Community Benefits Report

Fiscal Year 2020

Beth Israel Lahey Health
Winchester Hospital

TABLE OF CONTENTS

SECTION I: SUMMARY AND MISSION STATEMENT

Summary and Mission Statement:

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

At the heart of BILH is the belief that everyone deserves high-quality, affordable health care. This belief is what drives us to work with community partners across Winchester Hospital's Community Benefits Service Area (CBSA), comprised of nine cities and towns – Medford, North Reading, Reading, Stoneham, Wakefield, Wilmington, Winchester, Woburn, and Tewksbury – to promote health, expand access, and deliver the best care in the communities we serve.

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

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

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

Winchester Hospital's Community Benefits mission is fulfilled by:

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

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

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

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

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

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

Target Populations:

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

- Low-Resource Individuals & Families
- Older Adults
- Youth and Adolescents
- Individuals with Chronic/Complex Conditions

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

Basis for Selection:

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

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

Quantitative Data Sources:

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

Qualitative Data Sources:

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

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

Key Accomplishments for FY20:

The accomplishments highlighted in this report are based on priorities identified and programs contained in Winchester Hospital's FY19 CHNA and FY20-22 IS:

- ***Community Home Blood Draw Program*** – Winchester Hospital Phlebotomy staff provided home blood draws for 10,293 patients who were homebound due to illness, injury, or transportation issues.
- ***Food Insecurity Relief Initiative*** – In response to the significant increase in food insecurity due to factors associated with the COVID-19 pandemic, Winchester Hospital provided more than $40,000 in support to help local food pantries, senior centers, and various community organizations reduce food insecurity for over 20,000 community members and families. In addition to on-site pickup locations, local organizations provided home deliveries of food and essential items from March through September to reduce transportation barriers and respond to concerns people had about the safety of leaving their home.
- ***Metro Housing Boston Co-Location Program*** – Free counseling was provided to 107 low- to moderate-income individuals and families to help prevent them from being evicted, increase housing stability and economic self-sufficiency, and improve their overall quality of life. Counselors also helped with housing searches, emergency assistance, rapid rehousing, and benefits maximization, and connected participants to community resources.

- ***Community and Hospital Asthma Management Program (CHAMP)*** – In FY20, 84 children were enrolled in CHAMP, a pediatric asthma management program in which the pediatric asthma nurse specialist works collaboratively with the child, family, doctor, and school personnel to improve each child's management of asthma, which resulted in fewer missed school days and emergency room visits and improved overall quality of life.

- ***Mobile Mental Health Program*** – In collaboration with Mystic Valley Elder Services, the Mobile Mental Health Program provided home-based mental health services to 329 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.

- ***Chronic Disease Management Program*** – In FY20, 72 adults with chronic diseases participated in this program, which helped them better manage their health and overall quality of life by addressing the physical and psychological effects of chronic disease and improve their coordination of care.

For the FY20 reporting year, Winchester Hospital dedicated a great deal of time and resources at the local level in response to the COVID-19 pandemic. Winchester Hospital was intentional when assessing risk factors within its CBSA, working closely with their local health department(s). Clinical staff provided infection control expertise to local health departments as they were developing their reopening plans. Winchester Hospital worked to expand community testing access and worked with BILH as a system to develop and distribute written materials (in nine languages) to the communities most impacted by COVID-19, to help slow the spread. Winchester Hospital redeployed staff and procured tangible necessities for both the community at large and hospital staff, such as personal protective equipment (PPE), food, hand sanitizer, and other critical items. Many of the programs highlighted in this report had to be modified significantly due to COVID-19 and related safety guidelines. In some cases, programs were expanded. In others, programs were cut or significantly reduced because of the pandemic.

Plans for Next Reporting Year:

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

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

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). These priority areas 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 FY19 CHNA provided new guidance and invaluable insights on quantitative trends and community perceptions that are being used to inform and refine Winchester Hospital's efforts. In completing the FY19 CHNA and FY20-22 Implementation Strategy, Winchester Hospital, along with its other health, public health, social services, and community partners, is committed to improving the health status and well-being of all residents living throughout its CBSA. As discussed above, based on the CHNA's quantitative and qualitative findings, including discussions with a broad range of community participants, there was agreement that Winchester Hospital's FY20-22 IS should prioritize certain demographic, socioeconomic, and geographic population segments that have complex needs and face barriers to care and a service gap, as well as other adverse social determinants of health. These factors put these segments at greater risk, limit their access to needed services, and can often lead to disparities in health outcomes. More specifically, the FY19 CHNA identified the importance of supporting initiatives that target low-resource individuals and families, youth, older adults, and individuals with chronic/complex conditions.

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

Organization	Focus Area	Level of Engagement
Boys & Girls Club of Stoneham/Wakefield	Mental Health	Collaborate
Council of Social Concern	Access to Food	Collaborate
Metro Housing Boston	Housing	Collaborate
Winchester Housing Authority	Access to Food	Collaborate
Stoneham Council on Aging	Chronic/Complex Conditions	Collaborate

Hospital Self-Assessment Form:

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

SECTION II: COMMUNITY BENEFITS PROCESS

Community Benefits Leadership & Community Benefits Advisory Committee:

The membership of Winchester Hospital's CBAC aspires to be representative of the constituencies and priority populations served by Winchester Hospital's programmatic endeavors, including those from diverse racial and ethnic backgrounds and of diverse age, gender, sexual orientation, and gender identity, as well as those from corporate and nonprofit community organizations. Senior management is actively engaged in the development and implementation of the Community Benefits plan, ensuring that hospital policies and resources are allocated to support planned activities.

Winchester Hospital FY20 CBAC Members:

- Richard Weiner, President, Winchester Hospital
- Jane Walsh, Winchester Board of Trustees Chair, Member of BILH Board and Community Benefits Committee
- Paul Andrews, Winchester Hospital Board of Trustees
- Michael Baldasarre, Assistant Superintendent, Woburn Public Schools
- Carla Beaudoin, Director of Development, Metro Housing Boston
- Dot Butler, Winchester SAFER Coalition
- Denise Flynn, Vice President of Philanthropy, Winchester Hospital
- Marylou Hardy, Regional Manager, Community Benefits and Community Relations, Winchester Hospital
- Christine Healey, Director of Community Benefits/Community Relations, BILH
- Karen Keaney, Associate Chief Nursing Officer, Emergency Department, and Case Management
- Deb McDonough, Winchester Hospital Board of Trustees
- Jennifer Murphy, Director of Health, Winchester Health Department
- Lauren Reid, Director of Community Programs, Mystic Valley Elder Services
- Adam Rogers, Executive Director, Boys & Girls Club of Stoneham & Wakefield
- Kathy Schuler, Chief Operating Officer, Chief Nursing Officer, Winchester Hospital
- Dean Solomon, Executive Director, Council of Social Concern, Woburn
- Joseph Tarby, Winchester Hospital Board of Trustees
- Matthew Woods, Vice President of Finance, Winchester Hospital
- Sue Powers, Associate Director of the Winchester Hospital Center for Healthy Living and Nursing Staff Development

It is not only the Board members and senior leadership who are held accountable for fulfilling Winchester Hospital's Community Benefits mission. Among Winchester Hospital's core values is the recognition that the most successful Community Benefits programs are implemented organization wide and integrated into the very fabric of the hospital's

culture, policies, and procedures. A commitment to Community Benefits is a focus and value manifested throughout Winchester Hospital's structure and reflected in how it provides care at the hospital and in affiliated practices.

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

The Winchester Hospital Community Benefits program is spearheaded by the BILH Community Benefits/Community Relations Regional Manager. The Regional Manager 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 Strategy Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of underserved populations are considered every day in discussions on resource allocation, policies, and program development.

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

Community Benefits Advisory Committee Meetings:

The Winchester Hospital CBAC met four times in FY20 to oversee and provide guidance on the Community Benefits programs and services outlined in the FY19-22 Implementation Strategy, and to provide feedback and direction on the FY19 CHNA process and the development of Winchester Hospital's corresponding IS.

CBAC meeting dates: October 30, 2019; March 3, 2020; April 23, 2020; and September 30, 2020.
In addition, Winchester Hospital held a public meeting in conjunction with its CBAC on December 13, 2019. The public meeting was held at the Winchester Hospital Center for Cancer Care, 620 Washington Street, Winchester. The location was selected because it is centrally located in WH's CBSA, is easily accessible via public transportation, and has parking. The agenda included an overview of the findings from the 2019 CHNA, FY19 Community Benefits program highlights, and plans for FY20-22 Community Benefits programming, as outlined in the Implementation Strategy. The group provided feedback on the identified priority needs and proposed strategies to address the needs. The meeting was attended by more than 40 community members and organizations from all nine cities and towns in WH's CBSA.

Community Partners:

Winchester Hospital recognizes its role as a community hospital in a larger health system and knows that to be successful it needs to collaborate with its community partners and those it serves. Winchester Hospital's Community Health Needs Assessment and the associated Implementation Strategy were completed in close collaboration with Winchester Hospital's staff, its health and social services partners, and the community at large. Winchester Hospital's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of Winchester Hospital's mission.

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

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

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

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

The following is a comprehensive listing of FY20 community partners with which Winchester Hospital joins in assessing community need as well as planning, implementing, and overseeing its Community Benefits Implementation Strategy:

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

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY19 Community Health Needs Assessment along with the associated FY20-22 Implementation Strategy was developed over a 10-month period from October 2018 to August 2019. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and Federal Internal Revenue Service (IRS) requirements. More specifically, these activities fulfill Winchester Hospital's need to conduct a community health needs assessment, engage the community, identify priority health issues, inventory community assets, assess impact, and develop an implementation strategy. However, these activities are driven primarily by Winchester Hospital's dedication to its mission, its covenant to care for the underserved, and its commitment to community health improvement. Below is a summary description of the FY19 CHNA approach, methods, and key findings.

Approach and Methods:

The assessment began in December 2018 and was conducted in three phases, allowing for the collection of an extensive amount of quantitative and qualitative data:
Phase 1 – Preliminary assessment and engagement
Phase 2 – Targeted engagement
Phase 3 – Strategic planning and reporting
Hundreds of individuals from across Winchester Hospital's service area were engaged in the assessment and planning process, including health and social services providers, public health officials, elected officials, public school nurses and administrators, first responders, leaders of faith-based organizations, BILH senior leadership, staff, and board members, and community residents.

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

- U.S. Census Bureau, American Community Survey 5-Year Estimates (2013-2017)
- Massachusetts Department of Elementary and Secondary Education: School and District Profiles
- FBI Uniform Crime Reports (2017)
- Massachusetts Department of Public Health, Registry of Vital Records and Statistics (2015)
- Massachusetts Department of Public Health, Bureau of Substance Abuse Services (2017)
- Massachusetts Department of Public Health, Annual Reports on Births (2016)
- Massachusetts Department of Public Health, Opioid Related EMS Incidents (2018)

- Massachusetts Bureau of Infectious Disease and Laboratory Sciences (2017)
- Massachusetts Center for Health Information Analysis (CHIA) Hospital Profiles (FY 2013-2017)
- Massachusetts Center for Health Information Analysis (CHIA) Hospital Discharges (2017)
- Massachusetts Healthy Aging Collaborative, Community Profiles (2018)
- Middlesex League Youth Risk Behavior Survey (2019)
- Changing Faces of Greater Boston, Boston Foundation (2019)

Qualitative Data Sources:

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

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

Individuals provided input through interviews, focus groups, community listening sessions, and a widely distributed Community Health Survey. While it was not possible for the CHNA to involve all community stakeholders, every effort was made to be as inclusive as possible and provide a broad range of opportunities for participation. Winchester Hospital's Community Benefits program is built on partnership and dialogue with our many communities. Our understanding of these communities' needs is derived from discussions with and observations by health care and health-related workers in the neighborhoods as well as from more formal assessments of public health data and through focus groups, surveys, etc. This data was then augmented by demographic and health status information from a variety of sources including the Massachusetts Department of Public Health, federal resources such as the Institute of Medicine and the Centers for Disease Control and Prevention, and review of literature relevant to a particular community's needs. An articulation of each specific community's needs (crafted jointly by Winchester Hospital and community partners) informs Winchester Hospital's decision-making about priorities for Community Benefits efforts. We work in concert with community residents and leaders to design specific actions to be undertaken each year. Each component of the plan is woven into the goals and agenda for Winchester Hospital's Community Benefits Implementation Strategy, adopted by the Board of Trustees.

Summary of FY19 CHNA Key Health-Related Findings:

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

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

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

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

Section IV: Community Benefits Programs

Priority Area #1: Mental Health & Substance Use Disorders

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

Brief Description or Objective

This program utilizes an innovative approach to screening, identifying, and providing intervention as early as possible for youth who have or are at risk of developing mental health or substance use disorders. The program is delivered on-site at the Boys & Girls Club by staff members who know the participants and see them on a regular basis. Staff members are the participants' mentors and are highly liked and respected. Administering the program in this nonauthoritarian, safe environment results in more natural, open, and honest dialogue. The program incorporates three components:

1. **Screening:** Two screening tools are used based on age (older teens get a combination of the two):
   - CRAFFT behavioral screening tool – ages 12-17
   - QPR – ages 8 and up
2. **Interventions (ongoing):**
   - Positive reinforcement: inoculation effects on at-risk youth
   - Weekly meetings between at-risk youth and an assigned mentor
   - Group discussions led by social workers and staff, focused on current events and challenges
3. **Referral to Treatment:** Youth with symptoms of mental health or substance use disorder are referred immediately to guardians and treatment providers. In addition, they receive ongoing support with opening a dialogue with their parents and accessing treatment.

Target Population (select as many as needed)

- **Regions Served:** Stoneham/Wakefield
- **Gender:** All • **Age Group:** Children, Teenagers • **Race/Ethnicity:** All
- **Language:** English, Spanish
- **Environment Served:** ☐All ☐Urban ☐Rural ☒Suburban
- **Additional Target Population Status:**
  ☐ Disability Status ☐ LGBT Status ☐ Incarceration History ☒ NA
  ☐Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status

Program Type

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

DoN Priorities (up to 3)

☐Built Environment
☒Social Environment
☐Housing
☐ Violence
☐Education
☒ Employment
☐ NA

EOHHS Health Need

☐Chronic Disease
☐Housing/Homelessness
☒ Mental Health/Mental Illness
☒ Substance Use
☒ Additional Health Needs

Additional Program Descriptors

☒Community Education
☐Community Health Center Partnership
☐ Health Professional/Staff Training
☒ Health Screening
☒ Mentorship/Career Training/Internship
☐Physician/Provider Diversity
☐ Prevention
☐ Research
☐ Support Group

Program Goal	Identify youths who have or are at risk of developing mental health or substance use disorders, deliver immediate intervention and/or referral to treatment to those at risk, and ensure sustainability by training staff to become leaders/mentors who in turn train additional staff.
Goal Status	• Four staff members were trained in early recognition, basic treatment, and SBIRT methodology, bringing the total to 31 staff members trained. • Four staff members were trained in screening techniques, motivational interviewing, treatment of substance use disorders, and suicide prevention, bringing the total to 10 trained staff members. • 220 youths were screened in FY20, resulting in the following: o One participant was referred to treatment. o 22 participants were referred to staff mentors. o 91% of referred participants attended weekly mentoring sessions. o 91% of referred participants maintained a connection with a mentor into the next school year. o 91% reported they were less likely to participate in risky behaviors. o 91% identified an adult to talk to if they felt depressed or had thoughts of self-harm. o 65% of all participants improved their accuracy in estimating peer marijuana and tobacco use.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Community Partner:	**Website Address:**
Boys & Girls Club of Stoneham & Wakefield	Bgcstoneham.org
Stoneham Coalition for a Healthy Community	stoneham-ma.gov
Riverside Healthcare	Riversidehealthcare.org

Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org

Priority Health Need: Mental Health & Substance Use Disorders
Program Name: Winchester High School Zen Garden
Health Issue: Mental Health, Substance Use

Brief Description or Objective	Winchester Hospital provided financial support for this community-backed, student-led initiative for the development and construction of a multifunctional reflective garden on-site at Winchester High School. The goal of the garden is to help students reduce their levels of stress and improve their overall mental health by ensuring that all students have access to a peaceful and beautiful space where they can relax, meditate, and/or converse quietly in a safe outdoor environment.
Target Population (select as many as needed)	• **Regions Served:** Winchester • **Gender:** All • **Age Group:** Teenagers • **Race/Ethnicity:** All • **Language:** English • **Environment Served:** ☐All ☐Urban ☐Rural ☒Suburban • **Additional Target Population Status:** ☐Disability Status ☐LGBT Status ☐ Incarceration History ☒ NA ☐Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐Direct Clinical Services ☐Access/Coverage Supports ☐ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☒ Total Population or Communitywide Intervention

DoN Priorities (up to 3)	☐Built Environment ☒Social Environment ☐Housing	☐ Violence ☐Education ☒ Employment	☐ NA
EOHHS Health Need	☐Chronic Disease ☐Housing/Homelessness	☒ Mental Health/Mental Illness ☒ Substance Use	☒ Additional Health Needs
Additional Program Descriptors	☒Community Education ☐Community Health Center Partnership ☐ Health Professional/Staff Training ☒ Health Screening	☒ Mentorship/Career Training/Internship ☐Physician/Provider Diversity	☐ Prevention ☐ Research ☐ Support Group
Program Goal	The goal of the garden is to help students reduce their levels of stress and improve their overall mental health by ensuring that all students have access to a peaceful and beautiful space where they can relax, meditate, and/or converse quietly in a safe outdoor environment.		
Goal Status	In 2020, despite the many demands on the school department due to COVID-19, its leadership and the project management team at Winchester's town hall were able to support the student Zen Club in the construction of most of the garden. This included managing the public bid process over late summer and completion of the site work and installation of pathways, asphalt foundation, stonework, and a fountain. Spring 2021 will see the installation of plantings and a labyrinth design. While access to the site has been limited by school policies about congregating on school grounds for the short term, the garden is visible to all who enter the building and is available for small groups of students during lunch, when students are particularly encouraged to be out of doors. The progress of the garden has been encouraging to the student body and staff, and it is expected that it will be able to be enjoyed by the student body of almost 1,500 by late spring. As school returns to its full capacity and rules on congregating in person are eased, the Zen Club fully expects that the garden as a place to reflect, relax, and take a break from the business and stress of the school day will be more welcome than ever.		

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

Community Partner:	**Website Address:**
Winchester High School	Winchesterps.org
Town of Winchester	Winchester.ma.gov

Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org

Priority Health Need: Mental Health & Substance Use Disorders **Program Name: Winchester Interface Referral Service** **Health Issue: Mental Health, Substance Use**	
Brief Description or Objective	As per findings from recent local data including the Winchester Schools Youth Risk Behavior Survey, 2018 police reports, and a 2018 communitywide survey distributed to all Winchester residents, mental health and stress were reported to be among the top three health issues having an impact on members of the community. The survey also revealed that there is a great need for community members to learn about and connect with mental health resources in a more convenient and confidential way. In response to this need, Winchester Hospital collaborated with the Winchester SAFER Coalition to support the development of the Interface helpline, launched in January 2020. The service incorporates the William James Interface Referral Service, a confidential service offered for free to all community members. The Interface counselor matches callers with providers and counselors based on their needs, and follows up with each caller to ensure the match was successful and that the caller has received the help they need. COVID-19 has led to increased mental health challenges and levels of stress for residents. The Interface service was integral in addressing this need by connecting residents to mental health providers and wellness services.
Target Population (select as many as needed)	• **Regions Served:** Winchester • **Gender:** All • **Age Group:** All • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☐All ☐Urban ☐Rural ☒Suburban • **Additional Target Population Status:** ☐Disability Status ☐LGBT Status ☐ Incarceration History ☒ NA ☐Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐Direct Clinical Services ☐Access/Coverage Supports ☒Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☐Built Environment ☐ Violence ☐ NA ☒Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Health Need	☐Chronic Disease ☒ Mental Health/Mental Illness ☐ Additional Health Needs ☐Housing/Homelessness ☒ Substance Use
Additional Program Descriptors	☒Community Education ☐ Mentorship/Career Training/Internship ☒ Prevention ☐Community Health Center Partnership ☐Physician/Provider Diversity ☐ Research ☐ Health Professional/Staff Training ☐ Support Group ☐ Health Screening
Program Goal	To address mental health challenges of residents and increase access to care by connecting participants/callers to mental health and wellness resources in a timely manner.

Goal Status	The Interface service was launched in January 2020. In FY20, 85 residents were served. As a result of the COVID-19 pandemic, there was an increased demand for the service from March through September, with more than 83% of the total for the year served during that time. Of the 82 residents served in FY20: • 59.6% were female, 40.4% male • Races and ethnic groups served included white, Latino, Asian, and multiracial • The top three presenting issues were anxiety, depression, and COVID-19-related issues/stress • The age ranges of those served were: ○ 6-12 years old – 27.2% ○ 18-24 years old – 6.4% ○ 13-17 years old – 38.3% ○ 25-59 years old – 21.3% ○ 60+ years old – 6.4%

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**

Community Partner:	**Website Address:**
Winchester SAFER Coalition	Winchestercoalitionsafercommunity.com
Winchester Health Department	Winchester.us

Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org

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

Brief Description or Objective	Winchester Hospital collaborated with Mystic Valley Elder Services (MVES) to support the Mobile Mental Health Program in providing home-based mental health services to older adults in Medford, North Reading, Reading, Stoneham, and Wakefield. The program addresses a variety of issues affecting older adults' emotional well-being and quality of life such as hoarding, depression, anxiety, adjustment to loss, and substance use. The goal is to get trained professionals to clients as soon as possible to ensure recovery. A Clinical Caseworker provides participants with ongoing communication and linkages to health care services such as in-home mental health therapy, medication evaluation, and other supports as needed. The COVID-19 pandemic had an impact on the program, and beginning in March 2020, treatment was flexibly designed to continue the program despite COVID-19 restrictions. For participants already in the program prior to the pandemic, caseworkers reached out by phone to check in and assess needs. Caseworkers provided additional phone counseling to those in need, and continued to make referrals to counseling or peer services for participants not already enrolled. Currently, Clinical Caseworkers and assigned therapists are continuing to rely on telephone and online technology as the primary method of communication. Decisions to make during in-person visits are being carefully determined and carried out only as deemed necessary during the pandemic to ensure the safety and health of the older adult and the Clinical Caseworker are maintained. In all cases, in-home visits are carried out with the appropriate PPE and social distancing for both the older adult and the Clinical Caseworker. Despite the virus, staff continues to stay on top of the needs of Mobile Mental Health Program participants.
Target Population (select as many as needed)	• **Regions Served:** Medford, North Reading, Reading**,** Stoneham/Wakefield • **Gender:** All • **Age Group:** Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☐All ☐Urban ☐Rural ☒Suburban • **Additional Target Population Status:** ☒ Disability Status ☐LGBT Status ☐ Incarceration History ☐ NA ☐Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status

Program Type	☐Direct Clinical Services ☐ Community Clinical Linkages ☐Total Population or Communitywide Intervention ☒ Access/Coverage Supports ☐Infrastructure to Support Community Benefits
DoN Priorities (up to 3)	☒ Built Environment ☒Social Environment ☐Housing ☐ Violence ☐Education ☒ Employment ☐ NA
EOHHS Health Need	☒ Chronic Disease ☐Housing/Homelessness ☒ Mental Health/Mental Illness ☒ Substance Use ☐ Additional Health Needs
Additional Program Descriptors	☒Community Education ☐Community Health Center Partnership ☐ Health Professional/Staff Training ☒ Health Screening ☒ Mentorship/Career Training/Internship ☐Physician/Provider Diversity ☐ Prevention ☐ Research ☐ Support Group
Program Goal	To address behavioral and mental health concerns in order to improve mental health and emotional well-being of older adults and to increase access to mental health care by providing home-based mental health counseling and direct care services including diagnosis, prescription medication, and therapy in Medford, North Reading, Reading, Stoneham, and Wakefield.
Goal Status	As a result of the COVID-19 pandemic, treatment was redesigned in FY20 to make it possible to continue the program, with Clinical Caseworkers and therapists pivoting to telephone and online technology as the primary methods of communication. Despite the challenges, the Mobile Mental Health Program provided services to a total of 329 community members, 34% (114) in the Winchester Hospital CBSA: Medford (46), Stoneham (25), North Reading (6), Reading (20), and Wakefield (17). • There was an average of 15 new referrals per month. • Caseworkers provided 211 hours of counseling. • Services provided to residents living in the WH CBSA included: - Case management – 65 - One-to-one counseling – 48 - Referrals to community resources/services – 44 - Financial assistance – 11 - Resource management (arranging and dropping off food, furniture, medications, etc.) – 11 - Provider collaboration – 38 - Family support/collaboration – 24 - Wellness checks –10 - Transportation arrangements – 4 • Number of self-reported and observed diagnosis/conditions or increased risk: - Depression – 51 - General anxiety – 38 - Dementia – 7 - Suicidal – 5 - PTSD – 5 - Comorbid psychiatric illness – 6 - Decreased ability managing daily activities – 37 - Unstable housing- 7 - Financial instability- 6 - Risk of suicide or self-harm- 7 - Risk for abuse, neglect or exploitation- 9 - Risk for significant health issues- 32 • Participants reported the following outcomes in a survey administered by the caseworker: - Improved health outcomes (100 participants) - Changed or improved healthy lifestyle behaviors (98 participants) - Root causes of participants' health issues were depression, anxiety, grief, and loneliness. • Health inequities addressed included low-income, homebound, and mobility issues.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**
Community Partner: Mystic Valley Elder Services	**Website Address:** MVES.org	

Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org

Priority Area #2: Chronic/Complex Conditions

Priority Health Need: Chronic Complex Condition
Program Name: High-Risk Intervention Program
Health Issue: Chronic Disease, Care Coordination

Brief Description or Objective	Every day, millions of people with chronic diseases struggle to manage their symptoms. According to the National Council on Aging, approximately 80% of older adults have at least one chronic disease, 68.4% have two or more, and 36.4% have four or more. Chronic diseases such as heart failure and chronic obstructive pulmonary disease can affect a person's ability to perform important activities, restricting their engagement in life and their enjoyment of family and friends. In addition, these progressive conditions can result in frequent hospital readmissions and fragmented care. In response to this need, Winchester Hospital created the High-Risk Intervention Program to help adults with chronic disease manage and improve their health. The program includes a consultation with a nurse from the Center for Healthy Living, followed by at least two phone consultations to help patients manage their care and medications, assist with medical appointments, and facilitate communication among all members of the patient's care team. The team also works to identify and address any social determinants of health that could be negatively impacting the patient's health. Conversations regarding end-of-life and palliative care are also initiated when appropriate. The program was offered upon discharge to at-risk patients who have multiple health conditions and/or social determinants of health that could put their health and safety at risk, such as lower income, problems with their physical home environment, lack of family support, and lack of access to care.
Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** All • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban • **Additional Target Population Status:** ☒ Disability Status ☐LGBT Status ☐ Incarceration History ☐Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☒ Direct Clinical Services ☐Access/Coverage Supports ☐ Community Clinical Linkages ☐Total Population or Communitywide Intervention ☐Infrastructure to Support Community Benefits
DoN Priorities (up to 3)	☐Built Environment ☐ Violence ☐ NA ☒Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Health Need	☒ Chronic Disease ☒ Mental Health/Mental Illness ☐ Additional Health Needs ☐Housing/Homelessness ☒ Substance Use
Additional Program Descriptors	☒Community Education ☐ Mentorship/Career Training/Internship ☒ Prevention ☐Community Health Center Partnership ☐Physician/Provider Diversity ☐ Research ☐ Health Professional/Staff Training ☐ Support Group ☐ Health Screening

Program Goal	The program goals are to help participants effectively manage their health and enhance their overall quality of life by addressing the physical and psychological effects of chronic disease and improving coordination of care, and to help those being treated with prednisone recover and successfully taper the dosage without medical complications.
Goal Status	Due to COVID-19, the program was put on hiatus from January to June because the nurses were deployed to the Incident Command Center, and the program was eliminated in August due to reallocation of funds and resources. The outcomes for the five months of operation (October, November, and December 2019 and June and July 2020) were: • 72 patients were discharged on a prednisone taper and enrolled in the Prednisone Taper Protocol. • One patient was readmitted having failed the prednisone taper.

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Process Goal**
Community Partner: NA	**Website Address:**	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Health Need: Chronic/Complex Conditions
Program Name: CHAMP Pediatric Asthma Program
Health Issue: Chronic Disease, Asthma, Pediatric Asthma

Brief Description or Objective	According to the American Academy of Pediatrics, pediatric asthma continues to be a leading cause of hospital admissions in the U.S., with readmission rates of between 10% and 40%. Asthma is the leading chronic disease in children, affecting about 10% of those under age 18. In addition, it is the No. 1 reason for missed school days. According to Winchester Hospital's 2019 CHNA, hospital admission rates for asthma patients under the age of 20 were significantly higher in certain towns in its service area, such as Woburn (35% higher than the county and 16% higher than the state) and Medford (29% higher than the county and 20% higher than the state). According to the CDC's Vital Signs report on pediatric asthma, action plans can decrease the rate of asthma-related hospitalizations by more than 5%. As a result, Winchester Hospital's Center for Healthy Living developed and launched CHAMP, a model of care that uses a team approach proven to help children with asthma manage the condition more effectively. The team consists of family members, caregivers, the child's pediatrician and/or primary care physician, clinical staff from Winchester Hospital, the child's school nurse, child care personnel, classroom teachers, and anyone else who may be in a position to advise the child and his/her parents about asthma management.
Target Population (select as many as needed)	• **Regions Served:** Winchester • **Gender:** All • **Age Group:** Children, Teens • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☐All ☐Urban ☐Rural ☒Suburban • **Additional Target Population Status:** ☐Disability Status ☐LGBT Status ☐ Incarceration History ☐Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐Total Population or Communitywide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits

DoN Priorities (up to 3)	☒ Built Environment ☐ Social Environment ☐Housing	☐ Violence ☐Education ☐ Employment	☐ NA
EOHHS Health Need	☒ Chronic Disease ☐Housing/Homelessness	☐ Mental Health/Mental Illness ☐ Substance Use	☐ Additional Health Needs
Additional Program Descriptors	☒Community Education ☐Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening	☐ Mentorship/Career Training/Internship ☐Physician/Provider Diversity	☒ Prevention ☐ Research ☐ Support Group
Program Goal	To reduce emergency department visits for pediatric asthma patients by ensuring effective control of the disease through treatment and through education of patients, families, physicians, and other health professionals.		
Goal Status	Due to COVID-19, CHAMP was put on hold from March to September 2020, as the Pediatric Asthma Nurse Specialist was reassigned to the hospital. During this time, she maintained contact via email or text messages with CHAMP families as needed, and the following outcomes were achieved: • Four new children were enrolled in the program, bringing the total to 85 children enrolled. • Of the 85 enrolled in the program, there were only four emergency department visits and zero hospital admissions, compared to the state average of 18.5 visits as reported in the Massachusetts Department of Public Health's "Asthma among Children in Massachusetts" 2017 report. This demonstrates that the program is effective and that the parents and children were using their asthma action plans appropriately, giving medications and calling their primary care physician when needed to avoid trips to the hospital. • Winchester Hospital's Pediatric Asthma Nurse Specialist provided community outreach in the WH service area in FY20 via education and training sessions and private consultations and visits to educate students, teachers, and families about pediatric asthma. Efforts included: • 56 home visits. • 36 school or camp visits (due to the COVID-19 pandemic, most of the schools in the service area were closed or remote and visitors were not allowed in the buildings. As a result, the Pediatric Asthma Nurse Specialist did not make any school visits from April through September 2020.) • Four school education/training sessions reaching 37 school nurses. • 163 Asthma Action Plans completed and filed with schools and daycare centers, a 45% increase over FY19.		

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**
Community Partner: NA	**Website Address:**	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Health Need: Chronic/Complex Conditions
Program Name: Winchester Hospital Weight Management Program
Health Issue: Chronic Disease, Overweight & Obesity, Nutrition

Brief Description or Objective

The Winchester Hospital HMR Weight Management Program is designed to help people lose weight and keep it off. Named the No.1 Best Fast Weight-Loss Diet by *U.S. News & World Report* for five years in a row (2015-2020), the program utilizes clinically proven behavior change techniques. The program offers participants a simple, structured, and effective way to lose weight while learning lifestyle skills that can help improve health and overall quality of life. What differentiates this program from other weight-loss programs is the wide variety of individually tailored components that reduce barriers to participation and provide each participant with tools, resources, and ongoing support to maintain weight loss and achieve optimal health. The highly structured program is facilitated by a team of registered dietitians. The comprehensive approach incorporates:

- Weekly clinic or virtual classes focused on the use of meal replacements in the weight-loss phase and learning and practicing skills for healthy food choices and meal preparation in maintenance.
- Diet plans tailored to meet each person's needs.
- Medical supervision during the weight-loss phase, if needed (diabetes, hypertension).
- Individualized phone coaching is also offered with a registered dietitian to accommodate people who are homebound, live far away, or are unable to attend in person during the COVID-19 pandemic.
- In-person, individual weekly weigh-in visits offered with consultation with registered dietitians.
- Long-term support for maintaining weight loss and healthy behavioral changes.

Target Population (select as many as needed)

- **Regions Served:** Massachusetts
- **Gender:** All • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All
- **Language:** All
- **Environment Served:** ☐All ☐Urban ☐Rural ☒Suburban
- **Additional Target Population Status:**

☐Disability Status ☐LGBT Status ☐ Incarceration History ☒ NA
☐Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status

Program Type

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

DoN Priorities (up to 3)

☐ Built Environment
☒ Social Environment
☐Housing
☐ Violence
☐Education
☐ Employment
☐ NA

EOHHS Health Need

☒ Chronic Disease
☐Housing/Homelessness
☐ Mental Health/Mental Illness
☐ Substance Use
☐ Additional Health Needs

Additional Program Descriptors

☒Community Education
☐Community Health Center Partnership
☐ Health Professional/Staff Training
☐ Health Screening
☐ Mentorship/Career Training/Internship
☐Physician/Provider Diversity
☒ Prevention
☐ Research
☐ Support Group

Program Goal

To help participants lose weight and learn lifestyle skills and strategies for diet and physical activity in order to improve chronic health problems, prevent weight regain, improve mobility, and increase self-

	esteem.
Goal Status	In FY 2020, a monthly average of 85 people participated in the program: **1. Weight Loss Program/Phase 1.** An average of 17 people per month participated in either in-person or virtual classes for an average of nine months. In addition, 38 participated in one-on-one visits either by phone or by in-person visits with a dietitian. • Individual weight loss ranging from 10 pounds to 94 pounds • Group average weight loss of 32 pounds (9% of body weight), a medically significant reduction in BMI **2. Maintenance/Phase 2.** An average of 30 patients per month participated and achieved the following results up to one year: • 64% who continued to attend weekly classes maintained their weight loss or lost additional weight. • 46% maintained the recommended vegetable/fruit intake of five cups daily. • 35% maintained the goal of expending 2,000 calories a day. **3. Participant Survey.** 58 participants completed surveys, rating the following parts of the program on a scale from 1 to 10, with 10 being the highest score: • Quality of classes and education provided by dietitians: 9.8 • Dietitian instructors' knowledge: 9.6 • Attention to individual medical issues (by medical assistants and physicians): 9.8 • Responsiveness to questions/phone calls/emails: 9.7 • Likelihood of referring a friend/family member: 10

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**
Community Partner: NA	**Website Address:**	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Health Need: Chronic/Complex Conditions
Program Name: Outpatient Lactation Program
Health Issue: Chronic Disease, Maternal/Child Health

Brief Description or Objective	According to the American Academy of Pediatrics, there is a critical connection between breastfeeding and a baby's immune system. A mother passes antibodies to her baby through breast milk, which gives the baby a head start in fighting off infections, resulting in fewer illnesses and lower risk of asthma, allergies, obesity, and sudden infant death syndrome. Breastfeeding mothers also receive numerous health benefits, including lower risk of breast and ovarian cancer, diabetes, and heart disease. Recognizing this connection between breastfeeding and health of the mother and baby, Winchester Hospital launched the Outpatient Lactation Program in 1989. The program offers education and encouragement to new moms before the birth of their baby, during their hospital stay, and after their return home. The program, led by a Certified Lactation Specialist, provides free prenatal breastfeeding classes along with individual counseling to give new mothers tools and teach them techniques for successful breastfeeding. In addition, the Lactation Specialist helps coordinate care and educates new mothers about community resources, including Winchester Hospital's Nursing Mothers Support Group, where they can connect with other new moms, share resources, and discuss their questions and experiences. New moms can also receive follow-up visits with the Lactation Specialist, who provides weight checks and support and education throughout the first few months of the baby's life.

Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** Female • **Age Group:** Adults • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban • **Additional Target Population Status:** ☐Disability Status ☐ LGBT Status ☐ Incarceration History ☒ NA ☐Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐Total Population or Communitywide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☐ NA ☒ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Health Need	☒ Chronic Disease ☐ Mental Health/Mental Illness ☐ Additional Health Needs ☐Housing/Homelessness ☐ Substance Use
Additional Program Descriptors	☒Community Education ☐ Mentorship/Career Training/Internship ☒ Prevention ☐Community Health Center Partnership ☐Physician/Provider Diversity ☐ Research ☐ Health Professional/Staff Training ☐ Support Group ☐ Health Screening
Program Goal	To help mothers meet the breastfeeding goal set during their initial consultation with the Lactation Specialist and successfully breastfeed for at least six months, as recommended by the American Academy of Pediatrics.
Goal Status	Due to the COVID-19 pandemic, the Lactation Specialist conducted video consultations from March through September 2020. Both in-person and video consultations are currently available, and many mothers are still choosing to schedule video appointments. The Nursing Mothers Support Group began meeting online in March 2020 using Google Meet, and continues to do so. In FY20: • 314 mothers participated in the program. • 87% of the new mothers surveyed after the program reported meeting the breastfeeding goal they set during their initial consultation with the Lactation Specialist. • 81% reported successfully breastfeeding for six months or more.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**
Community Partner: NA	**Website Address:**	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Health Need: Chronic/Complex Conditions
Program Name: Free Breastfeeding Classes
Health Issue: Chronic Disease, Maternal/Child Health

Brief Description or Objective	Winchester Hospital's free Prenatal Breastfeeding class offers education to those considering breastfeeding and is for those in their 7th to 8th month of pregnancy. The focus of the class is on promoting a successful breastfeeding experience through education, practical information, and problem solving. The class is taught by an experienced board-certified lactation consultant and RN. The class is offered for free to those delivering at Winchester Hospital, thanks to a philanthropic donation.
Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** Female • **Age Group**: Adults • **Race/Ethnicity**: All • **Language:** All • **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban • **Additional Target Population Status:** ☐Disability Status ☐LGBT Status ☐ Incarceration History ☐Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☐ NA ☒ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Health Need	☒ Chronic Disease ☐ Mental Health/Mental Illness ☐ Additional Health Needs ☐Housing/Homelessness ☐ Substance Use
Additional Program Descriptors	☒Community Education ☐ Mentorship/Career Training/Internship ☒ Prevention ☐Community Health Center Partnership ☐Physician/Provider Diversity ☐ Research ☐ Health Professional/Staff Training ☐ Support Group ☐ Health Screening
Program Goal	To encourage women to breastfeed and, by providing free educational classes, to promote a successful breastfeeding experience.
Goal Status	In FY20, 29 free classes were conducted. Due to COVID-19 restrictions, classes were conducted virtually from April through September 2020. The following outcomes were achieved: • Staff dedicated 94 hours to organize and conduct 29 classes. • 289 couples completed the class. As per a survey completed by 50% of participants, 100% reported they were better informed on the subject as a result of completing the class.

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Process Goal**
Community Partner: NA	**Website Address:**	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Health Need: Chronic/Complex Conditions
Program Name: Winchester Hospital Meals on Wheels Program
Health Issue: Chronic Disease, Access to Healthy Foods

Brief Description or Objective	For more than three decades, Winchester Hospital has been preparing and delivering freshly cooked, nutritious meals at a discounted rate to Winchester residents of all ages who are unable to shop for or prepare food. Kitchen staff at Winchester Hospital prepare and pack the meals under the direction of staff dietitians, and the meals are delivered by Winchester Hospital volunteers. The meals are tailored to the dietary needs and preferences of the recipient, who can choose to receive meals up to two times per day, five days a week. Although providing healthy meals is the core of the program, the program also helps isolated residents remain safely in their homes by providing a daily check-in and social engagement with a trained and compassionate volunteer. The cost of the meals is subsidized through generous donations from local organizations and members of the community, and financial aid is available for those who need it.
Target Population (select as many as needed)	• **Regions Served:** Winchester • **Gender:** All • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☐ All ☐Urban ☐Rural ☒ Suburban • **Additional Target Population Status:** ☒ Disability Status ☐LGBT Status ☐ Incarceration History ☐Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☐Access/Coverage Supports ☐Infrastructure to Support Community Benefits
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☒ NA ☐ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Health Need	☒ Chronic Disease ☐ Mental Health/Mental Illness ☐ Additional Health Needs ☐Housing/Homelessness ☐ Substance Use
Additional Program Descriptors	☐ Community Education ☐ Mentorship/Career Training/Internship ☒ Prevention ☐Community Health Center Partnership ☐Physician/Provider Diversity ☐ Research ☐ Health Professional/Staff Training ☐ Support Group ☐ Health Screening
Program Goal	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. The secondary goal is 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 4,500 meals to meet the dietary needs of participants. The meals were delivered by hospital volunteers to homebound residents.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**

Community Partner:	**Website Address:**
Winchester Council on Aging	winchester.us/150/Council-on-Aging

Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org

Priority Health Need: Chronic/Complex Conditions
Program Name: Oncology Nurse Navigator
Health Issue: Chronic Disease, Cancer, Senior Health Challenges/Care Coordination

Brief Description or Objective	The Oncology Nurse Navigator, an RN with oncology-specific clinical knowledge, offers individualized support to patients and their caregivers to help them make informed care decisions and overcome barriers to optimal care. The Navigator contributes to the hospital's mission by providing cancer patients with holistic care that includes communication and coordination with the patient's family and/or caregivers and a multidisciplinary team of physicians, clinicians, and social workers. The Navigator works in collaboration with the disease-specific clinical team to develop clinical pathways for appropriate care and acts as the clinical contact person for all patient-related concerns. The Navigator reviews all medical information prior to patient visits, ensures that physicians receive the information, and discusses it with the disease-specific physician prior to patient visits. In addition, the Navigator maintains contact with referring physicians to keep them up to date on the patient's care plan.
Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** All • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban • **Additional Target Population Status:** ☒ Disability Status ☐LGBT Status ☐ Incarceration History ☐Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☒ Access/Coverage Supports ☐Infrastructure to Support Community Benefits
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☒ NA ☐ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Health Need	☒ Chronic Disease ☐ Mental Health/Mental Illness ☐ Additional Health Needs ☐Housing/Homelessness ☐ Substance Use
Additional Program Descriptors	☐ Community Education ☐ Mentorship/Career Training/Internship ☒ Prevention ☐Community Health Center Partnership ☐Physician/Provider Diversity ☐ Research ☐ Health Professional/Staff Training ☐ Support Group ☐ Health Screening
Program Goal	To guide patients through the complexities of the disease, direct them to health care services for timely treatment and survivorship, and identify and address barriers to timely and appropriate treatment. In addition, the Nurse Navigator connects patients with resources, health care, and support services in their community and assists them in the transition from active treatment to survivorship.
Goal Status	In FY20, the Oncology Nurse Navigator dedicated 2,080 hours providing 6,500 consultations assisting more than 2,000 patients.

Program Year: Year 1	Of X Years: Year 3	Goal Type: Process Goal
Community Partner: NA	**Website Address:**	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Health Need: Chronic/Complex Conditions
Program Name: Breast Cancer Risk Assessment
Health Issue: Chronic Disease, Breast Cancer

Brief Description or Objective	Recognizing that breast cancer risk varies and some women need screening beyond the standard recommendations, Winchester Hospital implemented a confidential survey to help residents assess their lifetime risk of breast cancer. Assessment, evaluation, and follow-up are all provided at no cost to participants. Results are shared with each participant's physicians, 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.
Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** Female • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐LGBT Status ☐ Incarceration History ☐Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☒ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐ Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☒ NA ☐ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Need	☒ Chronic Disease ☐ Mental Health/Mental Illness ☐ Additional Health Needs ☐Housing/Homelessness ☐ Substance Use
Additional Program Descriptors	☐ Community Education ☐ Mentorship/Career Training/Internship ☒ Prevention ☐Community Health Center Partnership ☐Physician/Provider Diversity ☐ Research ☐ Health Professional/Staff Training ☐ Support Group ☒ Health Screening
Program Goal	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 FY20, Winchester Hospital conducted 3,342 free screenings. Of those screened: • 282 (8%) had a high-risk mutation. • 533 (16%) had a high lifetime risk of breast cancer. • 21% were between the ages of 40 and 49. • 290% were between the ages of 50 and 59. • 30% were between the ages of 60 and 69.

	• 17% were between the ages of 70 and 79. • 3% were over the age of 80. Follow-up consults were provided after each screening, and results were shared with participants' physicians to discuss recommended follow-up evaluation and care.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**

Community Partner:	**Website Address:**
American Cancer Society	Acs.org

Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org

Priority Health Need: Chronic/Complex Conditions
Program Name: Fighting Fatigue Program
Health Issue: Chronic Disease, Cancer

Brief Description or Objective	Numerous studies show that exercise can reduce the chance of cancer recurrence and help survivors reduce disability. At the Reno Center for Cancer Care at Winchester Hospital, more than 500 patients were assessed using the National Comprehensive Cancer Network Distress Thermometer, in which patients are asked to rate their distress over practical, family, emotional, physical, and spiritual problems. Findings from the study indicated fatigue was overwhelmingly the No. 1 concern. As a result, physical therapists from Winchester Hospital developed and launched the Fighting Fatigue Program. Facilitated by a physical therapist and a fitness specialist, the program supports patients before, during, and after cancer treatment. The program includes an initial screening followed by 12 weeks of fitness sessions tailored to each participant's ability. The sessions incorporate relaxation techniques such as breathing and meditation exercises. Without this program, most patients would not be able to exercise independently due to impairment from their illness or side effects from treatment. In FY20, in-person classes took place once a week until March 2020 due to COVID-19 regulations. In May, the Fighting Fatigue classes resumed but were facilitated virtually, and participants were screened in person before participating. Virtual classes continued through the end of September 2020, and participants were seen at regular intervals by a Physical Therapist either via virtual visits or in-person visits as needed to re-evaluate individual patient status and goals.
Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** All • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban • **Additional Target Population Status:** ☒ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☒ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐ Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☐ NA ☒ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS	☒ Chronic Disease ☐ Mental Health/Mental Illness ☐ Additional Health

Need	☐Housing/Homelessness ☐ Substance Use Needs
Additional Program Descriptors	☐ Community Education ☐ Mentorship/Career Training/Internship ☒ Prevention ☐Community Health Center Partnership ☐Physician/Provider Diversity ☐ Research ☐ Health Professional/Staff Training ☐ Support Group ☒ Health Screening
Program Goal	To enable cancer patients to gain confidence in self-care independence, establish an exercise program to combat the effects of cancer treatment, and maintain or regain a healthy sense of well-being.
Goal Status	In FY20, a total of 94 classes were held, with 13 participants completing the 12-week program. Their diagnoses included gynecological, breast, and blood cancers. There were 11 female and two male participants, all between the ages of 63 and 77 years. Due to the numerous challenges of COVID-19, such as virtual programming, restrictions around in-person office visits, etc., the number of referrals into the program was affected, as well as the ability to collect data. Of the 13 participants surveyed, the following outcomes were reported. **Subjective Data Results:** ・13% average decrease in fatigue on Visual Analog Scale (VAS) ・43% decrease in pain on VAS ・10.7% increase on ABC Confidence Scale **Objective Data:** ・2.4% improvement in completion time of Timed Up and Go test ・22% improvement in completion time of a Sit to Stand test

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Community Partner:	**Website Address:**
American Cancer Society	Acs.org

Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org

Priority Health Need: Chronic/Complex Conditions
Program Name: Integrative Therapies for Cancer Patients
Health Issue: Chronic Disease, Cancer

Brief Description or Objective	Winchester Hospital's Center for Healthy Living offers free integrative therapies to help cancer patients reduce stress and anxiety, relieve symptoms and side effects from treatment, and increase their general sense of health and well-being. The therapies include massage and acupuncture which are conducted during infusion treatments or individual appointments, hypnotherapy by individual appointment, and healing yoga classes.
Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** All • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban • **Additional Target Population Status:** ☒ Disability Status ☐LGBT Status ☐ Incarceration History ☐ NA ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status

Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐Infrastructure to Support Community Benefits
DoN Priorities (up to 3)	☐ Built Environment ☒ Social Environment ☐Housing ☐ Violence ☐Education ☐ Employment ☐ NA
EOHHS Need	☒ Chronic Disease ☐Housing/Homelessness ☐ Mental Health/Mental Illness ☐ Substance Use ☐ Additional Health Needs
Additional Program Descriptors	☒ Community Education ☐Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening ☐ Mentorship/Career Training/Internship ☐Physician/Provider Diversity ☒ Prevention ☐ Research ☐ Support Group
Program Goal	To help cancer patients reduce stress and anxiety, relieve symptoms and side effects from treatment, and increase their general sense of health and well-being.
Goal Status	In FY20, Winchester Hospital provided 584 free integrative therapy sessions to more than 500 patients undergoing cancer treatment. The therapies, which included massage therapy, acupuncture, and hypnotherapy, were conducted during infusion treatments or through individual appointments upon request. In addition, 13 yoga classes were offered to cancer patients in treatment or recovery, reaching approximately 50 participants. Due to the COVID-19 pandemic, Integrative Therapies and Healing Yoga closed in March 2020. Hypnotherapy resumed in May using telehealth. Healing Yoga classes resumed in May via online classes using Zoom. Integrative Therapy appointments and infusion sessions reopened in July. Therapists returned to work between July and October. The overall number of treatments provided was significantly lower in FY20 as compared to FY19 (2,308) due to cleaning and disinfecting protocols in place between sessions to ensure patient safety. According to a survey administered to participants, 100% of massage and yoga and 75% of acupuncture participants reported the treatment effectively reduced their level of stress and relieved the side effects of their cancer treatment.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**
Community Partner: American Cancer Society	**Website Address:** Acs.org	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Health Need: Chronic/Complex Conditions
Program Name: A Caring Place Wig Donation Program
Health Issue: Chronic Disease, Cancer

Brief Description or Objective	Battling cancer can be a huge physical and emotional burden. While undergoing treatment, many patients experience hair loss, which can have a huge impact on their self-image and self-esteem. Through generous donations from the Winton Club, a fundraising arm of Winchester Hospital, the professional staff at A Caring Place (located at the Winchester Hospital Center for Cancer Care) provides beautiful and natural-looking wigs free of charge to women experiencing hair loss due to cancer treatment. The professionally trained staff provides a consultation that includes a proper fitting and thorough instructions on how to style and care for the wig.
Target Population (select as	• **Regions Served:** Massachusetts • **Gender:** Women • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All • **Language:** All

many as needed)	• **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☒ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐ Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☐ NA ☒ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Need	☒ Chronic Disease ☐ Mental Health/Mental Illness ☐ Additional Health Needs ☐Housing/Homelessness ☐ Substance Use
Additional Program Descriptors	☒ Community Education ☐ Mentorship/Career Training/Internship ☐ Prevention ☐Community Health Center Partnership ☐ Research ☐ Health Professional/Staff Training ☐Physician/Provider Diversity ☐ Support Group ☐ Health Screening
Program Goal	To provide emotional support for and improve the self-image of women coping with hair loss from cancer treatment by providing wigs at no cost to patients with financial difficulties. Patients unable to afford a wig are provided with this product and the service of a wig stylist.
Goal Status	In FY20, Winchester Hospital provided wigs free of charge to more than 30 women. In addition, staff and volunteers dedicated more than 350 hours to providing consultations and wig fittings.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**
Community Partner: American Cancer Society	**Website Address:** Acs.org	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Health Need: Chronic/Complex Conditions **Program Name: "Aging on Your Own Terms" Senior Outreach Initiative** **Health Issue: Senior Health Challenges, Chronic Disease**	
Brief Description or Objective	The senior population is the fastest-growing demographic group in the United States. Currently, there are more than 33 million Americans over the age of 65, and that number is expected to double by the year 2030. In addition, the health needs of this population are complex. With this in mind, Winchester Hospital launched the "Aging on Your Own Terms" Senior Outreach Initiative in September 2001. This series of programs educates active aging adults on how to meet their health needs, and provides events and activities to enhance their social well-being and quality of life. Winchester Hospital works with senior centers and eldercare agencies to offer a variety of programs and services at no cost to area seniors. Events are held at locations throughout the community that are accessible via public transportation. The educational programs align with the health needs identified through the FY19 CHNA and feedback from

	participants and community partners. A distinguishing component of the program is the integration of social programming to address isolation, depression, and social well-being. Due to the COVID-19 pandemic, programming was suspended between March and September 2020, and the program funds were reallocated to local senior centers to address urgent needs that emerged as a result of COVID-19.
Target Population (select as many as needed)	• **Regions Served:** Middlesex County • **Gender:** All • **Age Group:** Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☐ All ☐Urban ☐Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☒ Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☐ NA ☒ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Need	☒ Chronic Disease ☐ Mental Health/Mental Illness ☒ Additional Health Needs ☐Housing/Homelessness ☐ Substance Use
Additional Program Descriptors	☒ Community Education ☐ Mentorship/Career Training/Internship ☒ Prevention ☐Community Health Center Partnership ☐ Research ☐ Health Professional/Staff Training ☐Physician/Provider Diversity ☐ Support Group ☐ Health Screening
Program Goal	To provide a broad array of programs designed to improve health, enhance social and emotional well-being of older adults, and address various social determinants of health.
Goal Status	Prior to the start of the COVID-19 pandemic in March, Winchester Hospital partnered with local senior centers to provide two social events and one educational program reaching approximately 400 seniors in the hospital's service area: - Understanding the Aging Eye Education Session (100 attendees) - Social events in Medford and Stoneham (300 attendees) Programming was suspended in March 2020, and funds were reallocated to local senior centers to meet urgent needs that emerged as a result of COVID-19. A participant survey measuring the impact of the program is conducted triennially and will be administered again in FY21. The FY18 survey, completed by 265 seniors, found: • 87% identified resources to increase access to health services. • 86% made new friends. • 83% reduced or learned to better manage stress. • 82% increased daily intake of healthier foods. • 71% spent less time at home and more time socializing.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**

Community Partner:	**Website Address:**
Medford Council on Aging	Medfordma.org

Stoneham Council on Aging	Stonehamseniorcenter.org
Wilmington Council on Aging	Wilmingtonma.gov
Woburn Council on Aging	Woburnma.gov
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org	

Priority Health Need: Chronic/Complex Conditions
Program Name: Healthy State Web-Based
Health Issue: Chronic Disease, Nutrition, Safety

Brief Description or Objective

More people are turning to web-based resources for health information. By providing expert health information, personal stories, and connections to resources, Healthy State provides health information to educate and influence people to change their unhealthy behaviors and encourage interventions capable of improving health status. Healthy State is a health news website that highlights the expertise of practitioners across Beth Israel Lahey Health. Healthy State staff collaborate with practitioners (doctors, advanced practitioners, staff, etc.) on stories across various service lines to share information relevant to site visitors. Story topics range from health and wellness to patients and colleagues to community programs.
The site, https://www.myhealthystate.org, offers free, easy-to-read articles for the community and provides health news, living well tips, and real stories to engage the community. Topics include:
- Cancer awareness/education about prevention, detection, treatment, and support
- Reducing risk factors for chronic disease such as diabetes, hypertension, and heart disease
- Seasonal health including nutrition, mental health, and preventing seasonal illness and injuries
- Child health including information related to ADHD, febrile seizures, and asthma

Target Population (select as many as needed)

- **Regions Served:** Massachusetts
- **Gender:** All • **Age Group:** Teens, Adults, Elderly • **Race/Ethnicity:** All
- **Language:** All
- **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban
- **Additional Target Population Status:**

☐ Disability Status ☐LGBT Status ☐ Incarceration History
☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status

Program Type

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

DoN Priorities (up to 3)

☐ Built Environment
☒ Social Environment
☐Housing
☐ Violence
☐Education
☐ Employment
☐ NA

EOHHS Need

☒ Chronic Disease
☐Housing/Homelessness
☒ Mental Health/Mental Illness
☐ Substance Use
☐ Additional Health Needs

Additional Program Descriptors

☒ Community Education
☐Community Health Center Partnership
☐ Health Professional/Staff Training
☐ Health Screening
☐ Mentorship/Career Training/Internship
☐Physician/Provider Diversity
☒ Prevention
☐ Research
☐ Support Group

Program Goal	To influence personal health choices and inform people about ways to enhance health or avoid specific health risks by increasing knowledge and awareness of health issues, influencing behaviors and attitudes toward health issues, and dispelling misconceptions about health.
Goal Status	In FY20, there were 72,205 page views, including more than 8,700 views from returning users. In addition, the average time spent on the site was 24 seconds, with 1.13 pages viewed per session.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**
Community Partner: NA	**Website Address:** NA	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Health Need: Chronic/Complex Conditions
Program Name: Mount Vernon House Resident Health Program
Health Issue: Chronic Disease

Brief Description or Objective	Winchester Hospital clinicians provided acupuncture and massage therapy at no cost to residents at the Mount Vernon House and to Winchester residents over the age of 65. Many of the residents who received treatment reported relief of chronic pain for a period of time and improved or maintained their health.
Target Population (select as many as needed)	• **Regions Served:** Winchester • **Gender:** All • **Age Group:** Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☐ All ☐Urban ☐Rural ☒ Suburban • **Additional Target Population Status:** ☒ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☒ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐ Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☒ Built Environment ☐ Violence ☐ NA ☐ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Need	☒ Chronic Disease ☐ Mental Health/Mental Illness ☐ Additional Health Needs ☐Housing/Homelessness ☐ Substance Use
Additional Program Descriptors	☒ Community Education ☐ Mentorship/Career Training/Internship ☐ Prevention ☐Community Health Center Partnership ☐Physician/Provider Diversity ☐ Research ☐ Health Professional/Staff Training ☐ Support Group ☐ Health Screening
Program Goal	To provide temporary pain relief for elder adults with chronic health issues to help them improve or maintain their health.

Goal Status	From March to September, due to COVID-19 restrictions, visits to residents were prohibited. In spite of the restrictions, Winchester Hospital provided 45 treatments to residents at the Mount Vernon House and an additional 610 treatments to Winchester residents. Health issues treated included back weakness, leg stiffness, edema in the lower legs, leg numbness, shoulder pain, sinus headaches, hip and knee problems, arthritis of the lower back, neck pain, sciatica, carpal tunnel syndrome, and balance trouble. Most patients either improve or maintain their health status. Most use the program to get help with neck or back pain. Some just go for the massage. According to a participant survey, 57% decreased their level of pain, and 21% improved their balance.

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Process Goal**
Community Partner: Winchester Mount Vernon House	**Website Address: Wmvh.org**	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Health Need: Chronic/Complex Conditions
Program Name: Center for Healthy Living Health Education Programs
Health Issue: Chronic Disease, Parenting Skills, CPR, Stress Management

Brief Description or Objective	The Center for Healthy Living at Winchester Hospital helps community members take charge of their health and well-being by offering more than 30 programs and services each year, including CPR and first aid training, childbirth education classes, safe babysitting courses, and integrative therapies including massage, acupuncture, and hypnotherapy. In addition, the center offers a variety of specialized yoga and fitness classes led by highly trained educators, targeting people of all ages and fitness levels and those with physical limitations or mobility issues. The classes include Traditional and Ageless Yoga, Building Bones, and Flex and Stretch. Many of the health education programs paused during the onset of COVID-19 in March 2020, but resumed in April, May, and June with online options. Some programs such as yoga, fitness, community CPR, and nurse aid training have not resumed due to challenges and risks associated with COVID-19 restrictions.
Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** All • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☒ Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☐ NA ☒ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Need	☒ Chronic Disease ☐ Mental Health/Mental Illness ☐ Additional Health Needs ☐Housing/Homelessness ☐ Substance Use

Additional Program Descriptors	☒ Community Education ☐ Mentorship/Career Training/Internship ☒ Prevention ☐Community Health Center Partnership ☐ Research ☐ Health Professional/Staff Training ☐Physician/Provider Diversity ☐ Support Group ☐ Health Screening
Program Goal	To help people prevent disease and injury, improve health, and enhance quality of life.
Goal Status	Many of the health education programs paused during the onset of COVID-19 in March 2020 but resumed in April with online options. Some programs such as yoga, fitness, and community CPR have not resumed due to challenges and risks associated with COVID-19 restrictions. In spite of these challenges, more than 1,993 community members participated in classes or educational programs in FY20.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**
Community Partner: NA	**Website Address:** NA	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Health Need: Chronic/Complex Conditions
Program Name: Mount Vernon House Lifeline Program
Health Issue: Chronic Disease

Brief Description or Objective	According to the CDC, falls are the leading cause of injuries and accidental death in adults over the age of 65. Estimates say that each year, one in three seniors falls. Nearly half of older adults who fall cannot get up on their own, resulting in extended periods of lying on the floor and leading to serious medical complications, including pressure ulcers, hyperthermia, dehydration, and more. To help keep older adults safe at home and ensure they get immediate medical attention if needed, Winchester Hospital offers the Lifeline Personal Emergency Response System. It helps seniors live independently by providing early intervention and the security of knowing that help is just a button push away, 24 hours a day. There is a monthly fee for the service, and many seniors do not qualify to receive financial benefits through insurance. Through a grant from the Mount Vernon House, Winchester Hospital provides the monthly service to seniors who need financial assistance.
Target Population (select as many as needed)	• **Regions Served:** Winchester • **Gender:** All • **Age Group:** Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☐ All ☐Urban ☐Rural ☒ Suburban • **Additional Target Population Status:** ☒ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☒ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐ Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☒ Built Environment ☐ Violence ☐ NA ☐ Social Environment ☐Education ☐Housing ☐ Employment

EOHHS Need	☒ Chronic Disease ☐Housing/Homelessness	☐ Mental Health/Mental Illness ☐ Substance Use	☐ Additional Health Needs
Additional Program Descriptors	☒ Community Education ☐Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening	☐ Mentorship/Career Training/Internship ☐Physician/Provider Diversity	☐ Prevention ☐ Research ☐ Support Group
Program Goal	To provide the Lifeline service to economically insecure older adults needing financial assistance.		
Goal Status	In FY20, 11 seniors received a full year of Lifeline service and two seniors received a partial year of Lifeline service for free. Of those, the following was reported: • 31% used the service for a medical emergency. • 100% received needed help after pushing the button. • 36% of help calls were for known falls.		

Program Year: Year 1	**Of X Years: Year 1**	**Goal Type: Process Goal**
Community Partner: Winchester Mount Vernon House	**Website Address: Wmvh.org**	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Area: Chronic/Complex Conditions
Program Name: Support Groups
Health Need: Chronic Disease, Cancer, Overweight & Obesity

Brief Description	Support groups for patients dealing with a variety of diseases or conditions including cancer, diabetes, and Alzheimer's. Due to COVID, support groups were offered remotely from March to September, 2020.
Target Population (Select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** All • **Age:** Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Incarceration History ☐ Refugee/Immigrant Status ☐Domestic Violence History ☐ LGBT Status ☐ Veteran Status
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☒ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population/Communitywide Intervention
DoN Health Priorities (up to 3)	☐ Built Environment ☐ Violence ☐ NA ☒ Social Environment ☐ Education ☐ Housing ☐ Employment
EOHHS Health Need	☒ Chronic Disease ☐ Mental Health/Mental Illness ☐ Additional ☐ Housing/Homelessness ☐ Substance Use
Additional Program Descriptors (Tags)	☐ Community Education ☐ Physician/Provider Diversity ☐ Community Health Center Partnership ☐ Prevention ☐ Health Professional/Staff Training ☐ Research ☐ Health Screening ☒ Support Group ☐ Mentorship/Career Training/Internship
Goal Description	Provide emotional support, educational information, and community resources for patients during difficult times.
Goal Status	Although support groups were conducted remotely from March through September due to COVID, attendance was not negatively impacted, and remained consistent with FY19 attendance**.** In FY20, Winchester Hospital conducted 761 sessions for 13 different support groups, reaching 2,755 participants.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**

Community Partner	**Website Address**
American Cancer Society	Acs.org

Contact Information: Marylou Hardy (781) 744-3131 – Marylou.hardy@bilh.org

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

Priority Health Need: Social Determinants of Health & Access to Care
Program Name: Home Blood Draw Program
Health Issue: Access to Health Care, Chronic Disease

Brief Description or Objective	The Winchester Hospital Home Blood Draw Program was developed to enhance access to phlebotomy services for homebound patients who have difficulty getting to a laboratory or drawing station. Homebound patients are defined as people with a condition due to surgery, illness, or injury that precludes them from accessing medical care outside their home.
Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** All • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban • **Additional Target Population Status:** ☒ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☒ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐ Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☐ NA ☒ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Need	☒ Chronic Disease ☐ Mental Health/Mental Illness ☒ Additional Health Needs ☐Housing/Homelessness ☐ Substance Use
Additional Program Descriptors	☒ Community Education ☐ Mentorship/Career Training/Internship ☐ Prevention ☐Community Health Center Partnership ☐Physician/Provider Diversity ☐ Research ☐ Health Professional/Staff Training ☐ Support Group ☐ Health Screening
Program Goal	Increase access to phlebotomy services for homebound patients who have difficulty getting to a laboratory/drawing station due to illness or injury.
Goal Status	In FY20, Winchester Hospital Lab Services provided 10,293 free in-home blood draws, a 3.3% increase over FY19. In addition to appreciating the convenience of the home blood draw, patients reported reduced feelings of isolation, as the visit with the phlebotomist provided them with a social opportunity.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**

Community Partner: NA **Website Address:** NA

Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org

Priority Health Need: Social Determinants of Health & Access to Care
Program Name: Heidbreder Comfort Fund
Health Issue: Income & Poverty, Chronic Disease, Cancer

Brief Description or Objective	Due to generous donations made in memory of Dr. Richard Heidbreder, former Medical Director of Radiation Oncology, Winchester Hospital is able to provide comfort and assistance to patients fighting cancer. The funds help offset daily living expenses (transportation, food, etc.) and the cost of integrative therapies provided by staff from Winchester Hospital's Center for Healthy Living.
Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** All • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☒ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐ Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☐ NA ☒ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Need	☒ Chronic Disease ☐ Mental Health/Mental Illness ☐ Additional Health Needs ☐Housing/Homelessness ☐ Substance Use
Additional Program Descriptors	☒ Community Education ☐ Mentorship/Career Training/Internship ☐ Prevention ☐Community Health Center Partnership ☐ Research ☐ Health Professional/Staff Training ☐Physician/Provider Diversity ☐ Support Group ☐ Health Screening
Program Goal	To help alleviate the burden and hardship of the cancer journey by providing support and financial assistance with living expenses beyond the standard of care.
Goal Status	Winchester Hospital provided assistance to 62 patients being treated for cancer in FY20.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**
Community Partner: American Cancer Society	**Website Address:** Acs.org	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Health Need: Social Determinants of Health & Access to Care
Program Name: Cuddler Program
Health Issue: Maternal/Child Health, Substance Use

Brief Description or Objective	Cuddling is an important part of a baby's development. This is especially true for newborns in the Special Care Nursery and ones who are experiencing neonatal abstinence syndrome. Families find comfort during this difficult and emotional time knowing their babies are being held and cared for by our exceptional Neonatal Nurses and dedicated volunteers. These "cuddlers" rock, hold, and soothe babies to provide them with comfort, warmth, and human connection.
Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** All • **Age Group:** Infants • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☐ All ☐Urban ☐Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☒ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐ Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☒ Built Environment ☐ Violence ☐ NA ☐ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Need	☐ Chronic Disease ☐ Mental Health/Mental Illness ☐ Additional Health Needs ☐Housing/Homelessness ☒ Substance Use
Additional Program Descriptors	☒ Community Education ☐ Mentorship/Career Training/Internship ☒ Prevention ☐Community Health Center Partnership ☐Physician/Provider Diversity ☐ Research ☐ Health Professional/Staff Training ☐ Support Group ☐ Health Screening
Program Goal	To support babies' growth and development during the critical early stages of life by providing them with comfort and a feeling of security through personal interaction and calming human touch.
Goal Status	Trained volunteers spent more than 300 hours cuddling six babies in FY20. The program was temporarily suspended in March 2020 due to the hospital's COVID-19 restrictions.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**
Community Partner: NA	**Website Address:**	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Health Need: Social Determinants of Health & Access to Care
Program Name: Safe Sleep Initiative
Health Issue: Maternal/Child Health, Parenting Skills

Brief Description or Objective	According to a study by the American Academy of Pediatrics, approximately 3,500 infants die annually in the U.S. from sleep-related causes, including sudden unexpected infant death, ill-defined deaths, and accidental suffocation and strangulation. In 2014, there were 29 instances of sudden unexpected infant death in Massachusetts, according to the DPH Registry of Vital Records and Statistics. In addition, the FY19 CHNA revealed that two of the nine towns in Winchester Hospital's service area (Wilmington and Woburn) had infant mortality rates higher than the state and county rates, and the town of Tewksbury's rate was higher than that of the county. Recognizing the need to provide critically important educational information about safe infant sleep practices, Winchester Hospital, in collaboration with the Middlesex District Attorney's Office, developed and launched its Safe Sleep Initiative. The program provides extensive patient education and two free tools proven to help increase safety: **1. Baby Box:** Baby boxes have been credited with helping Finland achieve one of the world's lowest rates of infant mortality. Our boxes come with a firm mattress and snug sheet, in line with the recommendations of the American Academy of Pediatrics. The baby box can be used as a portable crib or as the baby's main bed for the first four months of life. Before receiving a box, parents must complete an online course at "Baby Box University," developed by Winchester Hospital health care experts to reduce infant mortality and improve maternal and child health. Videos at Baby Box University discuss safe sleep practices, the impact and causes of shaken baby syndrome, and general newborn care. Winchester Hospital also provides education about safe sleep, which includes always placing a baby on his/her back in a secure setting – whether that's a crib, a bassinet, or the baby box – with no bumpers, blankets, or stuffed toys. **2. Sleep Sack:** All mothers who deliver a baby at Winchester Hospital receive a sleep sack. The sleep sack is a wearable blanket that replaces loose blankets, which can cover a baby's face and interfere with breathing. The sleep sack also helps reduce the risk of the baby overheating.
Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** All • **Age Group:** Adults • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐Infrastructure to Support Community Benefits
DoN Priorities (up to 3)	☒ Built Environment ☐ Violence ☐ NA ☐ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Need	☐ Chronic Disease ☐ Mental Health/Mental Illness ☒ Additional Health Needs ☐Housing/Homelessness ☐ Substance Use
Additional Program Descriptors	☒ Community Education ☐ Mentorship/Career Training/Internship ☒ Prevention ☐Community Health Center Partnership ☐Physician/Provider Diversity ☐ Research ☐ Health Professional/Staff Training ☐ Support Group ☐ Health Screening

Program Goal	To provide families with education and resources to ensure a safe start to babies' lives and reduce the risk of sudden, unexplained infant death.
Goal Status	In FY20, sleep sacks were provided to 2,502 mothers, a 6% increase over FY19. In addition, 60 mothers completed Baby Box University online training in order to receive a baby box.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**

Community Partner: Middlesex District Attorney Office **Website Address:** Middlsexda.org

Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org

Priority Health Need: Social Determinants of Health & Access to Care
Program Name: Winchester Housing Authority Farmers Market
Health Issue: Access to Healthy Food, Income & Poverty

Brief Description or Objective	According to research from the American Diabetes Association, increasing daily intake of fruits and vegetables may help reduce the risk of chronic disease and improve overall health in older adults. Findings from Winchester Hospital's FY19 CHNA indicated that lack of access to healthy foods is a major health issue for segments of the population, specifically low-income individuals and older adults. Interviewees and community forum participants reported that significant numbers of people struggled to buy fresh produce and other nutritional foods, and referred to food insecurity and food scarcity as a major concern. In addition, according to the 2018 Massachusetts Healthy Aging Report, only 28% of adults age 60 or older living in Winchester report getting the recommended five servings of fruits and vegetables per day. Lack of access and information, as well as financial insecurity, play a role in these low figures. To address this need, Winchester Hospital partnered with New Entry Sustainable Farming Project, an organization that grows organic produce locally for Middlesex County, to provide free produce for 20 consecutive weeks to residents living in Winchester Housing. To reduce transportation barriers, farmers markets were held at both Winchester Housing locations. Each week, more than six varieties of fresh produce were provided for free, along with a newsletter that included nutrition information and healthy recipes featuring that week's produce. In FY20, in order to reduce the spread of COVID-19, Winchester Housing Authority employees bagged each week's produce, and the bags were left in the courtyard for residents to pick up. Residents were also offered the opportunity to have the bags delivered to their residence.
Target Population (select as many as needed)	• **Regions Served:** Winchester • **Gender:** All • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☐ All ☐Urban ☐Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☒ Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☐ NA ☒ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS	☒ Chronic Disease ☐ Mental Health/Mental Illness ☒ Additional Health

Need	☐Housing/Homelessness ☐ Substance Use Needs
Additional Program Descriptors	☒ Community Education ☐ Mentorship/Career Training/Internship ☒ Prevention ☐Community Health Center Partnership ☐Physician/Provider Diversity ☐ Research ☐ Health Professional/Staff Training ☐ Support Group ☐ Health Screening
Program Goal	To help residents of the Winchester Housing Authority increase their daily intake of fruits and vegetables by reducing barriers to accessing produce and providing information about the benefits of a healthy diet.
Goal Status	The 20-week farmers market at Winchester Housing produced the following outcomes: - More than 40,000 pounds of fresh produce, including more than six varieties of fruits and vegetables, were delivered to the two Winchester Housing locations, free for all residents and their families. - A weekly newsletter featuring nutritional information and recipes for the fruits and vegetables was created and distributed with the produce. - More than 40% of the 112 residents participated in the program. - 60% of participants were 76 or older. - 71% of the participants were women. Per a post-program survey, program participants achieved the following results: • 79% ate a greater variety of fruits and/or vegetables. • 93% increased their daily intake of fruits and vegetables. • 65% learned more about locally grown fruits and vegetables. • 64% reported they had easier access to fruits and vegetables as a result of the program. • 43% increased their general knowledge about healthy eating.
Program Year: Year 1	**Of X Years:** Year 1 **Goal Type: Process Goal**
Community Partner: Winchester Housing Authority New Entry Sustainable Farming Project	**Website Address:** Winchesterha.org Nesfp.org
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org	

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

Brief Description or Objective	Winchester Hospital is committed to providing high-quality, affordable health care and strives to promote health, expand access, and deliver the best care in the communities it serves. As part of that commitment, Winchester Hospital dedicates resources to support and strengthen the capacity of its primary care offices throughout the community to help patients connect with and access timely, safe, quality patient care. In addition, Winchester Hospital is committed to providing care for everyone, regardless of their ability to pay, and dedicates representatives from Winchester Hospital's Patient Financial Services Department to assist people with limited financial resources by providing free counseling to help them find options to cover the cost of their care. The financial counselors meet with patients to explore options and help them apply for health coverage, public assistance, and/or the hospital's financial assistance program.
Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** All • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban

	• **Additional Target Population Status:** ☒ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☒ Access/Coverage Supports ☐ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐ Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☐ NA ☒ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Need	☒ Chronic Disease ☒ Mental Health/Mental Illness ☒ Additional Health Needs ☐Housing/Homelessness ☐ Substance Use
Additional Program Descriptors	☐ Community Education ☐ Mentorship/Career Training/Internship ☐ Prevention ☐Community Health Center Partnership ☐ Research ☐ Health Professional/Staff Training ☐Physician/Provider Diversity ☐ Support Group ☒ Health Screening
Program Goal	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 FY20, Patient Financial Services staff at Winchester Hospital dedicated 2,080 hours to providing free counseling for 24,000 patients with Medicaid coverage who completed an application with a Financial Navigator or who qualified for upgraded MassHealth coverage. There was an increase in the number of patients requesting the service as a result of change in employment status due to the COVID-19 pandemic. - Of those served, 3,260 were unemployed, 2,700 were employed (full or part time), 520 were self-employed, 2,300 were disabled, and 950 were students. More than 500 received assistance completing applications for Medicaid. - The ages were: 0-17 (33%), 18-35 (30%), 36-53 (22%), 54-70 (14%), and 71-107 (1%).

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**
Community Partner: NA	**Website Address:** NA	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

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

Brief Description or Objective	Health insurance makes a difference in whether people receive medical care, where they get care, and ultimately how healthy they are. People without adequate insurance are much more likely to postpone preventive care, health screenings, and necessary treatment. The cost of putting off medical care, not filling prescriptions, and skipping routine exams can be severe, particularly when preventable or treatable diseases go undetected. The Winchester Hospital SHINE collaboration helps address health care costs Medicare beneficiaries struggle with by connecting people with health insurance that meets their health care needs, lifestyle, and budget. SHINE counselors help Medicare beneficiaries understand what insurance coverage they need based on medical history, current health, prescribed medications, and the costs they incur by not having supplemental insurance. A one-hour visit with a SHINE counselor who

	helps patients compare plans using a new Medicare plan-finder tool can save a patient thousands of dollars in out-of-pocket costs. Counselors also have access to Common Resources, a password-protected intranet containing proprietary information developed by the Executive Office of Elder Affairs, CMS, and the MA Department of Health and Human Services. SHINE counselors are part accountant, part software specialist, part researcher, part nurse, part pharmacist, part social worker, and part advocate, often seeing consumers yearly for a "health insurance checkup." 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. Data from each counseling session is stored in the Administration for Community Living STARS database, which is used to analyze national, state, and local trends and capture consumer demographics. In addition to face-to-face counseling, SHINE counselors conduct presentations to educate people new to Medicare and those enrolled in Medicare and a supplemental plan about their health care coverage choices. To help homebound individuals connect with SHINE counselors, information regarding Medicare and SHINE is distributed to anyone receiving Meals on Wheels and is publicized using local cable, social media, and print media. Due to COVID-19 restrictions, all counseling sessions were conducted via phone between March and September 2020.
Target Population (select as many as needed)	• **Regions Served:** Stoneham, Wilmington, Winchester, Woburn • **Gender:** All • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☐ All ☐Urban ☐Rural ☒ Suburban • **Additional Target Population Status:** ☒ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☒ Access/Coverage Supports ☐Infrastructure to Support Community Benefits
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☒ NA ☐ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Need	☐ Chronic Disease ☐ Mental Health/Mental Illness ☒ Additional Health Needs ☐Housing/Homelessness ☐ Substance Use
Additional Program Descriptors	☐ Community Education ☐ Mentorship/Career Training/Internship ☐ Prevention ☐Community Health Center Partnership ☐ Research ☐ Health Professional/Staff Training ☐Physician/Provider Diversity ☐ Support Group ☐ Health Screening
Program Goal	To provide Medicare beneficiaries and their families with confidential and unbiased health insurance information to address inpatient, outpatient, and prescription drug benefit gaps in coverage. The counseling sessions help Medicare beneficiaries and their caregivers: - Navigate the complex health insurance options - Understand the language of the plans and how the components work - Review their current coverage and compare the costs and benefits of available options - Enroll in assistance programs if needed
Goal Status	In FY20, SHINE counselors conducted a total of 254 free confidential, unbiased counseling sessions for community members at two locations: the Jenks Center in Winchester (221 people) and the Winchester

	Hospital Center for Cancer Care (33 people). This was a 23% decrease since FY19 due to COVID-19. As of March, due to COVID restrictions, all counseling sessions were conducted over the phone. Of the 254 participants: - 94% were over the age of 65. - 68% were female; 32% were male. - 43% were below 150% of the federal poverty level, with 83% above and 11% below the low-income subsidy asset limit. This information was not reported for 6% of the participants. The following outcomes were reported by 193 participants who completed a post-program evaluation: - 151 had insurance but were enrolled in a Medigap supplemental plan. - 42 were new to Medicare and benefited from the information/assistance received on the various plans.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Outcomes Goal**
Community Partner: Minuteman Senior Services		**Website Address:** Minutemansenior.org
Winchester Council on Aging		Winchester.us
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Health Need: Social Determinants of Health & Access to Care
Program Name: Metro Housing Boston Co-Location Program
Health Issue: Access to Affordable Housing, Income & Poverty

Brief Description or Objective	Winchester Hospital financially supported Metro Housing Boston to provide the co-location program in Winchester, Woburn, and Medford, which, according to the FY19 CHNA, have the greatest need. 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.
Target Population (select as many as needed)	• **Regions Served:** Medford, Wilmington, Winchester, Woburn • **Gender:** All • **Age Group:** Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☐ All ☐Urban ☐Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☒ Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☐ NA ☐ Social Environment ☐Education ☒ Housing ☐ Employment
EOHHS Need	☒ Chronic Disease ☐ Mental Health/Mental Illness ☐ Additional Health Needs ☒ Housing/Homelessness ☐ Substance Use

Additional Program Descriptors	☒ Community Education ☐ Mentorship/Career Training/Internship ☒ Prevention ☐Community Health Center Partnership ☐ Research ☐ Health Professional/Staff Training ☐Physician/Provider Diversity ☐ Support Group ☐ Health Screening
Program Goal	To offer eviction-prevention services and housing-stabilization services to low- and moderate-income families in Winchester Hospital's CBSA.
Goal Status	In FY20, eviction-prevention and housing-stabilization counseling was provided to 107 families in three locations: Medford, Winchester, and Woburn. As a result of COVID-19 restrictions, all counseling sessions were via phone from March through September 2020. Of those served: -14% were Black/African American, 50% white/Caucasian, and 27% Hispanic of any race. 36% did not disclose their race. -81% lived in Woburn, 18% in Medford, and 1% in Winchester. -76 families remained in their current residence. -10 families found new stable, affordable housing. All participants also received referrals to community resources such as workforce development, educational opportunities, income maximization, unemployment assistance, food stamps, etc.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**
Community Partner: Metro Housing Boston	**Website Address:** Metrohousingboston.org	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Health Need: Social Determinants of Health & Access to Care
Program Name: Food Insecurity Relief Initiative – COVID-19 Relief
Health Issue: Access to Healthy Food, Nutrition, Income & Poverty

Brief Description or Objective	According to an analysis by Feeding America (https://www.feedingamerica.org/hunger-in-america/massachusetts), Massachusetts has experienced the largest relative increase of food-insecure individuals in the nation due to COVID-19 and the highest increase of food-insecure children (102%). With record unemployment and lost wages and many having little to no savings to protect them from the economic impact of COVID-19, food insecurity has skyrocketed from 8.4% of households pre-pandemic to 17.5% of households in FY20. In addition, food banks in Winchester Hospital's CBSA have reported a more than 50% increase in demand for their services since March. These alarming numbers are expected to have a negative impact on the health of our communities, as food insecurity and hunger contribute to a multitude of chronic diseases such as diabetes, and pulmonary and heart disease, and can have a negative impact on education, mental health, productivity, and the economy. In response, Winchester Hospital provided funding to support local food pantries, senior centers, and various community organizations addressing these needs and to increase access to healthy food for adults, children, and families living in the hospital's service area. To reduce barriers to accessing food due to transportation and/or COVID-19 restrictions, local organizations provided home deliveries of food and essential items to those in need.
Target Population (select as many as needed)	• **Regions Served:** Medford, Stoneham, Wakefield, Wilmington, Winchester, Woburn • **Gender:** All • **Age Group:** Children, Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☐ All ☐Urban ☐Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐LGBT Status ☐ Incarceration History

	☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐Infrastructure to Support Community Benefits
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☐ NA ☒ Social Environment ☐Education ☐ Housing ☐ Employment
EOHHS Need	☐ Chronic Disease ☐ Mental Health/Mental Illness ☒ Additional Health Needs ☐ Housing/Homelessness ☐ Substance Use
Additional Program Descriptors	☐ Community Education ☐ Mentorship/Career Training/Internship ☒ Prevention ☐Community Health Center Partnership ☐Physician/Provider Diversity ☐ Research ☐ Health Professional/Staff Training ☐ Support Group ☐ Health Screening
Program Goal	To support local organizations and food banks in reducing hunger and food insecurity, resulting in improved health for food-insecure residents.
Goal Status	In response to the significant increase in food insecurity due to factors associated with the COVID-19 pandemic, Winchester Hospital is providing more than $40,000 in support to help local food pantries, senior centers, and various community organizations reduce food insecurity for over 20,000 community members and families. In addition to on-site pickup locations, local organizations provided home deliveries of food and essential items from March to September to reduce transportation barriers and respond to concerns people had about the safety of leaving their home. In addition, Winchester Hospital staff donated more than 25 hours of time to support and provide direction to community coalitions through Board involvement and/or by participating in fundraising events to support the organization's cause.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**

Community Partner:	**Website Address:**
Boys & Girls Club of Stoneham & Wakefield	BGCstoneham.org
Council of Social Concern Woburn	Socialconcern.org
Medford Council on Aging	Medfordma.org
Stoneham Council on Aging	Stonehamseniorcenter.org
Woburn Council on Aging	Woburnma.gov

Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org

Priority Health Need: Social Determinants of Health & Access to Care
Program Name: Regional Center for Poison Control
Health Issue: Public Safety

Brief Description or Objective	Winchester Hospital makes an annual contribution to support the Regional Center for Poison Control and Prevention, a not-for-profit organization that provides assistance and expertise in the diagnosis, management, and prevention of poisonings involving the people of Massachusetts and Rhode Island. In addition to staffing the Poison Help Hotline 24 hours a day, seven days a week, the doctors, nurses, and pharmacists at the center collaborate with other professionals to extend the reach of their poison-prevention message to the public.
Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** All • **Age Group:** All • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☒ Access/Coverage Supports ☐ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐ Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☒ NA ☐ Social Environment ☐Education ☐ Housing ☐ Employment
EOHHS Need	☐ Chronic Disease ☐ Mental Health/Mental Illness ☒ Additional Health Needs ☐ Housing/Homelessness ☐ Substance Use
Additional Program Descriptors	☐ Community Education ☐ Mentorship/Career Training/Internship ☒ Prevention ☐Community Health Center Partnership ☐ Research ☐ Health Professional/Staff Training ☐Physician/Provider Diversity ☐ Support Group ☐ Health Screening
Program Goal	To provide assistance and expertise in the diagnosis, management, and prevention of poisonings.
Goal Status	The center manages over 50,000 phone calls annually. Exposure calls originate primarily from private residences, with other calls coming from health care facilities and medical professionals. The center maintains a standard of excellence in clinical research and health care professional development, continually improving the quality of medical care available throughout the health care system.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**
Community Partner: NA	**Website Address:**	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Health Need: Social Determinants of Health & Access to Care
Program Name: Read to Me Program
Health Issue: Maternal/Child Health, Parenting Skills

Brief Description or Objective	The joy of reading is one of the greatest gifts a parent can share with a child. The Read to Me Program was established in 1997 by the Friends of Winchester Hospital. Since then, Winchester Hospital has emphasized the importance of reading to children by giving tens of thousands of storybooks to new parents. The program, based on research by reading specialist Jim Trelease, promotes the concept that listening comprehension comes before reading comprehension, so it is very important to start reading to children from birth so they hear language in an organized way. Studies have shown that children who are read to early on become better readers and thus better students who typically feel better about themselves. This information is presented in childbirth classes and followed up with the presentation of a new book to the parent of each infant born at Winchester Hospital.
Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** All • **Age Group:** Adults • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☒ Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☐ NA ☒ Social Environment ☐Education ☐Housing ☐ Employment
EOHHS Need	☐ Chronic Disease ☐ Mental Health/Mental Illness ☒ Additional Health Needs ☐Housing/Homelessness ☐ Substance Use
Additional Program Descriptors	☒ Community Education ☐ Mentorship/Career Training/Internship ☐ Prevention ☐Community Health Center Partnership ☐ Research ☐ Health Professional/Staff Training ☐Physician/Provider Diversity ☐ Support Group ☐ Health Screening
Program Goal	To educate parents about the impact that reading to a newborn has on the child's long-term reading comprehension.
Goal Status	In FY20, 13 educational sessions were conducted reaching approximately 230 expectant parents, and 2,550 books were distributed to expectant parents. Due to COVID-19, only five months of sessions in FY20 were held in person; and beginning March 2020, volunteers ceased going into childbirth classes and didn't participate in virtual classes.

Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**
Community Partner: Friends of Winchester Hospital	**Website Address:** Winchesterhospital.org	
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org		

Priority Health Need: Social Determinants of Health & Access to Care
Program Name: Medford Snap Gap

Health Issue: Access to Healthy Food, Income & Poverty	
Brief Description or Objective	Medford Snap Gap is a multidisciplinary program executed by a diverse network of state and local partners – including Mass in Motion, the City of Medford Board of Health, the Medford Family Network, and Tufts University – that are focused on addressing food insecurity in Medford. The overall goal of the program is to identify and understand the barriers and protective factors for accessing the Supplemental Nutrition Assistance Program (SNAP), increase enrollment and participation among eligible families with young children who reside in Medford, and create awareness about available food resources.
Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** All • **Age Group:** All • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Communitywide Intervention ☐ Access/Coverage Supports ☐Infrastructure to Support Community Benefits
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☒ NA ☐ Social Environment ☐Education ☐ Housing ☐ Employment
EOHHS Need	☐ Chronic Disease ☐ Mental Health/Mental Illness ☒ Additional Health Needs ☐ Housing/Homelessness ☐ Substance Use
Additional Program Descriptors	☐ Community Education ☐ Mentorship/Career Training/Internship ☒ Prevention ☐Community Health Center Partnership ☐Physician/Provider Diversity ☐ Research ☐ Health Professional/Staff Training ☐ Support Group ☐ Health Screening
Program Goal	The overall goal of the program is to identify and understand the barriers to accessing SNAP and to increase enrollment and participation among eligible families with young children who reside in Medford. The program also aims to inform and educate the community about available food assistance benefits and how to access them.
Goal Status	With the onset of the COVID-19 pandemic, the program could not be implemented as originally intended. Due to COVID-19 restrictions, recruitment was done primarily by sharing information by word of mouth and with the help of community partners. In addition, programs were conducted virtually, rather than in person. In spite of these challenges, the following outcomes were reported for FY20: • 10 low-income families with young children facing food insecurity were enrolled in SNAP. • 10 service providers that support families facing food insecurity were engaged in the program. • 1,498 Medford Public School students received Pandemic Electronic Benefits Transfer (P-EBT) cards. As this program targets policy and systems change, it is difficult to estimate the exact number of community members reached by the program. • A school advisory group was created to focus on issues of equity and food insecurity as well as cultural competency, and on how to address the pandemic-exacerbated child food insecurity crisis. • A point person was assigned in City Hall to support SNAP and food assistance applications. • A Food Access Guide was created, with input from families with lived experience of food access

	difficulty, and translated into various non-English languages including Haitian Creole, Portuguese, Spanish, and Arabic. The publication date was January 2021 (in co-release with the Housing Production Plan).

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

Community Partner:	**Website Address:**
Medford Council on Aging	Medfordma.org/department/council-on-aging
Cambridge Health Alliance	Challiance.org
The Medford Family Network	Themedfordfamilynetwork.org
Medford Food Security Network	Medfordma.org/food-resources-in-medford

Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org

Priority Area: Social Determinants of Health & Access to Care
Program Name: Community-Based Behavioral Health & Collaborative Care
Health Need: Access to Health Care, Mental Health, Substance Use Disorder

Brief Description or Objective	The National Alliance on Mental Illness (NAMI) reports that one-in-four individuals experience a mental illness each year, underscoring a critical need for mental healthcare access across all patient populations. In the FY19 CHNA, mental health – including depression, anxiety, stress, serious mental illness, and other conditions – was overwhelmingly identified as one of the leading health issues for residents of Winchester Hospital's service area. Further, individuals from across the health service spectrum discussed the burden of mental health issues for all segments of the population, specifically the prevalence of depression and anxiety. Winchester Hospital is committed to addressing this need by increasing access to Behavioral Health services in the community. In conjunction with Beth Israel Lahey Health Behavioral Health Services (BILHBS) services, a variety of services are provided including individual and group therapy for mental health and substance use issues; addiction treatment; family services; mobile crisis teams for behavioral and substance-related emergencies and inpatient psychiatric care. Additionally, centralized bed management monitors a behavioral health patient's progress through a facility's emergency department and coordinates the placement of such behavioral health patients in the inpatient unit best suited to their needs based on clinical presentation and geographic location.
Target Population (Select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** All • **Age:** Children, Adults, Elderly • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☐ All ☐ Urban ☐ Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ Incarceration History ☐ Refugee/Immigrant Status ☐Domestic Violence History ☐ LGBT Status ☐ Veteran Status
Program Type	☐ Direct Clinical Services ☒ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population/Communitywide Intervention
DoN Health Priorities (up to 3)	☐ Built Environment ☐ Violence ☒ NA ☐ Social Environment ☐ Education ☐ Housing ☐ Employment
EOHHS Health Need	☐ Chronic Disease ☒ Mental Health/Mental Illness ☐ Additional Health Needs ☐ Housing/Homelessness ☒ Substance Use
Additional Program Descriptors (Tags)	☐ Community Education ☐ Physician/Provider Diversity ☐ Community Health Center Partnership ☒ Prevention ☐ Health Professional/Staff Training ☐ Research ☐ Health Screening ☐ Support Group ☐ Mentorship/Career Training/Internship
Goal Description	To provide a collaborative approach among patients, clinicians, and family members to increase access to behavioral health services in order to identify and address health behaviors that may lead to mental health issues and substance use disorders.
Goal Status	In FY20, 624 patients received the service at three different primary care sites: Stoneham (248 patients), Tewksbury (206 patients), and Winchester (170 patients).

Program Year: Year 1	Of X Years: Year 3	Goal Type: Process Goal
Community Partner: NA	**Website Address:** NA	
Contact Information: Marylou Hardy (781) 744-3131 – Marylou.hardy@bilh.org		

Priority Health Need: Social Determinants of Health & Access to Care
Program Name: Interpreter Services
Health Issue: Access to Health Care

Brief Description or Objective	An extensive body of research illustrates the health disparities and differences in health care access and utilization that exist for diverse individuals/cohorts and foreign-born populations. According to the Centers for Disease Control and Prevention (CDC), non-Hispanic blacks have higher rates of premature death, infant mortality, and preventable hospitalization than do non-Hispanic whites. Hispanics have the highest uninsured rate of any racial or ethnic group in the United States. Asians are at a higher risk for developing diabetes than are those of European ancestry, despite a lower average body mass index (BMI). These disparities show the disproportionate and often avoidable inequities that exist within communities and reinforce the importance of understanding the demographic makeup of a community to identify populations more likely to experience adverse health outcomes. The WH service area is quite diverse. While many municipalities are predominantly white, there are significant populations of Asian and Hispanic/Latino residents throughout the service area. Language barriers pose significant challenges to providing effective and high-quality health and social services. To address this need, and in recognition that language and cultural obstacles are major barriers to accessing health and social services and navigating the health system, WH offers an extensive Interpreter Services program that provides interpretation (translation) and assistance in over 60 languages, including American Sign Language, and hearing augmentation devices for those who are hard of hearing. The Interpreter Services Department also routinely facilitates access to care, helping patients understand their course of treatment, and adherence to discharge instructions and other medical regimens. WH also routinely translates materials such as legal consents for treatment, patient education forms, and discharges, to further reduce barriers to care.
Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** All • **Age Group:** All • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☒ All ☐Urban ☐Rural ☐ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐ LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☒ Access/Coverage Supports ☐ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐ Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☒ NA ☐ Social Environment ☐Education ☐ Housing ☐ Employment
EOHHS Need	☐ Chronic Disease ☐ Mental Health/Mental Illness ☒ Additional Health Needs ☐ Housing/Homelessness ☐ Substance Use

Additional Program Descriptors	☐ Community Education ☐Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening	☐ Mentorship/Career Training/Internship ☐Physician/Provider Diversity	☒ Prevention ☐ Research ☐ Support Group
Program Goal	To overcome language barriers and increase access to care by providing free interpreter services via phone, video, or in-person sessions for community members with limited English proficiency.		
Goal Status	In FY20, Winchester Hospital interpreters assisted 1620 patients by providing free Interpreter Services sessions in person and remotely. As of March, 2020 the sessions were conducted remotely only due to COVID restrictions. The top three languages requesting interpreter services were: Spanish (324), Portuguese (168), Chinese-Mandarin (72) languages.		
Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**	
Community Partner: NA	**Website Address**: NA		
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org			

Priority Health Need: Social Determinants of Health & Access to Care
Program Name: Transportation
Health Issue: Access to Health Care, Access to Transportation

Brief Description or Objective	Winchester Hospital collaborated with Checker Cab of Woburn to provide free rides to and from medical and other appointments. Community members who have transportation difficulty due to financial problems, illness, or mobility issues are eligible for the service.
Target Population (select as many as needed)	• **Regions Served:** Massachusetts • **Gender:** All • **Age Group:** All • **Race/Ethnicity:** All • **Language:** All • **Environment Served:** ☐ All ☐Urban ☐Rural ☒ Suburban • **Additional Target Population Status:** ☐ Disability Status ☐LGBT Status ☐ Incarceration History ☐ Domestic Violence History ☐Veteran Status ☐ Refugee/Immigrant Status
Program Type	☐ Direct Clinical Services ☒ Access/Coverage Supports ☐ Community Clinical Linkages ☐Infrastructure to Support Community Benefits ☐ Total Population or Communitywide Intervention
DoN Priorities (up to 3)	☐ Built Environment ☐ Violence ☒ NA ☐ Social Environment ☐Education ☐ Housing ☐ Employment
EOHHS Need	☐ Chronic Disease ☐ Mental Health/Mental Illness ☒ Additional Health Needs ☐ Housing/Homelessness ☐ Substance Use

Additional Program Descriptors	☐ Community Education ☐Community Health Center Partnership ☐ Health Professional/Staff Training ☐ Health Screening	☐ Mentorship/Career Training/Internship ☐Physician/Provider Diversity	☒ Prevention ☐ Research ☐ Support Group
Program Goal	Increase access to health services by providing rides to individuals with no means of transportation due to medical or financial issues.		
Goal Status	In FY20, Winchester Hospital provided more than 90 indigent patients who had no access to public transportation with free rides via Checker Cab to and from Winchester Hospital locations for appointments.		
Program Year: Year 1	**Of X Years: Year 3**	**Goal Type: Process Goal**	
Community Partner: Checker Cab	**Website Address:** NA		
Contact Information: Marylou Hardy (781) 744-3131 Marylou.hardy@bilh.org			

CB Expenditures by Program Type	Amount	Amount Provided to Community Organizations
Direct Clinical Services	$973,920.11	
Community-Clinical Linkages	$436,628.43	
Total Population or Communitywide Interventions	$392,351.23	
Access/Coverage Supports	$326,836.47	

SECTION V: EXPENDITURES

Infrastructure to Support CB Collaborations	$187,268.00	
Total Expenditures by Program Type	$2,317,004.24	
CB Expenditures by Health Need		
Chronic Disease	$1,413,840.89	$0.00.00
Mental Illness	$77,110.50	$20,000.00
Substance Use Disorders	$68,933.27	$2,500.00
Housing Stability/Homelessness	$51,817.00	$5,000.00
Additional Health Needs Identified by Community	$705,302.58	$100,030.20
Total by Health Need	**$2,317,004.24**	$127,530.20
Leveraged Resources	$1,193,659.40	
Total Direct Community Benefits Programming	**$3,510,663.64**	
Net Charity Care Expenditures		
HSN Assessment	$1,836,265.00	
HSN Denied Claims	$1,053,376.00	
Total Net Charity Care	**$2,889,641.00**	
Total CB Expenditures	**$6,400,304.64**	
Additional Information		
Net Patient Services Revenue	$261,414,033.00	
CB Expenditure as % of Net Patient Services Revenue	**2.45%**	
PILOT Payments	$156,397.20	

SECTION VI: CONTACT INFORMATION

For more information, please contact Marylou Hardy, Community Benefits Regional Manager, at Marylou.hardy@bilh.org or (781) 744-3131. To view/print the Winchester Hospital 2019 Community Health Needs Assessment, previous community benefits reports, or our Community Resource Guide, visit **www.winchesterhospital.org/our-promise/supporting-our-community.**