Community Benefits Report

Fiscal Year 2023

Beth Israel Lahey Health
Winchester Hospital

Beth Israel Lahey Health

TABLE OF CONTENTS

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 6,488 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)*** – 117 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 135 older adults living in Medford, North Reading, Reading, Stoneham, and Wakefield. The program addressed a variety of issues affecting older adults' emotional well-being and quality of life through home-based mental health counseling and direct care services.
- ***Boys & Girls Club – Screening, Brief Intervention, Referral to Treatment*** –300 youth were screened, resulting in referrals to mental health treatment. 48 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 10 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 592 visitors and 216 visits 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 program 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:*

- ***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.*

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 14, 2022
- March 15, 2023
- June 21, 2023
- September 20, 2023

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. 48 at-risk youth were paired with mentors at the Youth & Teen Centers. Four campaign events and workshops included: pride night, pride celebration, gender neutral spa days, and Youth Mental Health First Aid Training. In the 2021 YRBS 82% of high school LGBTQ+ youth reported that their mental health was “not good”. According to the 2023 report, 67% of Transgender and Gender Diverse youth reported their mental health as “not good”. This is a significant improvement. Making a suicide plan: in 2021 69% of Gender Queer high school students made a plan to attempt suicide. In 2023 42% of Transgender/Gender Diverse students and 33% of LGBQ+ youth made a plan. In addition, there was significant improvement with middle school students: in 2021 50% of Gender Queer middle school youth had made a plan to commit suicide, versus 13% in 2023. Attempting suicide: in 2021 29% of Genderqueer high school youth had attempted suicide, while in 2023, 25% of Transgender/Gender Diverse youth, and 14% of LGBQ+ youth, attempted suicide. Significantly, in middle school, in 2021 24% of Genderqueer middle school youth attempted suicide, while in 2023 this number was reduced to 4%.	
Time Frame Year: Year 1	**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 ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
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 August 2023, 135 new consumers were enrolled. Results from a written survey show that 73% of MVES Mobile Mental Health Program consumers indicated that they were coping better with their daily problems from 1/1/23 - 6/30/23. This is measured by bi-annual written survey distributed by the MVES clinical caseworkers during a home assessment. Through June 2023, 90 consumers reported having a decrease in social isolation and loneliness. This is measured by a bi-annual assessment.

Time Frame Year: Year 1	**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)	Implement Mental Health First Aid Training for a minimum of 150 staff members (50 per grant year) and 15-20 YMCA teens. Implement the NAN Project peer mentorship model. Audit current youth mental health needs in Reading and surrounding towns and develop a taskforce to address needs. Implement social emotional learning curricula into existing after school and summer camp programs.		
Goal Status	Three Mental Health First Aid Trainings were held and 15 staff were trained. The NAN Project will commence in 2024. Two contractors were hired to audit youth mental health needs and implement youth mental health program elements, including ongoing staff trainings and curriculum implementation. Their work will commence in 2024. The YMCA Healthy Habits program has been updated to incorporate evidence-informed social emotional learning elements and will be administered in the after-school care programs in 2024.		
Time Frame Year: Year 1		**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 ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
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, 10 youth have been engaged as LET interns. 7 interns completed a survey assessing their ability to address mental health challenges, isolation, opportunities for mental health support, and resources for mental health support with themselves and their peers. Among the findings, the students reported a 3% increase in their ability to address mental health challenges, an 8.5% increase in their ability to address isolation, a 14% increase in their ability to address opportunities for mental health support, and a 23% increase in their ability to find mental health resources. Since the beginning of the grant period, 5 community events have been held. These included a Sports and Mental Health panel, post PRIDEfest Real Talk, Juneteenth Woburn, Healing through Art, and Mental Health and Social Media workshop. Attendance at these 5 programs numbered

	131. Participant feedback for these sessions was extremely positive, with adults and students alike. LET interns created a website, middlesex4mentalhealth.org, as a resource for youth mental health. The website has received 592 visitors and 216 visits to the mental health event listings on the site. There have been 6 blog posts added and over 100 calendar events. The resources pages of the website have been updated regularly, with a focus on resources related to the topics addressed at LET in-person events.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Town of Winchester Social Worker** **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 ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
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 46 cases in total for FY23. Out of the 46 cases, 11 cases have involved previous clients who have received ongoing support and services since FY22. 20 referrals have been made to community services and programs. For cases that did not have a completed referral to available community services and programs to which they qualified, the Town of Winchester Social work provides those individuals with ongoing monitoring and case coordination. The demographics of clients served were as follows: Age: 0-18y: 9; 19-25y: 4; 26-60y: 23; 61y+: 10; Gender: 21 males; 25 females. Race: Asian - 4; Indian -1; White-41.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Town of Stoneham 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 ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒ Total Population or Community Wide Intervention
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 FY23, 47 Stoneham residents were served by INTERFACE. The top call concerns were anxiety and depression. Other concerns included ADD/ADHD, behavioral issues, family-related issues, and trauma. Most callers, 86%, were seeking individual therapy. The ages of people served ranged from 7.1% older adults ages 60+, to 28.6% children ages 6-12, to 35.7% teenagers, to 28.6% adults ages 25-59. In terms of gender, 57.1% of callers were male and 42.9% of callers were female. All callers were white and spoke English. Nearly all callers had commercial insurance (92.9%). Most of the callers learned of the service through the schools. In Winchester, 38 individuals were served by INTERFACE. As in many communities Anxiety, and or Depression were some of the most reported issues callers were seeking services to address. 8 callers were calling for support in addressing family related issues. There was a decrease in callers who reported suicidal ideation.
Time Frame Year: Year 1	**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 ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒ Total Population or Community Wide Intervention

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	Two listening sessions were conducted via (1) in zoom and (1) in person to understand community needs related to establishing a formal LGBTQ+ community group. This was open to the full community. Report was prepared overviewing the needs of the Tewksbury LGBTQ+ community and the report was shared with DEI Committee and listening session members. The results of the report were used to inform community group goals and structure. The outcome of the needs assessment show that older adults do not have an interest in a community group. FY24 plans include continuing to explore a community group for youth. To inform group establishment, the program coordinator is working with the gender and sexuality inclusive student group at Tewksbury High School to establish a trusting relationship to build on for programming in FY24. LGBTQIA+ Cultural Competency training for school staff was planned and will take place in Spring 2024, spearheaded by the DEI Committee.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: HART House Tewksbury** **Health Issue: Mental Health/Mental Illness, Substance Use Disorders**		
Brief Description or Objective	A long-term residential recovery home providing a 24-hour structured rehabilitative environment for pregnant and parenting women recovering from substance use disorder and/or alcohol use disorder. Treatment offered includes individual, family, group therapy and parenting education.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☒☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits	
Program Goal(s)	Provide a 24-hour structured rehabilitative environment for pregnant and parenting women recovering from substance use disorder and/or alcohol use disorder. The program aims to provide women with the skills necessary to maintain their sobriety and the knowledge, skills and guidance to be effective, nurturing parents.	
Goal Status	In FY23 the HART House provided 5,155 bed days of care to program participants and served 67 women and 108 children.	
Time Frame Year: Year 1	**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 ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒☐ Total Population or Community Wide Intervention
Program Goal(s)	To provide skilled supportive care to behavioral health patients in the Winchester Hospital Emergency Department.
Goal Status	In FY23 two behavioral health technicians provided a total of 1,005 hours of behavioral health patient care in the Winchester Hospital Emergency Department.

Time Frame Year: Year 1	**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 ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒☐ Total Population or Community Wide Intervention
Program Goal(s)	To provide skilled supportive care to behavioral health patients in the Winchester Hospital Emergency Department.
Goal Status	In FY23 two behavioral health technicians provided a total of 1,005 hours of behavioral health patient care in the Winchester Hospital Emergency Department.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Mental Health and Substance Use **Program Name: Winchester Hospital 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 ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒☐ Total Population or Community Wide Intervention
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 1,250 consultations in FY23.
Time Frame Year: Year 1	**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, child care personnel, classroom teachers, and guardians about effective asthma management.
Program Type	☒ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population or Community Wide Intervention
Program Goal(s)	To 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 FY23, 117 children participated in CHAMP. In addition, Winchester Hospital's pediatric asthma nurse specialist provided community outreach in our service area in FY23 via education and training sessions and private consultations and visits to educate students, teachers, and families about pediatric asthma. Visits included 146 home visits, 32 Facetime visits, 27 Zoom visits, 11 school visits, and 4 camp visits. One school training session was held via Zoom. 218 Asthma Action Plans completed and filed with schools and daycare centers.

Time Frame Year: Year 1	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 FY23, 848 mothers participated in the program. 89% of the new mothers surveyed after the program reported meeting the breastfeeding goal, they set during their initial consultation with the Lactation Specialist. 88% reported successfully breastfeeding for six months or more.

Time Frame Year: Year 1	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 FY23, there were 1,694 classes/sessions. The breakdown was as follows: integrative therapies for cancer patients (580), Flex and Stretch (88), Building Bones (79), Care of the Newborn (163), Childbirth (322), and online Breastfeeding Course (462).

Time Frame Year: Year 1	Time Frame Duration: Year 3	Goal Type: Process Goal

☐ Direct Clinical Services
☐Community Clinical Linkages
☒Total Population or Community Wide Intervention
☐Access/Coverage Supports
☐Infrastructure to Support Community Benefits

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 FY23, 16 bi-monthly social-worker facilitated mental health support group sessions were held, reaching 50 patients receiving care at the Winchester Center for Cancer Care. Art and knitting classes were also offered, reaching 103 patients.

Time Frame Year: Year 1	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 FY3, Winchester Hospital conducted 4,216 free screenings, an increase from 4,027 screenings in FY22. 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 1	**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	The Oncology Nurse Navigator dedicated 1744 hours, serving 2324 new patients.	
Time Frame Year: Year 1	**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	795 patients were served by the Caring Place in FY23, including 369 cold cap fittings and 426 wig/head covering fittings.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health & 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 FY23, Winchester Hospital Lab Services provided 6,488 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 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: Winchester Housing Authority Farmers Market** **Health Issue: Additional Health Needs Identified by the Community (Access to Healthy Food)**		
Brief Description or Objective	To address food insecurity among Winchester Housing Authority residents, 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 living at Winchester Housing Authority sites. To reduce transportation barriers, farmers markets were held at both Winchester Housing locations. Each week, more than six varieties of fresh produce 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 residents of the Winchester Housing Authority 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 Winchester Housing Authority produced the following outcomes: More than 3200 pounds of fresh produce, including more than six varieties of fruits and vegetables, were delivered to the two Winchester Housing Authority locations. A weekly newsletter featuring nutritional information and recipes for the fruits and vegetables was created and distributed with the produce. 9 program participants completed a pre-post market survey. Median age of survey respondents was 81 years old. Of those who completed the survey: 71% ate a greater variety of fruits and/or vegetables, 71% increased their daily intake of fruits and vegetables, and 71% eaten better quality produce.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: 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 help individuals with limited financial resources find options to cover the cost of their care and to help them apply for health coverage, public assistance, and/or the hospital's financial assistance program.	
Goal Status	In FY23, Patient Financial Counselors dedicated 2,080 hours to providing financial counseling/screening to 13,802 patients of which 592 were approved for entitlement programs. The number of patients with HSN served at Winchester Hospital was 1,483.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: 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 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	In FY23 Minuteman Senior Services Regional SHINE Program served 639 consumers/ Three state certified SHINE counselors provided Medicare benefit assistance to 171 consumers in Winchester at the Winchester Council on Aging and Winchester Cancer Care Center. Minuteman Senior Services Regional SHINE program hosted 9 community education presentation to people new to Medicare turning 65 or retiring at Arlington Adult Education, Winchester Council on Aging, Arlington Housing Authority, Arlington Council on Aging and Burlington Council on Aging.

Time Frame Year: Year 1	**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	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.	
Time Frame Year: Year 1	**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	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.	
Time Frame Year: Year 1	**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 FY23, 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 program will reach all seven schools in the district.	
Goal Status	Council of Social Concern provided backpacks with healthy food and snacks to 5 students from the Woburn Public Schools each week in FY23. The program was offered to all seven schools in the district.	
Time Frame Year: Year 1	**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	15 unique families were served during the 17-week market season and a total of nearly $2,500 dollars in SNAP match dollars were distributed. An off-season food access program was established to spend unused SNAP match dollars. This program supplied matching funds for produce boxes and prepared meals from Wilmington Farmer's Market vendors to the 15 participating SNAP recipient families.	
Time Frame Year: Year 1	**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	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

	☒ Total Population or Community Wide Intervention
Program Goal(s)	To help isolated or homebound community members, or those unable to shop for or prepare a meal due to illness or injury, remain independent in their homes by delivering low-cost, healthy meals. To reduce isolation and provide an opportunity for social engagement for residents living alone.
Goal Status	Winchester Hospital's kitchen staff, under the direction of the hospital's team of registered dietitians, prepared and packed 4,780 meals to meet the dietary needs of participants. The meals were delivered by hospital volunteers to homebound residents.

Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health **Program Name: BILH Office of Diversity, Equity, and Inclusion** **Health Issue: Additional Health Needs Identified by the Community**	
Brief Description or Objective	BILH's Diversity, Equity, and Inclusion (DEI) office 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 Intervention ☒ 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. Increase spend with diverse businesses by 25% over the previous fiscal year across the system. Expand system-wide DEI learning, in alignment with enterprise learning management solution. Support creation or expansion of local DEI committees/resource groups.
Goal Status	Across BILH there was a 25% increase in BIPOC leadership (directors and above) and clinical (physicians and nurses) hires over FY22. More than $50 million was contracted to Women and Minority-owned Business Enterprises (WMBE) in FY23. This is a 22% increase over FY22. 8 system-wide DEI trainings were conducted for all BILH staff and hospitals. Winchester Hospital is forming a Diversity, Equity and Inclusion Council to guide the hospital's efforts to nurture and sustain a diverse, equitable and inclusive organizational culture – and to make meaningful and lasting change for our patients, our employees and our communities.

Time Frame Year: Year 1	**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 FY23, Workforce Development will continue to encourage community referrals and hires. In FY23, Workforce Development will attend events and give presentations about employment opportunities to community partners. In FY23, Workforce Development will offer internships in BILH hospitals to community members over the age of 18. In FY23, Workforce Development will hire interns hired after internships and place in BILH hospitals. In FY23, Workforce Development will offer English for Speakers of Other Languages (ESOL) classes to BILH employees. In FY23, Workforce Development will offer citizenship, career development workshops, and financial literacy classes to BILH employees.	
Goal Status	In FY23, 225 job seekers were referred to BILH and 70 were hired across BILH hospitals. In FY23, 67 events and presentations were conducted with community partners across the BILH service area. In FY23, 54 community members placed in internships across BILH hospitals to learn valuable skills. Winchester Hospital participated in offering these internships. In FY23, 22 interns were hired permanently in BILH hospitals. Winchester Hospital participated in these hirings. In FY23, 45 employees across BILH were enrolled in ESOL classes. Winchester Hospital employees participated in these classes. In FY23, 20 BILH employees attended citizenship classes, 135 BILH employees attended career development workshops and 189 BILH employees attended financial literacy classes. Winchester Hospital employees participated in these offerings.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Access to Care
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 FY23, Winchester Hospital implemented the Collaborate Care Model at 11 sites, serving 1,053 patients.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**		**Goal Type: Process Goal**

Priority Health Need: Access to Care **Program Name: Behavioral Health Crisis Consultation** **Health Issue: Mental Health/Mental Illness/Substance Use Disorder**			
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 Master's 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.		
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	In FY23, 1,250 screens were completed.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**		**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Patient Transportation Voucher Program** **Health Issue: Additional Health Need Identified by the Community (Transportation)**		
Brief Description or Objective	BILH's Diversity, Equity, and Inclusion (DEI) office 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 Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to health services by providing rides to individuals with no means of transportation due to medical or financial issues.	
Goal Status	In FY23, Winchester Hospital provided 130 rides to patients with transportation needs to and from medical appointments. In FY23 the Winchester Center for Cancer Care provided vouchers for 240 medical appointment rides for patients.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Social Determinants of Health & 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 FY23, Winchester Hospital provided 3,275 interpreter encounters. The top three language requests were: Spanish, Portuguese, and Chinese Mandarin.	
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Outcome Goal**

Priority Health Need: Infrastructure **Program Name: Infrastructure to support Community Benefits collaborations across BILH hospitals**

Health Issue: Health Professional/Staff Training			
Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital worked together to plan, implement, and evaluate Community Benefits programs. Community Benefits staff continued to understand state and federal regulations, build community engagement and evaluation capacity, and collaborate on implementing similar programs. BILH continues to refine the Community Benefits (CB) database, as part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.		
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits	
Program Goal(s)	By September 30, 2023, BILH Community Benefits and Community Relations staff will participate in workshops to build community engagement skills and expertise. By September 30, 2023, continue to refine a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits data to more accurately capture and quantify CB/CR activities and expenditures. By September 30, 2023, all BILH Hospitals will launch a Community Connections newsletter on a quarterly basis to communicate community benefits activities to community partners, residents, and vested parties.		
Goal Status	All 10 BILH Community Benefits hospitals participated in 4 community engagement workshops. All FY23 regulatory reporting data were entered into the Community Benefits Database. The ability for community organizations to apply for grants was added in FY23. Winchester Hospital launched and sent 2 newsletters to a mailing list of 83 organizations and people.		
Time Frame Year: Year 1	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**	

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$2,323,908.00	
Community-Clinical Linkages	$86,912.00	
Total Population or Community Wide Interventions	$608,344.00	$129,750.00
Access/Coverage Supports	$623,793.00	$355,511.00
Infrastructure to Support CB Collaborations	$19,314.00	
Total Expenditures by Program Type	$3,662,271.00	
CB Expenditures by Health Need		
Chronic Disease	$781,227.20	
Mental Health/Mental Illness	$1,372,449.70	
Substance Use Disorders	$419,313.80	
Housing Stability/Homelessness	$21,206.90	
Additional Health Needs Identified by the Community	$1,068,073.40	
Total by Health Need	$3,662,271.00	
Leveraged Resources	$2,287,807.00	
Total CB Programming	**$5,950,078.00**	
Net Charity Care Expenditures		
HSN Assessment	$1,717,777	
HSN Shortfall	$1,034,655	
HSN Denied Claims	$433,032.00	
Total Net Charity Care	$3,185,464.13	
Total CB Expenditures	**$9,135,542.13**	

Additional Information	
Net Patient Services Revenue	$338,554,349
CB Expenditure as % of Net Patient Services Revenue	3%
Approved CB Budget for FY24 (*Excluding expenditures that cannot be projected at the time of the report)	$9,135,542.13
Bad Debt	$2,668,436.00
Bad Debt Certification	Yes

Optional Supplement	
Comments	Winchester Hospital makes a PILOT payment to the Town of Winchester

SECTION VI: CONTACT INFORMATION

LeighAnne Taylor
Winchester Hospital
Winchester Hospital
Community Benefits & Community Relations
41 Highland Avenue
Winchester, MA 01890
Leighanne.taylor@bilh.org

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:

Al Campbell, President, Winchester Hospital **(new member);** Felisha Marshall, Director of Housing Supports, Metro Housing Boston **(new member)**; Jaimie Bowers, Information and Referral Benefits Specialist, Mystic Valley Elder Services **(new member)**; Jessie Bencosme, Executive Director, Council of Social Concern, Woburn; Angeline Brady, Community Health Programs Supervisor, Winchester Hospital Center for Healthy Living; Dot Butler, Winchester SAFER Coalition; Denise Flynn; Vice President of Philanthropy, Winchester Hospital; Christine Healey, Director of Community Benefits/Community Relations, Beth Israel Lahey Health; Karen Keaney, Chief Nursing Officer; Deb McDonough, Winchester Hospital Board of Trustees; Terri Marciello, Director of Elderly Services, Wilmington; Jennifer Murphy, Director of Health, Winchester Health Department; Sharon Ron, Public Health Planner, Metropolitan Area Planning Commission; Adam Rogers, Executive Director, Boys & Girls Club of Stoneham & Wakefield; Maureen Ryan, Assistant Superintendent, Woburn Public Schools; Joseph Tarby, Winchester Hospital Board of Trustees; LeighAnne Taylor, Regional Manager, Community Benefits and Community Relations Winchester Hospital; Matthew Woods, Chief Financial Officer, Winchester Hospital; Jane Walsh, Winchester Hospital Board of Trustees.

II. Community Engagement

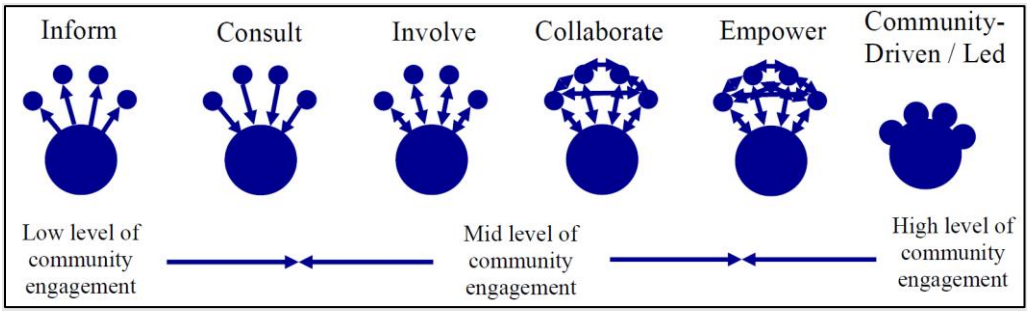
- Organizations Engaged in CHNA and/or Implementation Strategy
  If there have been any updates to the key partners with whom the hospital collaborates, please indicate in the table below. Please feel free to add rows as needed.

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).

III. <u>Updates on Regional Collaboration</u>

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.