments, clinical and social service providers, community-based organizations, community residents and Winchester Hospital's leadership/staff;
- prioritize leading health issues/population segments most at risk for poor health, based on review of quantitative and qualitative evidence;
- develop a three-year Implementation Strategy to address community health needs in collaboration with community partners, and;
- meet all federal and Commonwealth Community Benefits requirements per the Internal Revenue Service, as part of the Affordable Care Act, the Massachusetts Attorney General's Office, and the Massachusetts Department of Public Health.

Winchester Hospital's Community Benefits program is predicated on the hospital's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address inequities and socioeconomic barriers to accessing care, as well as the current and historical discrimination and injustices that underlie existing disparities. Throughout the CHNA process, efforts were made to

understand the needs of the communities that Winchester Hospital serves, especially the population segments that are often disadvantaged, face disparities in health-related outcomes, and who have been historically underserved. Winchester Hospital's understanding of these communities' needs is derived from collecting a wide range of quantitative data to identify disparities and clarify the needs of specific communities and comparing it against data collected at the regional, Commonwealth and national levels wherever possible to support analysis and the prioritization process, as well as employing a variety of strategies to ensure community members were informed, consulted, involved, and empowered throughout the assessment process.

Between October 2021 and February 2022, Winchester 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 community partners.

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. Winchester Hospital works in concert with community residents and leaders to design specific actions to be collaboratively undertaken each year. Each component of the plan is developed and eventually woven into the annual goals and agenda for the Winchester Hospital's Implementation Strategy that is adopted by the Winchester Hospital's Board of Trustees.

Summary of FY 2022 CHNA Key Health-Related Findings

Equitable Access to Care

- Individuals identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system level, meaning that the issues stem from the way in which the system does or does not function. System level issues included providers not accepting new patients, long wait lists, and an inherently complicated healthcare system that is difficult for many to navigate.
- There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forego 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.

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 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 economic insecurity, education, food insecurity, access to care/navigation issues, 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, survey, and listening sessions suggested that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, food security/nutrition, and economic stability.

Mental Health and Substance Use

- Anxiety, chronic stress, depression, and social isolation were leading community health concerns. The assessment identified specific concerns about the impact of mental health issues for youth and young adults, the mental health impacts of racism, discrimination, and trauma, 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.
- 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. Individuals 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).

Complex and Chronic Conditions

- Chronic conditions such as cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease contribute to 56% of all mortality in the Commonwealth 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.

For more detailed information, see the full FY 2022 Winchester Hospital Community Health Needs Assessment and Implementation Plan Report on the hospital's website.

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Mental Health and Substance Use **Program Name: Stoneham and Wakefield Boys & Girls Club – SBIRT** **Health Issue: Mental Health/Mental Illness, Substance Use Disorders**		
Brief Description or Objective	Screening, Brief Intervention, Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs as well as provide early intervention for potential mental illness. All Stoneham Boys and Girls Club staff are trained in SBIRT and support connecting youth to mental health supports.	
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 January 2024, 300 youth will be screened, including Stoneham LGBTQ+ youth, through the SBIRT program. At-risk youth will be partnered with mentors. The club will host a minimum of four campaign events and workshops. By the next Youth Risk Behavioral Survey there will be a 50% decrease in suicidal ideation among LGBTQ+ youth and double-digit percentage decreases in other risky behaviors.	
Goal Status	Over 300 Stoneham youth were screened by January 2024. 105 at-risk youth were paired with mentors at the Youth & Teen Centers. Two campaign events and workshops included: hosted a training for all staff called "Supporting LGBTQ+ Youth in School and Community Settings". This workshop reviewed theories of identity development related to LGBTQ+ youth and how this may present in today's world. It also reviewed common risk factors for behavioral and academic challenges. Lastly, participants learned how to create safe and supportive learning environments for students with diverse sexual orientations and gender identities. In addition, we hosted a "Youth Pride Social" at our Stoneham Teen Center. This event was a chance for teens to celebrate their identity and enjoy hearing from a guest speaker who identified as queer.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use Disorders **Program Name: Mystic Valley Elder Services Mobile Mental Health Program** **Health Issue: Mental Health/Mental Illness, Substance Use Disorders**	
Brief Description or Objective	Mystic Valley Elder Services' Mobile Mental Health Program provides home-based mental health services to older adults and people living with disabilities who reside in 11 communities north of Boston, including towns in Winchester Hospital's CBSA including: Medford, North Reading, Reading, Stoneham and Wakefield. This program addresses a number of issues affecting older adult emotional well-being and quality of life, such as depression, anxiety, social isolation, hoarding, substance abuse, as well as adjustment to loss. The goal of the program is to provide trained professionals to see clients as quickly as possible to

	ensure their recovery, providing linkages to health care services such as in-home mental health therapy, medication evaluation, and other supports where needed. The program addresses behavioral and mental health problems, as well as the need for ongoing care of both body and mind to support wellness, independence and dignity of older adults.
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 MVES Mobile Mental Health Program will enroll 140 new customers per fiscal year. At least 90% of participants will indicate that they have improved coping skills to address daily problems. At least 150 MVES Mobile Mental Health customers will report decreased loneliness and isolation as a result of participation in the program.
Goal Status	Through December 2024, 120 new consumers were enrolled. Results from a written survey show that 71% of MVES Mobile Mental Health Program consumers indicated that they were coping better with their daily problems from 1/1/24 - 12/31/24. This is measured by bi-annual written survey distributed by the MVES clinical caseworkers during a home assessment. Through December 2024, 182 consumers reported having a decrease in social isolation and loneliness. This is measured by a bi-annual assessment.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Town of Winchester Social Worker and Community Health Educator** **Health Issue: Mental Health/Mental Illness, Substance Use Disorders**	
Brief Description or Objective	Winchester Hospital financially supported the town of Winchester to hire a full-time licensed social worker to work with the Winchester Police Department to build relationships and mental health referrals for community residents. This person provides service reports to the Chief of Police, Board of Health Director, and Town Manager. The social worker offers referral sheets to first-line officers helping residents in crisis and assists with information for follow-up
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 social worker will provide resident referrals to mental health services in partnership with first-line officers. The social worker will report on number of clients served; demographics of clients served; number of referrals made; and number of police officers who complete the 40-hour Crisis Intervention Training.
Goal Status	There were 44 police department social work cases in total for FY24. 14 referrals have been made to community services and programs. The demographics of

	clients served were as follows: Asian: 4; White: 32; Haitian: 1; Hispanic: 1; Middle Eastern: 2; Other: 1; Female 18; Male 26; Age 0-18: 9; 19-25: 7; 26-60: 17; 60+: 10. The Community Health Program Manager led three major initiatives in FY24 which included: Living Alcohol-Free/Reducing Alcohol Consumption (with a focus on women and alcohol) in partnership with a certified Living Alcohol-Free (LAF) coach for three complementary educational program, reaching 80 individuals; Youth Mental Health First Aid trainings were held for public school staff and municipal staff, reaching over 100 attendees; and a lunch and learn at the high school focus on emotional well-being for 50 parents of graduating seniors and a lunch and learn for junior around coping skills and resiliency, reaching 300 students.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Town of Stoneham and Winchester Interface Referral Line** **Health Issue: Mental Health/Mental Illness, Substance Use Disorders**	
Brief Description or Objective	The William James INTERFACE Referral Service is a free, confidential referral service for residents of participating communities. Callers from these participating communities are matched with licensed mental health providers from an extensive database, on average, within 2 weeks of their call to INTERFACE. Each referral best meets the location, insurance, and specialty needs of the caller. INTERFACE is supported by Winchester Hospital funding in Winchester and Stoneham.
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 in Stoneham and Winchester and increase access to care by connecting participants to mental health and wellness resources in a timely manner.
Goal Status	In Stoneham from June 2023 to June 2024, 37 Stoneham residents were served by INTERFACE. The top call concerns were anxiety, depression, and ADD/ADHD. Other concerns included family-related issues, suicidal ideation, behavioral issues, and autism spectrum disorders. Most callers, 87%, were seeking individual therapy. The ages of people served included 39% children ages 6-12, 22% teens ages 13-17, 17% adults aged 25-59, 17% older adults ages 60+, and 6% young adults ages 18-24. In terms of gender 57% of people served were male and 43% were female. In terms of race, 57% of callers were white, 21% were Hispanic, 11% were multiracial, 7% declined to respond, and 4% were Asian. Most callers had commercial insurance (83.6%). Most of the callers learned of the service through the schools. In Winchester, 32 INTERFACE referrals were completed for children and 28 referrals for adults- 18+. Majority of the Winchester callers identified as female. Majority of Winchester INTERFACE identified as Caucasian. Requiring services predominately in English though there was also a request for services in Portuguese (1). Majority seeking Individual Therapy, followed my Medication Evaluation/Prescribing, and then other services in smaller numbers. The most reported issues callers were seeking services to address were: Anxiety (28), Family Related Issues (15), Depression (11), then others reported in smaller numbers. Concerning issues reported as current or

	recent included: Suicidal Ideation, Substance Use Concerns, and Self-Injurious Behaviors.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Town of Tewksbury Building Visibility and Resiliency for LGBTQIA+ Residents** **Health Issue: Mental Health/Mental Illness, Substance Use Disorders**			
Brief Description or Objective	Town of Tewksbury in partnership with the Tewksbury Diversity, Equity and Inclusion Advisory Committee, the Tewksbury Council on Aging, and the Tewksbury Public Schools Gay Straight Alliance are proposing to bring visibility and resiliency skills building opportunities to the LGBTQIA+ community in Tewksbury. This would be accomplished through creating supportive, sober, and safe gatherings where members of the community can come together to build connections, bring awareness to mental health and substance use issues facing them, bring awareness to other topics of interest, as well as create LGBTQIA+ visibility in Tewksbury.		
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)	Creation of a monthly LGBTQ+ community group at the library and/or senior center to accommodate youth and senior community members. Work with Tewksbury Public Schools to train 10 staff in LGBTQIA+ Cultural Competency.		
Goal Status	In FY24 funding supported capacity building workshops around Building Visibility and Resiliency for LGBTQIA+ Residents at the library and at the senior center. The program manager collaborated with the Town of Tewksbury Health Department to hold two sober LGBTQAI events with ~36 participants between both events. Funding supported the town's overdose vigil with ~200 participants, a PRIDE event picnic with~35 participants and a weekly meditation class at the library with an average of ~20 to 45 people per week.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Mental Health and Substance Use **Program Name: Winchester Hospital Emergency Department Behavioral Health Technicians** **Health Issue: Mental Health/Mental Illness, Substance Use Disorders**	
Brief Description or Objective	Winchester Hospital Behavioral Health technicians are healthcare professionals who work directly with patients whom present to the ED with psychiatric concerns. They provide skilled, creative, high-quality care to patients under the direction of an ED Registered Nurse. They perform a variety of direct and indirect patient care that include, but are not limited to, the use of skilled communication and diversion techniques, activities of daily living supports, and face-to-face interaction with patients and families at the bedside to ensure patient and employee safety.

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 skilled supportive care to behavioral health patients in the Winchester Hospital Emergency Department.	
Goal Status	In FY24 two behavioral health technicians provided a total of 2,047 hours of behavioral health patient care in the Winchester Hospital Emergency Department.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Behavioral Health Crisis Consultation** **Health Issue: Mental Health/Mental Illness, Substance Use Disorders**		
Brief Description or Objective	To provide 24/7/365 behavioral health crisis evaluation in the emergency department (ED) and throughout other hospital units for individuals experiencing mental health and substance use related crisis. Services are payer agnostic and provided via in-person or telehealth by a multidisciplinary team of qualified professionals, including Psychiatrists, independently licensed and Masters level clinicians, Nurse Practitioners, Registered Nurses, Certified Peer Specialists, and Family Partners. The services include initial assessments for risks, clinical stabilization, treatment initiation, care coordination, and ongoing evaluation to ensure appropriate level of care placement. Increase access to clinical and non-clinical support services for those with mental health and substance use issues, by providing behavioral health services in the hospital. A multidisciplinary team, comprised of qualified behavioral health providers, psychiatry, family partners, and peer specialists, is employed to provide behavioral health crisis consultations in the Emergency Department or medical floors of the hospital.	
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 clinical and non-clinical support services for those with mental health and substance use issues, by providing behavioral health services in the hospital.	
Goal Status	The team provided 1,667 consultations in FY24.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use Disorders **Program Name: Leaders for an Equitable Tomorrow (LET)** **Health Issue: Mental Health**	
Brief Description or Objective	Targeting a highly diverse population of high school students from Winchester and Woburn, this project aims to build awareness around, and utility of, a mental health website developed by the students, while also engaging participants through events (speakers, workshops or facilitated discussions) around topics they previously identified as priority areas to address, with a focus on the

	intersection of mental health with race, gender and sexuality, and socioeconomic status.
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)	Support 10 youth aged 14-18 to gain confidence and insight into discussing and addressing mental health challenges, both theirs and those that impact their larger peer group, as measured through pre and post self-administered surveys. Raise awareness of youth mental health and intersectional issues of class and gender as its impacts on youth and communities in both Winchester and Woburn through 4 public community programs and events reaching 200 people. Develop and advance the visibility of a LET intern mental health promotion website.
Goal Status	To date, 13 youth have been engaged as LET interns. In year two of the grant period, we held 6 public community events serving 303 unique individuals. The events included a panel discussion with 5 perspectives on post-high school pathways in March; a multi-generational workshop on technology and digital companionship in May; Asian American Native Hawaiian Pacific Islander festival in May; PRIDEfest and Juneteenth in June; and a workshop on fitness and nutrition as forms of self-care in October. In addition, the LET interns had several smaller-scale social events and engaged with community members in Woburn and Winchester at venues such as the SCI Summer Concert series at Horn Pond and the Winchester Farmers Market. LET interns created a website, middlesex4mentalhealth.org, as a resource for youth mental health. The website has received 622 website users and 1099 website views to the mental health event listings on the site.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: BILH Behavioral Health Access Initiative** **Health Issue: Substance Use Disorder, Mental Health/Mental Illness and Additional Health Needs (Access to Care)**	
Brief Description or Objective	To support increased access to mental health and substance use services and supports, Winchester Hospital participated with other BILH hospitals to pilot Behavioral Health Navigator grant programs, offer Mental Health First Aid (MHFA) trainings, provide behavioral health navigation and digital literacy trainings to BILH physical health navigators and amplify anti-stigma messaging, resources and supports.
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports

	☐ Community Clinical Linkages ☒ Total Population or Community-Wide Interventions ☐ Infrastructure to Support Community Benefits		
Program Goal(s)	Offer Mental Health First Aid (MHFA) trainings to community residents and BILH staff across the BILH Community Benefits Service Area (CBSA).		
Goal Status	More than 350 community residents and BILH staff attended one of 21 MHFA trainings provided across the BILH CBSA, of which 75% (274) completed all pre- and post-training requirements to receive Mental Health First Aid certification.		
Time Frame Year: Year 1		**Time Frame Duration: Year 3**	**Goal Type: Process Goal**
Program Goal(s)	Increase knowledge and awareness of available behavioral health services and supports among clinical and non-clinical staff who provide patients/clients with physical and/or social determinants of health navigation services.		
Goal Status	28 BILH, Community Health Center and Community Behavioral Health Center staff were trained. Trainees reported a 35% increase in identifying the essential elements of the behavioral health treatment systems of care; a 49% increase in feeling confident they can navigate patients to the appropriate level of behavioral health care, including outpatient, self -help, hotlines, and helplines; a 26%increase in feeling comfortable using different ways to promote patient engagement and activation; and a 37% increase in explaining the process of referrals to agencies.		
Time Frame Year: Year 1		**Time Frame Duration: Year 2**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Community Based Behavioral Health and Collaborative Care Model** **Health Issue: Additional Health Need Identified by the Community (Access to Care)**		
Brief Description or Objective	In an effort to improve access to behavioral health services, Beth Israel Lahey Health has committed to the implementation of the Collaborative Care Model in employed primary care practices. This 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. The primary care provider and the behavioral health clinician develop a treatment plan that is specific to the patient's personal goals.	
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 to address to mental health needs and substance use disorders in a primary care setting.	
Goal Status	In FY24, Winchester Hospital implemented the Collaborative Care Model in 11 practices, serving 1,607 patients.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health **Program Name: Burbank YMCA Youth Mental Health Action Plan** **Health Issue: Mental Health**		
Brief Description or Objective	Burbank YMCA will develop a community integrated approach to addressing the mental health needs of youth and families in the community. This will be accomplished through implementing evidence-based strategies for social emotional learning with staff and youth program participants; building a community-based task for to understand needs and challenges regarding youth mental health to inform an action plan; and implementing Youth Mental Health First Aid training with staff and NAN Project training with youth.	
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)	Refine our plan for the Burbank YMCA to provide effective and meaningful interventions to support the mental health of youth in Reading and the surrounding towns served by the Burbank YMCA. Impact over 1400 youth by creating initiatives and materials deliverable within the youth-based programming already a mainstay of the Burbank YMCA (after school, camp, swim team, youth/teen sports programs, family events, etc). This also alleviates any additional burden on already over-stretched parents from having to take on yet another program.	

Goal Status	We have successfully implemented our Youth Heathy Habits program and our Mental Health First Aid trainings for teens. The Healthy Habits program takes place during our afterschool programs and the Mental Health First Aid trainings take place during the training of our teen camp and center staff trainings. 51 participants that went through the training in 2024. Running the programs at these times allows us to meet the goal of providing these services without adding an additional burden to the parents of our participants.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Chronic/Complex Conditions **Program Name: CHAMP Pediatric Asthma Program** **Health Issue: Chronic Disease**			
Brief Description or Objective	Winchester Hospital's Center for Healthy Living Community Healthcare for Asthma Management and Prevention (CHAMP) program is a family-centered, patient-tailored, evidence-based 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, childcare personnel, classroom teachers, and guardians about effective 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 education of patients, families, physicians, and other health professionals. Participants report significantly fewer asthma-related hospital admissions and emergency department visits.		
Goal Status	In FY24, 109 children participated in CHAMP. In addition, Winchester Hospital's pediatric asthma nurse specialist provided community outreach in our service area in FY24 via education and training sessions and private consultations and visits to educate students, teachers, and families about pediatric asthma. Visits included 108 home visits, 3 Zoom visits, 14 school visits, and 2 camp visits. 2 school education/training sessions held on Zoom. 139 Asthma Action Plans completed and filed with schools and daycare centers.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

Priority Health Need: Chronic/Complex Conditions **Program Name: Outpatient Lactation Program** **Health Issue: Chronic Disease**

Brief Description or Objective	Winchester Hospital's Outpatient Lactation Program offers breastfeeding 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.	
Goal Status	In FY24, 615 mothers participated in the program. 80% of the new mothers surveyed after the program reported meeting the breastfeeding goal that they set during their initial consultation with the Lactation Specialist. 73% reported successfully breastfeeding for six months or more.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: Center for Healthy Living Health Education Programs** **Health Issue: Chronic Disease**		
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 free and reduced-cost programs and services, including childbirth education, prenatal breastfeeding online course and care of the newborn classes. 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.	
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 people residents in the Winchester Hospital service area improve their overall health and quality of life through free and reduced-cost health education and health promotion programs and classes.	
Goal Status	In FY24, the were a total of 120 classes and 1,078 class registrations with the breakdown is as follows: 9 Flex & Stretch class sessions with 70 registrations; 10 Building Bones class sessions with 77 registrations; 19 Care of the Newborn classes with 188 registrations; 44 Childbirth classes with 293 registrations; 38 Breastfeeding classes with 450 registrations.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: Center for Cancer Care Patient Support Groups** **Health Issue: Chronic Disease**		
Brief Description or Objective	Winchester Hospital Center for Cancer Care provides support groups to patients in treatment for cancer.	
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 mental health support and connection to patients in treatment of cancer.	
Goal Status	In FY24, 31 support group sessions were held, reaching 116 patients. Art and knitting classes were also offered, reaching 103 patients.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: Breast Cancer Risk Assessment** **Health Issue: Chronic Disease**		
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 FY4, Winchester Hospital conducted 2,989 free screenings. Follow-up consults were provided after each screening, and results were shared with participants' physicians to discuss recommended follow-up evaluation and care.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: Oncology Nurse Navigator** **Health Issue: Chronic Disease, Cancer**	
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 cancer 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 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 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 FY24 the Oncology Nurse Navigator dedicated 1680 hours providing over 1890 new patients between Hematology, Oncology, and Thoracic Surgery.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: A Caring Place** **Health Issue: Chronic Disease, Cancer**	
Brief Description or Objective	A Caring Place provides low-cost wigs, head coverings, and cold caps to patients receiving care at the Winchester Center for Cancer 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 provide low-cost wigs, head coverings, and cold caps to patients receiving care at the Winchester Center for Cancer Care.
Goal Status	In FY24, 359 patients were served with mastectomy fittings, compressions, and cold cap fittings.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Equitable Access to Care **Program Name: Patient Financial Counseling** **Health Issue: Additional Health Needs Identified by the Community (Access to Health Care)**

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. Winchester Hospital is dedicated to providing care for everyone, regardless of their ability to pay, and provides 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 assist patients throughout the BILH Systems who are uninsured and under insured to obtain eligibility for and align them with state financial assistance and hospital-based financial assistance programs. This includes MassHealth, MassHealth ACOs, Health Connector, Pharmacy Programs and Hospital Charity programs.
Goal Status	In FY24 Winchester Hospital screened 5,319 patients for assistance programs of which 295 patients qualified for Masshealth. 42 patients applied for hospital charity programs of which 18 were approved. The number of uninsured patients that utilized the Health Safety Net was 1,904.

Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Serving Health Insurance Needs of Everyone (SHINE)** **Health Issue: Additional Health Needs Identified by the Community (Access to Health Care)**	
Brief Description or Objective	The Winchester Hospital SHINE collaboration helps address health care costs for Medicare beneficiaries, by connecting people with health insurance that meets their health care needs, lifestyle, and budget. On-site 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.
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)	Minuteman Senior Services (MSS) Regional SHINE program will provide Medicare benefits counseling to 2100 individuals who reside in Burlington, Arlington and Winchester, MA during the grant cycle (seven hundred annually). Minuteman Senior Services Regional SHINE program will offer 21 (7 annually) community education presentations to people new to Medicare turning sixty-five or retiring to ensure consumers make educated health insurance decisions.
Goal Status	MSS provided 579 individuals residing in Arlington, Burlington and Winchester with Medicare benefits counseling, public benefits screening, and plan/cost comparisons. 373 individuals resided in Arlington and Winchester or received treatment at Winchester Cancer Center. Sixty-four individuals who received support in Arlington or Winchester were below low-income subsidy ($1903 individual $2505 couple with assets of up to $17,220 individual $34,360 couple). All low-income/asset individuals received public benefits screening and/or health / pharmacy benefits application support. Minuteman Senior Services SHINE did not reach the goal of 700 counseling sessions due, in part, to the retirement of the Burlington COA SHINE counselor who typically served 100+ consumers annually. This particular goal will be reviewed and updated to reflect current resources. MSS performed 276 electronic consumer assessment surveys to SHINE consumers in eighteen communities who received services in the report period 11/15/23 – 11/15/24. In Arlington, Burlington and Winchester 27 surveys were completed. Five consumers in the BILH service area required further information regarding meal delivery, homecare, or transportation. MSS contacted these consumers and connected three people eligible to home delivered meals, one person was referred to transportation resources and one did not meet homecare eligibility. MSS hosted eleven community education workshops. Workshops were held at Winchester Council on Aging, Winchester and Arlington Housing Authorities and Arlington Adult Education. Topics included: Medicare Savings Program, Medicare Preventative Benefits, New to Medicare and Understanding IRMAA. SHINE education focused on audiences that were new to Medicare, low-income and people with disabilities. In addition, the BILH Medicare Benefits Specialist met with clinical staff at Winchester Cancer Center to provide an introduction to SHINE.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Equitable Access to Care **Program Name: Home Blood Draw Program** **Health Issue: Additional Health Needs Identified by the Community (Access to Care)**	
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. 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 FY24, Winchester Hospital Lab Services provided 1,341 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.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Equitable Access to Care **Program Name: Interpreter Services** **Health Issue: Additional Health Need Identified by the Community (Access to Care)**		
Brief Description or Objective	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 live with hearing loss. The Interpreter Services Department facilitates access to care, helping patients understand their course of treatment, and adherence to discharge instructions and other medical regimens.	
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 FY24, Winchester Hospital provided 1,498 interpreter encounters in the outpatient setting and 1,661 interpreter services encounters in the Emergency Department setting. The top three language requests were: Spanish, Portuguese, and Haitian Creole.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Equitable Access to Care **Program Name: Patient Transportation Voucher Program** **Health Issue: Additional Health Need Identified by the Community (Transportation)**		
Brief Description or Objective	Winchester Hospital collaborated with Checker Cab of Woburn to provide free rides to and from medical appointments. The Winchester Hospital Center for Cancer Care partnered with the American Cancer Society to provide funds to support free rides for patients seeking cancer care who do not have transportation access. Community members who have transportation difficulty due to financial problems, illness, or mobility issues are eligible for these services.	
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)	Increase access to health services by providing rides to individuals with no means of transportation due to medical or financial issues.	
Goal Status	In FY24, Winchester Hospital provided over 700 rides to patients with transportation needs to and from medical appointments. In FY24 the Winchester Center for Cancer Care provided vouchers for 120 one-way medical appointment rides for patients.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Equitable Access to Care **Program Name: Diversity, Equity, and Inclusion** **Health Issue: Additional Health Needs (Access to Care)**		
Brief Description or Objective	BILH Community Benefits sits within the Office of Diversity, Equity and Inclusion (DEI). BILH's Office of Diversity, Equity, and Inclusion develops and advocates for policies, processes and business practices that benefit the communities and our workforce. The DEI vision is to "Transform care delivery by dismantling barriers to equitable health outcomes and become the premier health system to attract, retain and develop diverse talent."	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community-Wide Interventions	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Across BILH, increase BIPOC representation among new leadership (directors and above) and clinical (physicians and nurses) hires with an aim of at least 25% representation.	
Goal Status	Across BILH, 18% of new hires in leadership (directors and above) and clinical (physicians and nurses) positions identified as BIPOC.	
Program Goal(s)	Increase spend with diverse businesses by 25% over the previous fiscal year across the system.	
Goal Status	More than $70 million was contracted to Women and Minority-owned Business Enterprises (WMBE) in FY24. This is a 28% increase over FY23.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: New Entry Sustainable Farming Project-Free Produce Program** **Health Issue: Additional Health Needs Identified by the Community (Access to Healthy Food)**	
Brief Description or Objective	To address food insecurity, Winchester Hospital partners 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 in partnership with local community-based organizations (FY22-FY23 Winchester Housing Authority, FY24 Medford Council on Aging). Each week, more than six varieties of fresh produce are provided for free, along with a

	newsletter that includes nutrition information and healthy recipes featuring that week's produce.
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 food insecure clients of the Medford Council on Aging access healthy foods and 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 Medford COA produced the following outcomes: More than 3200 lbs. of fresh produce, including more than six varieties of fruits and vegetables, were delivered to the Medford Council on Aging. A weekly newsletter featuring nutritional information and recipes for the fruits and vegetables was created and distributed with the produce. 69% of the participants completed the survey. The median age of participants was 75 years old. Per a post-program survey, program participants reported: 90% ate a greater variety of fruits and/or vegetables, 80% increased their daily intake of fruits and vegetables, and 85% ate better quality produce.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Council of Social Concern Food Insecurity Relief Program** **Health Issue: Additional Health Need Identified by the Community (Food Access)**	
Brief Description or Objective	The Council of Social Concern's Food Pantry weekly backpack program is a partnership with the Woburn Public Schools, which provides food insecure students with healthy food and snacks each Friday during the school year to take home over the weekend.
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 the end of FY24, Council of Social Concern's Food Pantry will provide backpacks with healthy food and snacks to 30 students weekly in the Woburn Public Schools. The backpack program serves all five elementary schools.
Goal Status	The Council of Social Concern provides backpacks with healthy food and snacks to 35-50 students from the Woburn Public Schools each week in FY24. The program serves all five elementary schools.
Time Frame Year: Year 2	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Wilmington Farmer's Market SNAP Match** **Health Issue: Additional Health Need Identified by the Community (Food Access)**

Brief Description or Objective	The Wilmington Farmers Market Association will establish acceptance of SNAP benefits on behalf of all eligible food-based vendors at the Wilmington Farmer's Market and will and will match SNAP funds up to $20 per week per SNAP customer during the seasonal Market.		
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)	This project will increase the healthy food budget of up to 20 families per week by $20 for the 17-week market season		
Goal Status	For FY24, as of October 31, 2024, this project provided 116 families with food insecurities access to fresh and locally sourced food utilizing their SNAP benefit cards. As of October 31, 2024, this project increased the healthy food budgets by $48 for an average of 5 families per week, for 18 weeks during the season.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**		**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: Winchester Hospital Meals on Wheels Program** **Health Issue: Additional Health Need Identified by the Community (Food Access)**			
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 5,143 meals to meet the dietary needs of participants. The meals were delivered by hospital volunteers to homebound residents.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**		**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: Metro Housing Boston Co-Location Program**

Health Issue: Additional Health Need Identified by the Community (Housing)		
Brief Description or Objective	Metro Housing's Co-Location program helps 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. Winchester Hospital supports this program for residents of Winchester, Woburn, Stoneham and Medford.	
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 towns of Winchester, Woburn, Stoneham and Medford.	
Goal Status	In FY24, Metro Housing served 18 participants who presented with a housing concern or crisis. Over 60% of participants stabilized their housing situation and reported an increased knowledge of the housing search process.	
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health **Program Name: BILH Workforce Development** **Health Issue: Additional Health Need Identified by the Community**		
Brief Description or Objective	BILH is strongly committed to workforce development programs that enhance the skills of its diverse employees and provide career advancement opportunities. BILH offers incumbent employees "pipeline" programs to train for professions such as Patient Care Technician, Central Processing Technician and Associate Degree Nurse Resident. BILH's Employee Career Initiative provides career and academic counseling, academic assessment, and pre-college and college-level science courses to employees at no charge, along with tuition reimbursement, competitive scholarships and English for Speakers of Other Languages (ESOL) classes. BILH is also committed to making employment opportunities available to qualified community residents through training internships conducted in partnership with community agencies and hiring candidates referred by community programs.	
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)	In FY24, Workforce Development will continue to encourage community referrals and hires. In FY24, Workforce Development will attend events and give presentations about employment opportunities to community partners. In FY24, Workforce Development will offer internships in BILH hospitals to community members over the age of 18. In FY24, Workforce Development will hire interns hired after internships and place in BILH hospitals. In FY24, Workforce Development will offer English for Speakers of Other Languages (ESOL) classes to BILH employees. In FY24, Workforce Development will	

	offer citizenship, career development workshops, and financial literacy classes to BILH employees. In FY24, Workforce Development will offer employees career development services. In FY24, Workforce Development will establish clinical affiliation agreements with vocational technical high schools to hire young people from the community for cooperative education paid and unpaid internships in nursing assistant, medical assistant, and other hospital-specific positions.
Goal Status	In FY24, 412 job seekers were referred to BILH and 111 were hired across BILH hospitals. In FY24, 33 events and presentations were conducted with community partners across the BILH service area. In FY24, 107 community members placed in internships across BILH hospitals to learn valuable skills. Winchester Hospital participated in offering these internships. In FY24, 37 interns were hired permanently in BILH hospitals. Winchester Hospital participated in these hirings. In FY24, 82 employees across BILH were enrolled in ESOL classes. Winchester Hospital employees participated in these classes. In FY24, 14 BILH employees attended citizenship classes, 15 BILH employees attended career development workshops and 207 BILH employees attended financial literacy classes. Winchester Hospital employees participated in these offerings. In FY24, 1,044 BILH employees received career development services. In FY24, Workforce Development established 10 clinical affiliation agreements with vocational technical high schools, which resulted in the hiring of 47 high school students in paid cooperative education placements and 11 into unpaid clinical placements. Winchester Hospital participated in offering these trainings.
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Infrastructure **Program Name: Community Benefits Administration and Infrastructure** **Health Issue: Health Professional/Staff Training**	
Brief Description or Objective	Community Benefits and Community Relations staff implement programs and services in our Community Benefits Services Area, encourage collaborative relationships with other providers and government entities to support and enhance community health initiatives, conduct Community Health Needs Assessments and address priority needs and ensure regulatory compliance and reporting. Additionally, Community Benefits and Community Relations staff at BILH hospitals work together and across institutions to plan, implement, and evaluate Community Benefits programs. In FY24, the staff worked collaboratively to begin the Community Health Needs Assessment, sharing community outreach ideas and support, and help to distribute the community survey and identify key community residents for interviews and focus groups.
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)	Offer evaluation capacity workshops to partner organizations and grantees to increase better understand impact.		
Goal Status	BILH offered two evaluation workshops to 30 organizations and grantees. 100% of organizations and grantees who attended were Satisfied or Very Satisfied with the workshops and 90% stated it was directly relevant to their role at their organization.		
Time Frame Year: Year 2	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

SECTION V: EXPENDITURES

Item/Description	Amount
CB Expenditures by Program Type	
Direct Clinical Services	$2,205,775
Community-Clinical Linkages	$101,278
Total Population or Community Wide Interventions	$517,344
Access/Coverage Supports	$135,303
Infrastructure to Support CB Collaborations	$22,506
Total Expenditures by Program Type	$3,663,984
CB Expenditures by Health Need	
Chronic Disease	$858,844
Mental Health/Mental Illness	$989,407

Substance Use Disorders	$719,769
Housing Stability/Homelessness	$22,803
Additional Health Needs Identified by the Community	$1,073,162
Total by Health Need	$3,663,984
Leveraged Resources	$545,963
Total CB Programming	$4,209,947
Net Charity Care Expenditures	
HSN Assessment	$1,717,777
HSN Shortfall	$921,379
HSN Denied Claims	$709,829
Total Net Charity Care	$4,209,947
Total CB Expenditures	$7,558,932

Additional Information	
Net Patient Services Revenue	$369,918,000
CB Expenditure as % of Net Patient Services Revenue	2.04%
Approved CB Budget for FY24 (*Excluding expenditures that cannot be projected at the time of the report)	$5,381,761
Bad Debt	$2,764,577
Bad Debt Certification	Yes
Optional Supplement	
Comments	Winchester Hospital makes a PILOT payment to the Town of Winchester Winchester Hospital is subsidizing Behavioral Health Services outside of its Community Benefits Service Area.

SECTION VI: CONTACT INFORMATION

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Community Benefits & Community Relations
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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: full Community Benefits Advisory Committee list below with new members indicated:

Susan Bibbins, Medford Disabilities Commission **(new member)**; Karen Ruth McAlmon, Winchester Hospital Board of Trustees **(new member)**; Janice Mirabassi, Wakefield resident **(new member)**; Kristin Ross, Metro Housing Boston **(new member)**; Dr. Josh Sheehan, BILH Primary Care **(new member)**; Casey Taylor, Advocates, Waltham CBHC - behavioral health **(new member)**; Jessie Bencosme, Executive Director, Council of Social Concern, Woburn; Jaimie Bowers, Information and Referral Benefits Specialist, Mystic Valley Elder Services Angeline Brady, Community Health Programs Supervisor, Winchester Hospital Center for Healthy Living; Dot Butler, Winchester SAFER Coalition; Al Campbell, President, Winchester Hospital; Christine Healey, Director of Community Benefits/Community Relations, Beth Israel Lahey Health; Karen Keaney, Chief Nursing Officer; Terri Marciello, Director of Elderly Services, Wilmington; Jennifer Murphy, Director of Health, Winchester Health Department; Adam Rogers, Executive Director, Boys & Girls Club of Stoneham & Wakefield; Sharon Ron, Public Health Planner, Metropolitan Area Planning Commission; Maureen Ryan, Assistant Superintendent, Woburn Public Schools; LeighAnne Taylor, Regional Manager, Community Benefits and Community Relations Winchester Hospital; Matthew Woods, Chief Financial Officer, Winchester Hospital

II. Community Engagement

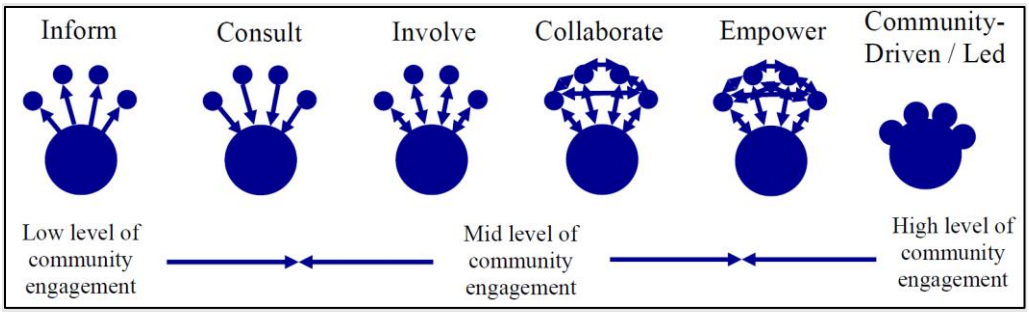
- Organizations Engaged in CHNA and/or Implementation Strategy
  If there have been any updates to the key partners with whom the hospital collaborates, please indicate in the table below. Please feel free to add rows as needed.

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)

Boys and Girls Club of Stoneham and Wakefield	Adam Rogers, Executive Director	Other	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 FY22 CHNA and in engaging youth in the FY22 CHNA process. In addition, the BGC provided programs and services to address the urgent needs in the community in response to COVID-19, focusing on youth mental health, which are ongoing in FY23 and will continue through FY25, with funding support from Winchester Hospital.
Council of Social Concern (COSC)	Jessie Bencosme, Executive Director	Social service organizations	As a member of the CBAC, Jessie 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 two of Winchester Hospital's CBSA cities and towns. Winchester Hospital provided this organization with a three-year grant for FY23-25 for a food insecurity backpack program with Woburn Public Schools.
Metro Hosing Boston	Felisha Marshall, Director of Housing Supports	Housing organizations	Felisha is a new member of the CBAC. Winchester Hospital works collaboratively with the Metro Housing Boston to increase housing stability and security for people in the Winchester Hospital CBSA. Winchester Hospital provided this organization with a three-year grant for FY23-25 for housing stability and eviction prevention counseling services for residents in the Winchester Hospital CBSA.
Mystic Valley Elder Services	Jaimie Bowers Director of Community Programs	Social service organizations	Winchester Hospital engages with MVES on the Mobile Mental Health Program, which meets mental health needs of older adults in the Winchester Hospital CBSA. Jaimie is a new member on the Winchester Hospital CBAC. Winchester Hospital provided this organization with a

			three-year grant for FY23-25 for their Mobile Mental Health Program which provides in-home mental health services and supports to older adults.

- Level of Engagement Across CHNA and Implementation Strategy
  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 address the significant needs documented in its CHNA, and the effectiveness of its community engagement process.



For a full description of the community engagement spectrum, see page 11 of the Attorney General's Community Benefits Guidelines for Non-Profit Hospitals.

A. Implementation Strategy
Please assess the hospital's level of engagement in developing and implementing its plan to 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	Goal was met. Winchester Hospital involved its community partners and CBAC members in the development of the FY23-25	Collaborate

[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.

		IS to address identified health needs.	
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Collaborate	Goal was met. CBAC members and external community partners served on the hospital's grant selection committee	Collaborate
Implementing Community Benefits programs	Collaborate	Goal was met. Winchester Hospital has collaborative community partnership and grant programs to address CHNA-identified health needs.	Collaborate
Evaluating progress in executing Implementation Strategy	Collaborate	Goal was met. Community grantees attended BILH's evaluation workshops and track their program progress, as defined in the IS.	Collaborate
Updating Implementation Strategy annually	Consult	Goal was met. Winchester Hospital conducts an annual review of the IS to assess for needed revisions, in consultation with the CBAC.	Consult

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

- <u>Opportunity for Public Feedback</u>
  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 its Annual Public Meeting on September 20, 2023 at the Winchester Hospital Center for Cancer Care (620 Washington Street, Winchester, MA).

Maternal Health Focus

- How does your organization assess maternal health status in the Community Health Needs Assessment Process? (150-word limit)
  Winchester Hospital's Community Health Needs Assessment includes comprehensive collection and review of primary and secondary data sources. Secondary data sources include March of Dimes, MDPH, National Center for

Health Statistics. Data specific to maternal health are included in the hospital's data table under Reproductive Health and include low birth weight, Mothers with late or no prenatal care, Births to adolescent mothers as well as data on screening for post-partum depression. In addition to secondary data capture and review, throughout the CHNA Winchester Hospital engages with the community to collect primary data on priorities identified by community residents. This is through a community survey as well as focus groups.

- How have you measured the impact of your Community Benefits programs and what challenges have you faced in this measurement? (150-word limit)

  Winchester Hospital is a member of Beth Israel Lahey Health, which, as a system is working to address maternal health equity. Beth Israel Lahey Health established its Maternal Health Quality and Equity Council (MHQEC) in September of 2023. The Council's objective is to improve maternal health outcomes and eliminate inequities in care, with an overarching aim to reduce the occurrence of maternal morbidity and mortality. The Council is comprised of representatives from all of the BILH hospitals providing maternity services, as well as BILH leadership, including BILH Health Equity system leadership. BILH's Chief Clinical Officer serves as the Executive Sponsor. FY 24 was the Council's inaugural year and MHQEC established initial goals related to Equitable Access to Doulas & Midwifery, Perinatal Mental Health, and Severe Maternal Morbidity. Additionally, BILH established a health equity goal beginning in FY 25 – a year over year improvement in maternal transfusion rate (the goal is to reduce disparities in maternal transfusion rates measured at the system level).

- Do you need assistance identifying community-based organizations doing maternal health work in your area?

  Winchester Hospital's maternal health work will be guided by the MHQEC and looks forward to spreading this work and collaborating with its myriad of long-standing community partners in pursuit of maternal health equity.

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.

Since working together as a system on the 2022 CHNA process, all 10 licensed hospitals of the BILH system, including Winchester Hospital, continue to work collaboratively on addressing identified health priorities of our respective CBSAs.

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.