Community Benefits Report

Fiscal Year 2022

Beth Israel Lahey Health
Winchester Hospital

TABLE OF CONTENTS

SECTION I: SUMMARY AND MISSION STATEMENT

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

At the heart of BILH is the belief that everyone deserves high-quality, affordable health care. This belief is what drives BILH to work with community partners across the region to promote health, expand access, and deliver the best care in the communities BILH serves. Winchester Hospital's Community Benefits staff are committed to working collaboratively with its communities to address the leading health issues and creating a healthy future for individuals, families and communities. While Winchester Hospital oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure makes sure that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WECARE:*

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

Winchester Hospital's mission is "To Care. To Heal. To Excel. In Service to Our Community." This mission is supported by the hospital's commitment to personalized, excellent care for patients; a workforce committed to individual accountability, mutual respect, and collaboration; and a commitment to maintaining financial health. Winchester Hospital is also committed to being active in the community. Service to

community is at the core of Winchester Hospital's mission. The Winchester Hospital founders made a covenant to care for the underserved in the hospital's service area, attend to unmet needs, and address disparities in access to care and health outcomes. Winchester Hospital's commitment to this covenant and the people it serves remains steadfast today.

In 2013, Winchester Hospital's Community Benefits Advisory Committee 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 Community Benefits Service Area (CBSA), community health priorities, priority populations, community partners, and detailed descriptions of its Community Benefits programs and their impact.

More broadly, Winchester Hospital's Community Benefits mission is fulfilled by:

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

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

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

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

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

- **Facilitating collaboration and partnership within and across sectors** (e.g., state/local public health agencies, health care providers, social service organizations, businesses, academic institutions, community health collaborative, and other community health organizations) to advocate for, support, and implement effective health policies, community programs, and services.

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

Priority Cohorts

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

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

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

- Youth
- Low-Resourced Populations

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

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

Key Accomplishments for Reporting Year
Winchester Hospital's most recent CHNA and IS were conducted and approved by the Board during the fiscal year ended September 30, 2022. That CHNA and IS will inform the Community Benefits mission and activities of Winchester Hospital for the fiscal years ending September 30, 2023; September 30, 2024; and September 30, 2025.

This report covers Winchester Hospital's fiscal year ending September 30, 2022. The previous CHNA and accompanying IS were approved by the Winchester Hospital Board before September 30, 2019 and informed Winchester Hospital's Community Benefits initiatives for the fiscal years ending September 30, 2020; September 30, 2021; and September 30, 2022. As such, the accomplishments and activities included in this section as well as in Section IV: Community Benefits Programs relate to the CHNA and Implementation Strategy approved as of September 30, 2019.

Program accomplishments include:

- ***Community Home Blood Draw Program*** – Winchester Hospital Phlebotomy staff provided home blood draws for 12,234 patients who were homebound due to illness, injury, or transportation issues.
- ***Council of Social Concern Food Insecurity Relief Initiative*** – Winchester Hospital supported the Council of Social Concern food pantry to provide food security relief for 1,440 individuals living in Woburn and Winchester. 97% of households served reported that the food assistance and information regarding community resources they received from the Food Pantry made it easier for them to meet their other basic monthly financial needs.
- ***Metro Housing Boston Co-Location Program*** – Free counseling was provided to 257 low- to moderate-income individuals and families to prevent eviction, increase housing stability and economic self-sufficiency, and improve their overall quality of life. Counselors also helped with housing searches, emergency assistance, rapid rehousing, and benefits maximization, and connected participants to community resources.
- ***Community and Hospital Asthma Management Program (CHAMP)*** – In FY22, 104 children were enrolled in CHAMP, a pediatric asthma management program in which the pediatric asthma nurse specialist works collaboratively with the child, family,

doctor, and school personnel to improve each child's management of asthma. This program resulted in fewer missed school days and emergency room visits and improved overall quality of life for participants.

- ***Mystic Valley Elder Services Mobile Mental Health Program*** – The Mystic Valley Elder Services Mobile Mental Health Program provided home-based mental health services to 264 older adults living in Medford, North Reading, Reading, Stoneham, and Wakefield. The program addressed a variety of issues affecting older adults' emotional well-being and quality of life through home-based mental health counseling and direct care services.
- ***Boys & Girls Club – Screening, Brief Intervention, Referral to Treatment*** – In FY22, 175 youth were screened, resulting in referrals to mental health treatment and weekly sessions with mentors. Of those screened, 95% agreed to join weekly mentoring programs, 79% reported they were less likely to participate in risky behaviors, 97% identified an adult to talk to if they felt depressed or had thoughts of self-harm, and 75% of all participants improved their accuracy in estimating peer marijuana and tobacco use.

Plans for Next Reporting Year

In FY 2022, Winchester Hospital conducted a comprehensive and inclusive CHNA that included extensive data collection activities, substantial efforts to engage Winchester Hospital's partners and community residents, and thoughtful prioritization, planning, and reporting processes. These activities were in full compliance with the Commonwealth's updated Community Benefits Guidelines for FY 2019. In response to the FY 2022 CHNA, Winchester Hospital will focus its FY 2023 - 2025 IS on four priority areas. These priority areas collectively address the broad range of health and social issues facing residents living in Winchester Hospital's CBSA who face the greatest health disparities. These four priority areas are:

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

These priority areas are aligned with the statewide health priorities identified by the Executive Office of Health and Human Services (EOHHS) in 2017 (i.e., Chronic Disease, Housing Stability/Homelessness, Mental Illness and Mental Health, and Substance Use Disorders). Winchester Hospital's priorities are also aligned with the priorities identified by the Massachusetts Department of Public Health (DPH) to guide the Community-based Health Initiative (CHI) investments funded by the Determination of Need (DoN) process, which underscore the importance of investing in the Social Determinants of Health (i.e., built environment, social environment, housing, violence, education, and employment).

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

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

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

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

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

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

Hospital Self-Assessment Form

Working with its Community Benefits Leadership Team and its Community Benefits Advisory Committee (CBAC), the Winchester Community Benefits staff completed the Hospital Self-Assessment Form (Section VII, page 40) The Winchester Hospital Community Benefits staff also shared the Community Representative Feedback Form with its CBAC members who participated in Winchester Hospital's CHNA and asked them to submit the form to the AGO website.

SECTION II: COMMUNITY BENEFITS PROCESS

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

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. It is not only the Winchester Hospital's Board of Trustee members and senior leadership who are held accountable for fulfilling Winchester Hospital's Community Benefits mission. Among Winchester Hospital's core values are the recognition that the most successful Community Benefits programs are implemented organization wide and integrated into the very fabric of the hospital's culture, policies, and procedures. A commitment to Community Benefits is a focus and value manifested throughout BILH and Winchester Hospital's structure and reflected in how care is provided at the hospital and in affiliated practices.

While Winchester Hospital oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure makes sure that Community Benefits efforts, prioritization, planning, and strategy focus on equity and align and are integrated with local and system strategic and regulatory priorities to ensure health equity in fulfilling BILH's mission – *We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity* and values, encompassed by the acronym *WECARE:*

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

The Winchester Hospital Community Benefits program is spearheaded by LeighAnne Taylor, the Regional Manager of Community Benefits and Community Relations. The Regional Manager of Community Benefits and Community Relations has direct access, and is accountable to, the Winchester Hospital President and the BILH Vice President of Community Benefits and Community Relations, the latter of whom reports directly to the BILH Chief Diversity, Equity and Inclusion Officer. It is the responsibility of these leaders to ensure that Community Benefits is addressed by the entire organization and that the needs of cohorts who have been historically underserved are considered every day in discussions on resource allocation, policies, and program development.

This structure and methodology are employed to ensure that Community Benefits is not the purview of one office alone and to maximize efforts across the organization to fulfill the mission and goals of BILH and Winchester Hospital's Community Benefits program.

Community Benefits Advisory Committee (CBAC)

The Winchester Hospital Community Benefits Advisory Committee (CBAC) works in collaboration with Winchester Hospital's leadership, including the hospital's governing board and senior management to support Winchester Hospital's Community Benefits mission: to benefit all of the communities we serve by collaborating with community partners to identify health needs, improve the health status of community residents, address health disparities, and educate community members about prevention and self-care.
The CBAC provides input into the development and implementation of Winchester Hospital's Community Benefits programs in furtherance of Winchester Hospital's Community Benefits mission. The membership of Winchester Hospital's CBAC aspires to be representative of the constituencies and priority cohorts served by Winchester Hospital's programmatic endeavors, including those from diverse racial and ethnic backgrounds, age, gender, sexual orientation and gender identity, as well as those from corporate and non-profit community organizations.

The Winchester Hospital CBAC met on the following dates:

- December 16, 2021
- June 30, 2022
- September 8, 2022
- December 15, 2022

Community Partners

Winchester Hospital recognizes its role as an acute care, independent community hospital in a larger health system and knows that to be successful it needs to collaborate with its community partners and those it serves. Winchester Hospital's Community Health Needs Assessment (CHNA) and the associated Implementation Strategy were completed in close collaboration with Winchester Hospital's staff, community residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed

officials, hospital leadership and other key collaborators from throughout its CBSA. Winchester Hospital's Community Benefits program exemplifies the spirit of collaboration that is such a vital part of Winchester Hospital's mission.

Winchester Hospital currently supports numerous educational, outreach, community health improvement, and health system strengthening initiatives within its CBSA. In this work, Winchester Hospital collaborates with many of its local community-based organizations, public health departments, municipalities and clinical and social service organizations. The following is a listing of the community partners with which Winchester Hospital collaborated with on its FY 2020 – 2022 IS, as well as on its FY 2022 CHNA. The level of engagement of a select group of community partners can be found in the Hospital Self-Assessment Form (Section VII, page 40).

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

SECTION III: COMMUNITY HEALTH NEEDS ASSESSMENT

The FY 2022 Community Health Needs Assessment (CHNA) along with the associated FY 2023-2025 Implementation Strategy was developed over a twelve-month period from September 2021 to September 2022. These community health assessment, planning, and implementation efforts fulfill the Commonwealth of Massachusetts Attorney General's Office and federal Internal Revenue Service's (IRS) requirements. More specifically, these activities fulfill the Winchester Hospital's need to conduct a community health needs assessment, engage the community, identify priority health issues, inventory community assets, assess impact, and develop an Implementation Strategy. However, these activities are driven primarily by Winchester Hospital's dedication to its mission, its covenant to cohorts who have been historically underserved, and its commitment to community health improvement.

As mentioned above, Winchester Hospital's recent CHNA was completed during FY 2022. FY 2022 Community Benefits programming was informed by the FY 2019 CHNA and aligns with Winchester Hospital's FY 2020 – FY2022 Implementation Strategy. The following is a summary description of the FY 2022 CHNA approach, methods, and key findings.

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

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

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

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

Between October 2021 and February 2022, Winchester Hospital conducted 21 one-on-one interviews with key collaborators in the community, facilitated three focus groups with segments of the population facing the greatest health-related disparities, administered a community health survey involving more than 800 residents, and organized two community listening sessions. In total, the assessment process collected information from more than 1,000 community residents, clinical and social service providers and other community partners.

The articulation of each specific community's needs (done in partnership between Winchester Hospital and community partners) is used to inform Winchester Hospital's decision-making about priorities for its Community Benefits efforts. Winchester Hospital works in concert with community residents and leaders to design specific actions to be collaboratively undertaken each year. Each component of the plan is developed and eventually woven into the annual goals and agenda for the Winchester Hospital's Implementation Strategy that is adopted by the Winchester Hospital's Board of Trustees.

Summary of FY 2022 CHNA Key Health-Related Findings

Equitable Access to Care

- Individuals identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system level, meaning that the issues stem from the way in which the system does or does not function. System-level issues included providers not accepting new patients, long waitlists, and an inherently complicated healthcare system that is difficult for many to navigate.
- There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forego or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.

Social Determinants of Health

- The social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions influence and define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to economic insecurity, education, food insecurity, access to care/navigation issues, and other important social factors.
- There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, survey, and listening sessions suggested that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, food security/nutrition, and economic stability.

Mental Health and Substance Use

- Anxiety, chronic stress, depression, and social isolation were leading community health concerns. The assessment identified specific concerns about the impact of mental health issues for youth and young adults, the mental health impacts of racism, discrimination, and trauma, and social isolation among older adults. These difficulties were exacerbated by COVID-19.
- In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services.
- Substance use continued to have a major impact on the CBSA; the opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities, including mental health, housing, and homelessness. Individuals engaged in the assessment identified stigma as a barrier to treatment and reported a need for programs that address common co-occurring issues (e.g., mental health issues, homelessness).

Complex and Chronic Conditions

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

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

SECTION IV: COMMUNITY BENEFITS PROGRAMS

Priority Health Need: Mental Health & Substance Use Disorders **Program Name: Stoneham Boys & Girls Club – SBIRT and Youth Mental Health First Aid** **Health Issue: Mental Health/Mental Illness, Substance Use Disorders**	
Brief Description or Objective	Screening, Brief Intervention, Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs as well as provide early intervention for potential mental illness. The Boys and Girls Club youth SBIRT program includes training all club staff on two different screening tools: CRAFFT & QPR. CRAFFT is a clinical assessment tool designed to screen for substance-related risks in young people. CRAFFT stands for the key words in the assessment - Car, Relax, Alone, Forget, Friends, Trouble. QPR trains staff to Question, Persuade, and Refer, especially among young people causing self-harm or having suicidal thoughts. Youth Mental Health First Aid is a training to understand the unique risk factors and warning signs of mental health problems in adolescents ages 12-18 and emphasizes the importance of early intervention.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	In FY22, 300 youth will be screened, including 100% of our LGBTQ+ youth; the club will have hosted at minimum 4 youth mental health campaign events and workshops, and will have launched an LGBTQ+ mentoring program. In FY22 100% of newly hired staff will be trained in SBIRT, QPR, and CRAFFT.
Goal Status	In FY22 staff screened 175 youth. This resulted in one child being referred to intensive treatment and 22 were referred to additional treatment. Of all the children screened, 95% agreed to join weekly mentoring programs, 79% reported they were less likely to participate in risky behaviors, 97% identified an adult to talk to if they felt depressed or had thoughts of self-harm, and 75% of all participants improved their accuracy in estimating peer marijuana and tobacco use. 16 new staff members were training in SBIRT, QPR, and CRAFFT. Additional program successes include the establishment of a Girl Talk mentorship program with 70 participants and a youth-led LGBTQIA2S+ support group with 32 members. Two Pride events in support of LGBTQIA2S+ mental health were held, reaching 300 participants. 9 Youth Mental Health First Aid sessions were hosted, reaching 72 participants.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** | **Goal Type: Process Goal**

Priority Health Need: Mental Health & Substance Use Disorders **Program Name: INTERFACE Referral Service: Town of Winchester and Town of Stoneham** **Health Issue: Mental Health/Mental Illness**	
Brief Description or Objective	The William James INTERFACE Referral Service is a free, confidential referral service for residents of participating communities. Callers from these participating communities are matched with licensed mental health providers from an extensive database, on average, within 2 weeks of their call to INTERFACE. Each referral best meets the location, insurance, and specialty needs of the caller. Winchester Hospital financially supports INTERFACE in Winchester and Stoneham.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To address mental health challenges of residents in Winchester and Stoneham and increase access to care by connecting participants to mental health and wellness resources in a timely manner.
Goal Status	In Winchester in FY22, 107 callers utilized INTERFACE. The top referral concerns included suicidal ideation, self-harm, anxiety, and depression. In Stoneham in FY22, 91 Stoneham residents were served by INTERFACE. The top call concerns were anxiety and depression, including suicidal ideation and self-injury. Most callers were requesting individual therapy. Among callers: 24% were pre-teens; 27% were teens; 33% were adults; 16% were older adults, over 65. 69% were female; 27% were male; 4% were non-binary or transgender. 75% of callers had private insurance. Most of the callers learned of the service through Stoneham community-based organizations and the school system.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Mental Health & Substance Use Disorders **Program Name: Mystic Valley Elder Services Mobile Mental Health Program** **Health Issue: Mental Health/Mental Illness, Substance Use Disorders**	
Brief Description or Objective	Mystic Valley Elder Services' Mobile Mental Health Program provides home-based mental health services to older adults and people living with disabilities who reside in 11 communities north of Boston, including towns in Winchester Hospital CBSA including: Medford, North Reading, Reading, Stoneham and Wakefield. This program addresses a number of issues affecting older adult's emotional well-being and quality of life, such as depression, anxiety, social isolation, hoarding, substance abuse, as well as adjustment to loss. The goal of the program is to provide trained professionals to see clients as quickly as possible to ensure their recovery, providing linkages to health care services such as in-home mental health therapy, medication evaluation, and other supports where needed. The program addresses behavioral and mental health problems, as well as the need for ongoing care of both body and mind to support wellness, independence and dignity of older adults.

Program Type	☐ Direct Clinical Services ☒ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population or Community Wide Intervention
Program Goal(s)	To avert a mental crisis such as suicide, anger, abuse; to reduce isolation and loneliness; to see improvement in mental health symptoms; to achieve medication compliance; to avert in-patient stays for mental health conditions; and to prevent housing loss and eviction for program participants.
Goal Status	In FY22, 264 persons took part in the Mobile Mental Health program. Of those, 76 were from communities in the Winchester Hospital CBSA including: Medford, North Reading, Reading, Stoneham, and Wakefield. 92 percent of participants were 65 and over. Of the 264 served, case management reports indicate that 41 participants averted a mental health crisis, 113 reported reduced isolation, 138 reported improved mental health symptoms, 52 participants achieved medication compliance, and 23 participants were supported in stabilizing their housing through the program.
Time Frame Year: Year 3	**Time Frame Duration: Year 3** / **Goal Type: Outcomes Goal**

Priority Health Need: Mental Health & Substance Use Disorders **Program Name: North Reading Youth Substance Use Prevention Coalition – Guiding Good Choices & 40 Developmental Assets Training Program** **Health Issue: Mental Health/Mental Illness, Substance Use Disorders**	
Brief Description or Objective	The North Reading Youth Substance Use Prevention Coalition led two evidence-based mental health promotion and substance use prevention programs: Guiding Good Choices & 40 Developmental Assets. Guiding Good Choices is a 5-session workshop to give families information and tools to protect preteens and teens from the inevitable risks they encounter as they become more independent. 40 Development Assets is framework that focuses on external assets and internal assets youth can develop to build the strength and support they need to succeed. Both curriculums are designed to strengthen families, increase access to mental health resources, reduce potential substance use, and decrease risk factors.
Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒ Total Population or Community Wide Intervention
Program Goal(s)	Host a 5-session Guiding Good Choices program for families of North Reading and share the 40 Developmental Assets framework with schools and other community partners such as the Council on Aging.
Goal Status	Four Guiding Good Choices sessions were offered to the community in FY22. To address low attendance due to a high time demand, the coalition offered the entire program but marketed it into topical workshops and included dinner for participants. The 40 Developmental Assets framework was presented to families as well as public school educators and older adults at the Council on Aging. Between the two programs, 89 participants were reached: 64 via 40 Developmental Assets and 25 via Guiding Good Choices. 15 participants were youth under 18 years old.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**

Priority Health Need: Mental Health & Substance Use Disorders **Program Name: Winchester Public Schools Student Mental Health Mentoring Program** **Health Issue: Mental Health/Mental Illness, Substance Use Disorders**	
Brief Description or Objective	September, 2021, Winchester High School began implementation of a 9th grade student mentoring program. This program is meant to connect incoming freshman students with an upper class student mentor as well as a teacher mentor. Teacher mentors help co-facilitate groups with the student mentors aimed at helping incoming mentees make connections and navigate the new High School environment. The main focus areas for programming were: to make personal connections with the students, discuss and develop healthy coping strategies to support positive mental health, and learn executive functioning strategies that will help them to organize and plan more productively for a High School course load through a series of workshops, QPR training, and student trainings with the NAN Project.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By June 2022, at least 68 mentor students and 13 staff members will participate in a minimum of 2 of 3 workshops on risk prevention areas: Alcohol Use/Abuse, Self-Harm/Suicidality, and Dating Violence/Sexual Assault. By June 2022, at least 60% of student and teacher mentors will report confidence in talking about workshop topics with their September mentees and guiding them towards appropriate supports when discussed. Through this proposed grant, we will target a minimum of 75% of student/teacher mentors (68 students, 13 staff members) for the 2022-23 school year participating in 2 of the 3 workshop focus areas.
Goal Status	The NAN project conducted a QPR training for the 16 teacher facilitators on suicide prevention in September 2022. 70 student mentors and 16 teacher facilitators have pushed into 15 9th grade WIN blocks twice (9/15/22 and 10/3/22) to present two of four training modules. The final two mentor sessions with 9th graders will occur in March 2023 and May 2023. The teacher facilitators met 3 times in FY22 to review the data from the mentor sessions and create responsive programming based on that data for FY23. Overall, 365 9th grade students were served by the program. 9th graders served by race are as follows: 19% Asian, 2% Black, 66% White, 8% more than one race, 2% other. By ethnicity: 3% Latinx.
Time Frame Year: Year 1	**Time Frame Duration: Year 1** / **Goal Type: Process Goal**

Priority Health Need: Mental Health & Substance Use Disorders **Program Name: HART House Tewksbury** **Health Issue: Mental Health/Mental Illness, Substance Use Disorders**	
Brief Description or Objective	A long-term residential recovery home providing a 24-hour structured rehabilitative environment for pregnant and parenting women recovering from substance use disorder and/or alcohol use disorder. Treatment offered includes individual, family, group therapy and parenting education.

Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Provide a 24-hour structured rehabilitative environment for pregnant and parenting women recovering from substance use disorder and/or alcohol use disorder. The program aims to provide women with the skills necessary to maintain their sobriety and the knowledge, skills and guidance to be effective, nurturing parents.	
Goal Status	In FY22 the HART House provided 4.492 bed days of care to program participants and served 48 women and 47 children.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Mental Health & Substance Use Disorders **Program Name: Town of Winchester Social Worker and Health Inspector** **Health Issue: Mental Health/Mental Illness, Substance Use Disorders**		
Brief Description or Objective	Winchester Hospital financially supported the town of Winchester to hire a full-time licensed social worker to work with the Winchester Police Department to build relationships and mental health referrals for community residents. This person will provide service reports to the Chief of Police, Board of Health Director, and Town Manager. The social worker will offer referral sheets to first-line officers helping residents in crisis and assist with information for follow-up. This professional will have a relationship with community behavioral health services and substance abuse programs before a crisis, which will help the person(s) in need (short term and long term).	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	The social worker will provide resident referrals to mental health services in partnership with first-line officers. The social worker will report on: number of clients served; demographics of clients served; number of referrals made; and number of police officers who complete the 40-hour Crisis Intervention Training.	
Goal Status	43 clients were directly served by the social worker in FY22. The social worker also reported 50 external involvements involving family members, schools, external stakeholders, and providers. Approximately 20 referrals were made via parent support group members, section 12s, outpatient service providers, detoxification service providers, the Department of Mental Health, Minuteman Senior Services, and the Jenks Center. The demographics of clients served were as follows: Age: 0-18y: 10; 18-25y: 5; 26-60y: 16; 60y+: 12; Gender: 20 males; 23 females. Race: Asian - 4; Black -1; White-37.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: CHAMP Pediatric Asthma Program** **Health Issue: Chronic Disease**		
Brief Description or Objective	Winchester Hospital's Center for Healthy Living Community Healthcare for Asthma Management and Prevention (CHAMP) program is a family-centered, patient-tailored, evidence-based model of care that uses a team-approach, proven to help children manage their asthma more effectively. The team consists of family members, caregivers, the child's pediatrician, clinical staff from Winchester Hospital, the child's school nurse, child care personnel, classroom teachers, and guardians about effective asthma management.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To reduce emergency department visits for pediatric asthma patients by ensuring effective control of the disease through treatment and education of patients, families, physicians, and other health professionals.	
Goal Status	In FY22, 104 children participated in CHAMP. Participants report significantly fewer asthma-related hospital admissions and emergency department visits. In addition, Winchester Hospital's pediatric asthma nurse specialist provided community outreach in the hospital service area in FY22 via education and training sessions and private consultations and visits to educate students, teachers, and families about pediatric asthma. Of the children enrolled in CHAMP, there were a reported 16 ED visits for asthma. CHAMP efforts included: 100 home visits, 100 FaceTime and 26 Zoom visits; 18 school and 11 camp visits; 4 school education/training sessions; and 1 Pediatric Grand Rounds for Winchester and 1 Pediatric Grand Rounds at Beverly Hospital. Additionally, 212 Asthma Action Plans were completed and filed with schools and daycare centers.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: Outpatient Lactation Program** **Health Issue: Chronic Disease**		
Brief Description or Objective	Winchester Hospital's Outpatient Lactation Program offers breastfeeding education and encouragement to new moms before the birth of their baby, during their hospital stay, and after their return home. The program, led by a Certified Lactation Specialist, provides free prenatal breastfeeding classes, along with individual counseling, to give new mothers tools and teach them techniques for successful breastfeeding.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To help mothers meet the breastfeeding goal set during their initial consultation with the Lactation Specialist and successfully breastfeed for at least six months, as recommended by the American Academy of Pediatrics.	

Goal Status	In FY22, The Outpatient Lactation center provided in person and video consultations. In FY22, an additional Lactation Consultant joined the staff. The Nursing Mothers' Support Group met online weekly using Zoom. 601 mothers participated in the program. 84% of the new mothers surveyed after the program reported meeting the breastfeeding goal they set during their initial consultation with the Lactation Specialist. 90% reported successfully breastfeeding for six months or more.

Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

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.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To help isolated or homebound community members, or those unable to shop for or prepare a meal due to illness or injury, remain independent in their homes by delivering low-cost, healthy meals. To reduce isolation and provide an opportunity for social engagement for residents living alone.
Goal Status	Winchester Hospital's kitchen staff, under the direction of the hospital's team of registered dietitians, prepared and packed 4,939 meals to meet the dietary needs of participants. The meals were delivered by hospital volunteers to homebound residents.

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

Priority Health Need: Chronic/Complex Conditions **Program Name: Oncology Nurse Navigator** **Health Issue: Chronic Disease**		
Brief Description or Objective	The Oncology Nurse Navigator, an RN with oncology-specific clinical knowledge, offers individualized support to patients and their caregivers to help them make informed care decisions and overcome barriers to optimal cancer care. The Navigator contributes to the hospital's mission by providing cancer patients with holistic care that includes communication and coordination with the patient's family and caregivers and a multidisciplinary team of physicians, clinicians, and social workers. The Navigator reviews all medical information prior to patient visits, ensures that physicians receive the information, and discusses it with the disease-specific physician prior to patient visits. In addition, the Navigator maintains contact with referring physicians to keep them up-to-date on the patient's care plan.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To guide patients through the complexities of the disease, direct them to healthcare services for timely treatment and survivorship, and identify and address barriers to treatment. In addition, the Nurse Navigator connects patients with resources, healthcare, and support services in their community and assists them in the transition from active treatment to survivorship.	
Goal Status	In FY22, the Oncology Nurse Navigator dedicated 1,826 hours providing 1,034 new patient consults.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Chronic/Complex Conditions **Program Name: Breast Cancer Risk Assessment** **Health Issue: Chronic Disease**		
Brief Description or Objective	Winchester Hospital provides a confidential survey to help patients assess their lifetime risk of breast cancer. Assessment, evaluation, and follow-up are all provided at no cost to participants. Results are shared with each participant's physician, who can help determine whether the patient might benefit from preventive screening beyond regular checkups and mammograms. In addition, genetic counselors provide information and answer questions about genetic testing results.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To identify persons who may be at higher lifetime risk of developing breast cancer and to provide screening follow-up to their physicians.	
Goal Status	In FY22, Winchester Hospital conducted 4,027 free screenings. Of those screened: • 1025 (25%) had a high-risk mutation. • 756 (19%) had a high lifetime risk of breast cancer.	

	• 33% were between the ages of 40 and 49. • 27% were between the ages of 50 and 59. • 23% were between the ages of 60 and 69. • 11% were between the ages of 70 and 79. • 1.5% 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.

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

Priority Health Need: Chronic/Complex Conditions **Program Name: Integrative Therapies for Cancer Patients** **Health Issue: Chronic Disease**	
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 of 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, and yoga classes.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To help 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 FY22, Winchester Hospital provided 540 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, 17 Healing Yoga classes were offered to cancer patients in treatment or recovery, reaching approximately 40 participants. According to a survey administered to participants after receiving one Integrative Therapy session, the following reported the treatment to be effective at reducing stress and relieving the side effects of their cancer treatment: 100% of massage patients; 100% of hypnotherapy patients; 67% of acupuncture patients.

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

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 provide acupuncture and massage therapy at no cost to residents at the Mount Vernon House and to Winchester residents over the age of 65 to provide relief of chronic pain and improve health.
Program Type	☐ Direct Clinical Services ☒ Community Clinical Linkages ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

	☐ Total Population or Community Wide Intervention
Program Goal(s)	To provide temporary pain relief for older adults with chronic health issues to help them improve or maintain their health. 50% of those receiving therapy will show a decrease in pain, and improved flexibility.
Goal Status	In FY22, Winchester Hospital provided 853 treatments to Winchester and Mount Vernon residents. Health issues treated included back weakness, leg stiffness, edema in lower legs, leg numbness, shoulder pain, sinus headaches, hip and knee problems, arthritis of the low back, neck pain, sciatica, carpal tunnel, and balance trouble. Per a survey completed by participants: 67% decreased their pain, 67% improved their flexibility, 50% improved their mood, 40% decreased their level of stress and anxiety, and 20% improved their balance.

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

Priority Health Need: Chronic/Complex Conditions **Program Name: Center for Healthy Living Health Education Programs** **Health Issue: Chronic Disease**	
Brief Description or Objective	The Center for Healthy Living at Winchester Hospital helps community members take charge of their health and well-being by offering free and reduced-cost programs and services, including childbirth education, prenatal breastfeeding and care of the newborn classes. In addition, the center offers a variety of specialized fitness classes led by highly trained educators, targeting people of all ages and fitness levels and those with physical limitations or mobility issues.
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To help people residents in the Winchester Hospital service area improve their overall health and quality of life through free and reduced-cost health education and health promotion programs and classes.
Goal Status	In FY22, more than 3,700 community members participated in classes and educational programs. Classes include: Flex and Stretch and Building Bones, held in 10-week sessions once per week; Breastfeeding classes; and Care of Newborn and Childbirth Classes.

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

Priority Health Need: Chronic/Complex Conditions **Program Name: Winchester Center for Cancer Care Support Groups** **Health Issue: Chronic Disease**	
Brief Description or Objective	Winchester Hospital Center for Cancer Care provides support groups to patients in treatment for cancer.

Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To provide mental health support and connection to patients in treatment of cancer.	
Goal Status	In FY22, 28 support group sessions were held, reaching 136 patients. Art and knitting classes were also offered, reaching 102 patients.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Home Blood Draw Program** **Health Issue: Additional Health Needs Identified by the Community (Access to Care)**		
Brief Description or Objective	The Winchester Hospital Home Blood Draw Program was developed to enhance access to phlebotomy services for homebound patients who have difficulty getting to a laboratory. Homebound patients are defined as people with a condition due to surgery, illness, or injury that precludes them from accessing medical care outside their home.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to phlebotomy services for homebound patients who have difficulty getting to a laboratory due to illness or injury.	
Goal Status	In FY22, Winchester Hospital Lab Services provided 12,234 free in-home blood draws. In addition to appreciating the convenience of the home blood draw, patients reported reduced feelings of isolation, as the visit with the phlebotomist provided them with a social opportunity.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Winchester Housing Authority Farmers Market** **Health Issue: Additional Health Needs Identified by the Community (Access to Healthy Food)**	
Brief Description or Objective	To address food insecurity among Winchester Housing Authority residents, Winchester Hospital partners with New Entry Sustainable Farming Project, an organization that grows organic produce locally for Middlesex County, to provide free produce for 20 consecutive weeks to residents living at Winchester Housing Authority sites. To reduce transportation barriers, farmers markets were held at both Winchester Housing locations. Each week, more than six varieties of fresh produce are provided for free, along with a newsletter that include nutrition information and healthy recipes featuring that week's produce.

Program Type	☐ Direct Clinical Services ☐ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☒ Total Population or Community Wide Intervention
Program Goal(s)	To help residents of the Winchester Housing Authority access healthy foods and increase their daily intake of fruits and vegetables, by reducing barriers to accessing produce and providing information about the benefits of a healthy diet.
Goal Status	Goal Status: The 20-week farmers market at Winchester Housing produced the following outcomes: • More than 2560 pounds of fresh produce, including more than six varieties of fruits and vegetables, were delivered to the two Winchester Housing locations. • A weekly newsletter featuring nutritional information and recipes for the fruits and vegetables was created and distributed with the produce. • More than 25% of the residents participated in the program. • 60% of participants were 76 or older. • 73% of the participants were women. • Per a post-program survey, program participants reported: 80% ate a greater variety of fruits and/or vegetables, 92% increased their daily intake of fruits and vegetables, and 73% learned more about locally grown fruits and vegetables.
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Patient Financial Counseling** **Health Issue: Additional Health Needs Identified by the Community (Access to Health Care)**	
Brief Description or Objective	Winchester Hospital is committed to providing high-quality, affordable health care and strives to promote health, expand access, and deliver the best care in the communities it serves. Winchester Hospital is dedicated to providing care for everyone, regardless of their ability to pay, and provides representatives from Winchester Hospital's Patient Financial Services Department to assist people with limited financial resources by providing free counseling to help them find options to cover the cost of their care. The financial counselors meet with patients to explore options and help them apply for health coverage, public assistance, and/or the hospital's financial assistance program.
Program Type	☐ Direct Clinical Services ☒ Access/Coverage Supports ☐ Community Clinical Linkages ☐ Infrastructure to Support Community Benefits ☐ Total Population or Community Wide Intervention
Program Goal(s)	To help individuals with limited financial resources find options to cover the cost of their care and to help them apply for health coverage, public assistance, and/or the hospital's financial assistance program.
Goal Status	In FY22, Patient Financial Services staff at Winchester Hospital and LHMC combined dedicated 9,360 hours of in-house staff time to patient financial counseling and 8,320 hours of contract counselor time. At Winchester Hospital, 1,841 in-patient referrals to patient financial counseling services were completed.

	• Of WH patients that received MassHealth 5% had an employed status (part-time & full-time) and 35% of the patients that received MassHealth assistance were disabled. • The ages of WH patients served were: 0 to 19 46% Ages 20 to 39 24% Ages 40 to 59 19% Ages 60 to 69 6% Ages 70 to 109 3%
Time Frame Year: Year 3	**Time Frame Duration: Year 3** / **Goal Type: Process Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Serving Health Insurance Needs of Everyone (SHINE)** **Health Issue: Additional Health Needs Identified by the Community (Access to Health Care)**	
Brief Description or Objective	The Winchester Hospital SHINE collaboration helps address health care costs for Medicare beneficiaries, by connecting people with health insurance that meets their health care needs, lifestyle, and budget. On-site SHINE counselors help Medicare beneficiaries understand what insurance coverage they need based on medical history, current health, prescribed medications, and the costs they incur by not having supplemental insurance. SHINE counselors also screen Medicare beneficiaries for eligibility for MassHealth, the Medicare Savings Program, Prescription Advantage, Health Safety Net, and free care/discounted prescriptions, and they help connect people with fuel assistance, home care, and food. In addition to face-to-face counseling, SHINE counselors conduct presentations to educate people new to Medicare and those enrolled in Medicare.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By the end of FY22, Minuteman Senior Services Regional SHINE program will perform 150 pre and post BILH specific consumer assessments to link consumers to community health resources. By the end of FY22 Minuteman Senior Services Regional SHINE program will provide Medicare benefits counseling to 650 individuals who reside in Arlington, Burlington and Winchester. By the end of FY22, Minuteman Senior Services Regional SHINE program will offer 6 community education presentation to people new to Medicare or who are retiring, to ensure consumers make educated health insurance decisions.

Goal Status	A revised pre/post assessment was launched in April 2022. 217 assessments were completed in FY22. Of those surveyed, 32 consumers wanted more information on Minuteman Services and 3 consumers were directed to their COA for more information on resources local to their community. In FY22 Minuteman Senior Services Regional SHINE program provided Medicare counseling to 652 consumers in Arlington, Burlington, and Winchester; 201 consumers were served in Winchester specifically. Minuteman Senior Services Regional SHINE program conducted 4 community education presentations in Arlington and 1 in-service for staff at Winchester Center for Cancer Care. Attendance at the community education classes included pre-retirees and individuals turning 65. The average attendance was 12 at each sessions. The Winchester Hospital funded SHINE Specialist returned to onsite counseling at Winchester Cancer Care Center in July 2022 and an orientation to SHINE was conducted for care professionals in order to direct patients and families to a resource that could potentially save on related health care costs and medications.

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

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Metro Housing Boston Co-Location Program** **Health Issue: Additional Health Need Identified by the Community (Housing)**	
Brief Description or Objective	Metro Housing's Co-Location program helps families prevent eviction and homelessness. The program provides free counseling services to individuals and families to help them increase housing stability and economic self-sufficiency and improve their overall quality of life. It also helps with housing searches, emergency assistance, rapid rehousing, benefits maximization, and community referrals. Winchester Hospital supports this program for residents of Winchester, Woburn, Stoneham and Medford.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To offer eviction-prevention services and housing-stabilization services to low- and moderate-income families in Winchester Hospital's CBSA towns of Winchester, Woburn, Stoneham and Medford.
Goal Status	In FY22, eviction-prevention and housing-stabilization counseling was provided to 257 families in four Winchester Hospital service area cities and towns: Medford, Stoneham, Winchester, and Woburn. Of the clients served: -23% were Black/African American, 63% white/Caucasian, 16% Hispanic of any race, 6% Asian, 1% mixed race, and 2% did not disclose their race. -88% received emergency financial assistance to remain to move to stabilized housing. -257 clients received brief counseling -227 clients submitted emergency rental assistance applications -73 clients received short/long term case management All participants also received referrals to community resources such as workforce development, educational opportunities, income maximization, unemployment assistance, and food stamps.

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

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Network for Social Justice – Winchester Housing Coalition** **Health Issue: Additional Health Need Identified by the Community (Housing)**	
Brief Description or Objective	The Winchester Housing Coalition focuses on raising awareness about the complex connection between affordable housing and racial/social equity with social determinants of health, particularly in older adults and individuals with cognitive challenges. The coalition has two main components: 1) Building support from targeted groups of key town stakeholders through a series of small events for leading members of Town Meeting, nonprofits, business leaders, community residents-at-large, and students, with the specific aim of generating support for amendments to current zoning laws across various sectors and 2) Holding a 'big tent' event with a high-profile panel of speakers to generate widespread community buy-in for an affordable housing campaign.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	By September 30, 2022, 50-75 Winchester stakeholders, including government elected or appointed officials, key community, nonprofit, and business leaders; community residents-at-large, and students, will have attended targeted events focused on raising awareness and supporting amendments to current zoning laws. By September 30, 2022, 150 diverse Winchester residents and business owners will have attended the public forum about the connection between affordable housing, racial/social equity, and social determinants of health. By September 30, 2022, an additional 200 Winchester residents and business owners will have viewed the public forum via WinCam or social media about the connection between affordable housing, racial/social equity, and social determinants of health.
Goal Status	The Winchester Housing Coalitions FY22 activities and events with numbers of clients reached included: Winchester Housing Coalition meetings: 15 members per session, 3 sessions; 6 key stakeholder meetings, a town-wide mailer to inform residents on a vote for an affordable housing projects reaching an estimated 400 residents; panel discussion attended by 75 people; and community events (PrideFest and Town Day) reaching 40 people. Combined, these events, plus online recordings of formal program elements reached approximately 636 people. Over the funding period, Network for Social Justice steadily succeeded in activating the Winchester Housing Coalition, which was in nascent stages of formation when this grant began. The work of the Coalition has begun to create a culture of collaboration around advancing affordable housing in Winchester. The best example, which could also be seen as a programmatic success, is the collaboration that formed around the Winchester Hospital-funded panel in September 2022. By forging a diverse group of established organizations to promote and raise awareness of the event (including Winchester Coalition for a Safer Community and the Church of the Epiphany), the Coalition moved the needle on the issue of housing's systemic connection to social emotional health and community wellbeing, a key goal of this grant.

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

Priority Health Need: Social Determinants of Health & Access to Care Program Name: Council of Social Concern Food Insecurity Relief Program Health Issue: Additional Health Need Identified by the Community (Access to Healthy Foods)	
Brief Description or Objective	The Council of Social Concern's Food Pantry is working to reduce food insecurity and hunger for individuals and families in need who live in the communities of Winchester and Woburn. The Food Pantry Program provides food to individuals and families without adequate resources to meet their basic needs caused by the hardships of reduced wages, job loss, and long-term illness. Low-income individuals, older adults and families in our service area find it financially difficult to afford healthy food choices on a low budget. The Food Pantry also runs a backpack program with the Woburn Public Schools, which provides food insecure students with healthy food and snacks to take home over the weekend.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	In FY22, 85% of the households served will report that the food assistance they received from the Food Pantry was enough food to last their households seven or more days per month. 95% of households served will report that they took food from most of the food types available at the Food Pantry each month. 95% of households served will report that the food assistance and information regarding other community resources that they received from the Food Pantry made it easier for them to meet their other basic monthly financial needs.
Goal Status	In FY22, 1,440 individuals were served by the Council of Social Concern Food Pantry Program. Approximately 116,000 pounds of food were distributed. The percentage of clients served by race was: 20% Black, 21% Latinx, 5% Asian, and 72% White. The percentage of clients served by age was: 32% under 18, 55% 18-64, and 12% 65 and over. 93% of households reported that the food assistance they received from the Food Pantry, along with the food they purchase on their own, was enough for each member of the household to eat at least two complete meals per day over a one-month period. 86% of households reported that the food assistance lasted 6 days or more, and 60% reported that it lasted 10 days or more. 85% of families took from most food types available, the 15% who did not stated that it was because those food types were not needed/wanted. 97% of households reported that they food assistance they received made it easier to meet their other basic needs. 100% reported that receiving food from the Food Pantry reduced their stress and anxiety levels.

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

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Community Based Behavioral Health and Collaborative Care Model** **Health Issue: Additional Health Need Identified by the Community (Access to Care)**		
Brief Description or Objective	In an effort to improve access to behavioral health services, Beth Israel Lahey Health has committed to the implementation of the Collaborative Care Model in employed primary care practices. This is a nationally recognized integrated model that specializes in providing behavioral health services in the primary care setting. The services are provided by an embedded licensed behavioral health clinician and they include short-term brief interventions, case review with a consulting psychiatrist, and care coordination. The behavioral health clinician works closely with the primary care provider in an integrative team approach. The primary care provider and the behavioral health clinician develop a treatment plan that is specific to the patient's personal goals.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To provide a collaborative approach among patients, clinicians, and family members to increase access to behavioral health services to address to mental health needs and substance use disorders in a primary care setting.	
Goal Status	In FY22, success included hiring and training behavioral health clinicians and expanding patient care capacity. Winchester Hospital implemented the Collaborate Care Model in 7 sites, serving 1918 patients.	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Behavioral Health Crisis Consultation** **Health Issue: Mental Health/Mental Illness/ Substance Use Disorder**		
Brief Description or Objective	To provide 24/7/365 behavioral health crisis evaluation in the emergency department (ED) and throughout other hospital units for individuals experiencing mental health and substance use related crisis. Services are payer agnostic and provided via in-person or telehealth by a multidisciplinary team of qualified professionals, including Psychiatrists, independently licensed and Master's level clinicians, Nurse Practitioners, Registered Nurses, Certified Peer Specialists, and Family Partners. The services include initial assessments for risks, clinical stabilization, treatment initiation, care coordination, and ongoing evaluation to ensure appropriate level of care placement.	
Program Type	☒ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to clinical and non-clinical support services for those with mental health and substance use issues, by providing behavioral health services in the hospital.	
Goal Status	A multidisciplinary team, comprised of qualified behavioral health providers, psychiatry, family partners, and peer specialists, is employed to provide behavioral	

	health crisis consultations in the Emergency Department or medical floors of the hospital. The team served 1,647 patients in FY22.

Time Frame Year: Year 3	Time Frame Duration: Year 3	Goal Type: Outcomes Goal

Priority Health Need: Social Determinants of Health & Access to Care Program Name: Patient Transportation Voucher Program Health Issue: Additional Health Need Identified by the Community (Transportation)	
Brief Description or Objective	Winchester Hospital collaborated with Checker Cab of Woburn to provide free rides to and from medical appointments. The Winchester Hospital Center for Cancer Care partnered with the American Cancer Society to provide funds to support free rides for patients seeking cancer care who do not have transportation access. Community members who have transportation difficulty due to financial problems, illness, or mobility issues are eligible for these services.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Increase access to health services by providing rides to individuals with no means of transportation due to medical or financial issues.
Goal Status	In FY22, Winchester Hospital provided 260 patients, who had no access to public transportation, with free rides via Checker Cab to and from Winchester Hospital locations for appointments. In FY22 the Winchester Center for Cancer Care provided vouchers for 277 one-way rides, serving 19 patients.

Time Frame Year: Year 3	Time Frame Duration: Year 3	Goal Type: Outcomes Goal

Priority Health Need: Social Determinants of Health & Access to Care Program Name: Mission of Deeds Kitchen Essentials and Food Access Program Health Issue: Additional Health Need Identified by the Community (Access to Healthy Foods)	
Brief Description or Objective	Mission of Deeds (MOD) is a nonprofit volunteer organization that gives purchased beds, donated furniture and basic household items, free of charge, to people who have been rehoused due to housing loss or housing instability. MOD clients are low-income families and individuals including survivors of domestic abuse, refugees, senior citizens, veterans, single parents, victims of fire and other disasters, and those with physical or mental disabilities. MOD Deeds Kitchen Essentials and Food Access Support Program provides clients with the kitchen items they need to cook at home and financial support to purchase groceries at a local supermarket.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits

Program Goal(s)	MOD Kitchen Essentials and Food Access Support Program provides clients with the kitchen items they need to cook at home and financial support to purchase groceries at a local supermarket.
Goal Status	68 families, totaling 140 people, were served by the MOD Deeds Kitchen Essentials and Food Access Support Program. The percentage of clients served by race for FY22 was: 19% Black, 13% Latinx, and 55% White. 46 of the clients were under 18 years of age. 68 $100 grocery store gift cards were distributed to support the purchase of healthy foods.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Tewksbury Farmer's Market SNAP Match** **Health Issue: Additional Health Need Identified by the Community (Access to Healthy Foods)**	
Brief Description or Objective	Winchester Hospital provided funding to the Tewksbury Farmer's Market support the market's ability to accept Supplemental Nutritional Assistance Program (SNAP) benefits from market customers. This program aims to increase the number of eligible SNAP recipients living in Tewksbury who shop for fresh fruits, vegetables, dairy, and seafood at the Tewksbury Farmer's Market. The focus of the program is to address food insecurity among low resource families and older adults.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention ☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	Establish the Tewksbury Farmer's Market as SNAP-eligible in partnership with the USDA.
Goal Status	In FY22 the market managers worked diligently to have the Tewksbury Farmer's Market become SNAP eligible through application to the USDA. There was a significant delay in receiving feedback from the USDA and making timely responses. This process is ongoing. The market was unable to implement the program prior to the last market of the season, September 29, 2022. The new goal is to have this up and running by the 2023 season.

Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Medford Farmers Market SNAP Matching and Senior Produce Program** **Health Issue: Additional Health Need Identified by the Community (Access to Healthy Foods)**	
Brief Description or Objective	The Medford Farmers Market SNAP Matching and Senior Produce Program increases access to healthy, local produce and food regardless of socio-economic status or transportation / access ability. The Medford Farmers Market SNAP/ EBT Matching Program provides additional market purchasing funds to recipients in need. The market also provides the Senior Healthy Produce Program to provide weekly bags of fresh produce at a significantly reduced cost for older adults who live in Medford.

Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☒ Total Population or Community Wide Intervention	☐ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	The FY22 goal was to provide $6,500 in SNAP match dollars, amounting to $30 match per customer weekly for 17 farmer's markets held during the grant period. The second FY22 goal was to continue the Medford Farmers Market Senior Healthy Produce Program in July and August for older adults, which subsidizes cost and delivers a bag of groceries worth $10-15 for only a $5 fee to the homes of older adult program participants.	
Goal Status	The Medford Farmer's Market served over 430 visitors weekly this season, with approximately 6% of those participating in the SNAP/EBT Matching and Senior Healthy Produce Programs. $8,509 dollars were matched, exceeding the original goal. 383 EBT/SNAP card holders, who likely represent 2-4 times that many representatives in their households, plus 20 older adults, were served through September 30. Additionally, the Senior Healthy Produce Program was successfully completed as initially developed for its full 8 weeks in July and August. The program served 20 older adults each week, for 8 weeks, exceeding the goal of 15 older adults reached. At 20 bags of produce weekly with an estimate of 7-10 pounds for 8 weeks, a total range of 1120 to 1600 pounds of food was delivered via this program.	
Time Frame Year: Year 1	**Time Frame Duration: Year 1**	**Goal Type: Outcomes Goal**

Priority Health Need: Social Determinants of Health & Access to Care **Program Name: Interpreter Services** **Health Issue: Additional Health Need Identified by the Community (Access to Care)**		
Brief Description or Objective	Language barriers pose significant challenges to providing effective and high-quality health and social services. To address this need, and in recognition that language and cultural obstacles are major barriers to accessing health and social services and navigating the health system, WH offers an extensive Interpreter Services program that provides interpretation and assistance in over 60 languages, including American Sign Language, and hearing augmentation devices for those who live with hearing loss. The Interpreter Services Department facilitates access to care, helping patients understand their course of treatment, and adherence to discharge instructions and other medical regimens.	
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention	☒ Access/Coverage Supports ☐ Infrastructure to Support Community Benefits
Program Goal(s)	To overcome language barriers and increase access to care by providing free interpreter services via phone, video, or in-person sessions for community members who are emerging bilinguals.	
Goal Status	In FY22, Winchester Hospital provided 6,350 interpreter encounters. The top three language requests were: Spanish (1,171), Portuguese (870), and Chinese Mandarin (472).	
Time Frame Year: Year 3	**Time Frame Duration: Year 3**	**Goal Type: Process Goal**

Priority Health Need: Infrastructure **Program Name: Infrastructure to support Community Benefits collaborations across BILH hospitals** **Health Issue: Health Professional/Staff Training**	
Brief Description or Objective	All Community Benefits staff at each Beth Israel Lahey Health (BILH) hospital worked together to plan, implement, and evaluate Community Benefits programs. Staff worked together to plan and implement the FY22 Community Health Needs Assessment and each created an Implementation Strategy that is uniform across all of the hospitals. Community Benefits staff continued to understand state and federal regulations, build evaluation capacity, and collaborate on implementing similar programs. BILH continues to refine the Community Benefits (CB) database, as part of a multi-year strategic effort to streamline and improve the accuracy of regulatory reporting, simplify the collection of and access to standardized CB financial data, and create a uniform, system-wide tracking and monitoring model.
Program Type	☐ Direct Clinical Services ☐ Community Clinical Linkages ☐ Total Population or Community Wide Intervention ☒ Access/Coverage Supports ☒ Infrastructure to Support Community Benefits
Program Goal(s)	Goal: By September 30, 2022, plan and implement the Community Health Needs Assessment and create the Implementation Strategy to address the priorities that is approved by the hospital Board of Trustees. Goal Status: All 10 BILH Community Benefits hospitals received Board of Trustee approval on their Community Health Needs Assessment and Implementation Plan. Goal: By September 30, 2022, in partnership with MGB, create and implement a database that collects all necessary and relevant IRS, AGO, PILOT, Department of Public Health (DoN), and BILH Community Benefits data to more accurately capture and quantify CB/CR activities and expenditures.
Goal Status	Goal Status: All FY22 regulatory reporting data were entered into the Community Benefits Database
Program Year: Year 3	**Of X Years: Year 3** | **Goal Type: Outcomes Goal**

SECTION V: EXPENDITURES

Item/Description	Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
CB Expenditures by Program Type		
Direct Clinical Services	$1,025,352.00	
Community-Clinical Linkages	$83,275.00	
Total Population or Community Wide Interventions	$743,726.00	$129,520.00
Access/Coverage Supports	$818,984.50	$385,888.50
Infrastructure to Support CB Collaborations	$17,446.00	
Total Expenditures by Program Type	$2,688,783.50	$515,408.50
CB Expenditures by Health Need		
Chronic Disease	$771,254.80	
Mental Health/Mental Illness	$462,881.30	
Substance Use Disorders	$417,446.20	
Housing Stability/Homelessness	$23,293.10	
Additional Health Needs Identified by the Community	$1,013,908.10	
Total by Health Need	$2,688,783.50	
Leveraged Resources	$2,615,476.00	
Total CB Programming	$5,670,230.95	
Net Charity Care Expenditures		
HSN Assessment	$2,652,176.93	
Free/Discounted Care		
HSN Denied Claims	$329,270.53	
Total Net Charity Care	$2,981,447.46	
Total CB Expenditures	$8,285,706.96	

Additional Information	
Net Patient Services Revenue	$314,861,000.00

CB Expenditure as % of Net Patient Services Revenue	2.63%
Approved CB Budget for FY22 (*Excluding expenditures that cannot be projected at the time of the report)	$8,285,706.96
Bad Debt	$2,954,349.15
Bad Debt Certification	Yes
Optional Supplement	
Comments	In addition to the above amounts, Beth Israel Lahey Health contributed $1 million to The Latino Equity Fund and the New Commonwealth Racial Equity and Social Justice Fund in support of addressing health disparities related to hypertension, diabetes and obesity and further integration and alignment, particularly regarding stakeholder engagement and convening with the Health Equity Compact. Winchester Hospital also makes a PILOT payment to the Town of Winchester.

SECTION VI: CONTACT INFORMATION

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

SECTION VII: HOSPITAL SELF-ASSESSMENT FORM

Hospital Self-Assessment Form – Year 1

Note: This form is to be completed in the Fiscal Year in which the hospital completed its triennial Community Health Needs Assessment

I. Community Benefits Process:

1. Community Benefits in the Context of the Organization's Overall Mission:
   - Are Community Benefits planning and investments part of your hospital's strategic plan? ☒Yes ☐No
   - If yes, please provide a description of how Community Benefits planning fits into your hospital's strategic plan. If no, please explain why not.

     Winchester Hospital is a member of Beth Israel Lahey Health (BILH). While Winchester Hospital oversees local Community Benefits programming and community engagement efforts, Community Benefits is under the purview of the BILH Chief Diversity, Equity and Inclusion Officer. This structure ensures that Community Benefits efforts, prioritization, planning and strategy align and/or are integrated with local hospital and system strategic and regulatory priorities and efforts to ensure health equity in fulfilling BILH's mission – **We create healthier communities – one person at a time – through seamless care and ground-breaking science, driven by excellence, innovation and equity.**

2. Community Benefits Advisory Committee (CBAC)
   - Members (and titles):
     CBAC Members: Carla Beaudoin, Director of Development, Metro Housing Boston; Jessie Bencosme, Executive Director, Council of Social Concern, Woburn; Angeline Brady, Community Health Programs Supervisor, Winchester Hospital Center for Healthy Living; Dot Butler, Winchester SAFER Coalition; Dr. Marie Condon Walsh, Medford Family Practice, Denise Flynn; Vice President of Philanthropy, Winchester Hospital; Christine Healey, Director of Community Benefits/Community Relations, Beth Israel Lahey Health; Karen Keaney, Chief Nursing Officer; Deb McDonough, Winchester Hospital Board of Trustees; Terri Marciello, Director of Elderly Services, Wilmington; Jennifer Murphy, Director of Health, Winchester Health Department; Lauren Reid, Director of Community Programs, Mystic Valley Elder Services; Sharon Ron, Public Health Planner, Metropolitan Area Planning Commission; Adam Rogers, Executive Director, Boys & Girls Club of Stoneham & Wakefield; Maureen Ryan, Assistant Superintendent, Woburn Public Schools; Joseph Tarby, Winchester Hospital Board of Trustees; LeighAnne Taylor, Regional Manager, Community Benefits and Community Relations Winchester Hospital; Dr. Richard Weiner, President, Winchester Hospital; Matthew Woods, Chief Financial Officer, Winchester Hospital; Jane Walsh, Winchester Hospital Board of Trustees.

- Leadership:
  Richard Weiner, MD, President; Matthew Woods, Chief Financial Officer; Dana Zitkovsky, MD, Chief Medical Officer; Karen Keaney, Chief Nursing Officer; Tushar Somani, Chief Operating Officer; Catharine Robertson, Vice President for Physician Services; Joanne Crowley Smith, Vice President of Human Resources; Denise Flynn, Vice President of Philanthropy

- Frequency of meetings:
  The Winchester Hospital's CBAC met quarterly during FY 2022 and also attended the hospital's annual Community Benefits public meeting.

3. Involvement of Hospital's Leadership in Community Benefits:
   Place a checkmark next to each leadership group if it is involved in the specified aspect of your Community Benefits Process.

	Review Community Health Needs Assessment	Review Implementation Strategy	Review Community Benefits Report
Senior leadership	☒	☒	☒
Hospital board	☒	☒	☐
Staff-level managers	☒	☒	☒
Community Representatives on CBAC	☒	☒	☒

For any check above, please list the titles of those involved and describe their specific role:

At BILH, our belief that everyone deserves high-quality, affordable health care is at the heart of who we are and what drives our work with our community partners. The organizations that are now part of BILH have always been deeply committed to serving their communities. Working collaboratively with our community partners, our Community Benefits Committee (CBC) and the Community Benefits team, such commitment is shared by staff at all levels within Winchester Hospital:

Hospital Board:
- Winchester Hospital Board of Trustees – reviewed and approved its CHNA and adopted its Implementation Strategy
- Winchester Hospital Community Benefits Advisory Committee - oversaw CHNA and Implementation Strategy process

Senior Leadership:

- Dr. Richard Weiner, President, Winchester Hospital - provided input on CHNA and Implementation Strategy; participated in meetings with CBAC and participated in prioritization process
- Karen Keaney, Chief Nursing Officer, Winchester Hospital – provided input on CHNA and Implementation Strategy and participated in the prioritization process; participated in meetings with CBAC
- Matt Woods, VP of Finance, Winchester Hospital - participated in prioritization process and meetings with CBAC
- Denise Flynn, VP of Philanthropy, Winchester Hospital - participated in prioritization process and CBAC meetings

Staff-level Managers:

- Nancy Kasen, BILH VP of Community Benefits and Community Relations, and Community Benefits team - designed, managed and conducted CHNA, managed prioritization process, drafted Implementation Strategy
- Angeline Brady, Community Health Programs Supervisor, Winchester Hospital Center for Healthy Living Director of Interpreter Services - participated in prioritization process

BILH Community Benefits Committee (CBC):

- BILH CBC - guided the process for the system

4. Hospital Approach to Assessing and Addressing Social Determinants of Health
   - How does the hospital approach assessing community needs relating to social determinants of health? (150-word limit)

     Winchester Hospital undertook a robust, collaborative and transparent assessment and planning process. The approach involved extensive quantitative and qualitative data collection and substantial efforts to engage community residents, with special emphasis on population segments often left out of assessments. The assessment was supported by Winchester Hospital's Community Benefits Advisory Committee. The Community Benefits Advisory Committee is comprised of community members, service providers, and other stakeholders that either live in and/or work Winchester Hospital's CBSA. Winchester Hospital's Implementation Strategy (IS) reflects the hospital and the CBAC's prioritization of the following social determinants of health: food security, housing stability, and economic security.

   - How does the hospital incorporate health equity in its approach to Community Benefits? (150-word limit)

Winchester Hospital and BILH are committed to health equity, the attainment of the highest level of health for all people, required focused and ongoing societal efforts to address avoidable inequalities, socioeconomic barriers to care, and both historical and contemporary injustices. Throughout Winchester Hospital's assessment process, Winchester Hospital worked to understand the needs of populations that are often disadvantaged, face disparities in health-related outcomes, and are deemed most vulnerable. Winchester Hospital's IS is rooted in health equity and was developed with a focus on reaching the geographic, demographic and socioeconomic segments of populations most at risk, as well as those with physical and behavioral health needs in the hospital's CBSA.

- How does the hospital approach allocating resources to Total Population or Community-Wide Interventions? (150-word limit)

The Winchester Hospital's IS includes a diverse range of programs and resources to addresses the prioritized needs within the Winchester Hospital Community Benefits Service Area. The majority of Winchester Hospital's community benefits initiatives are focused on cohorts and sub-populations due to identified disparities or needs. Winchester Hospital's strategies include increasing access to care through support of SHINE insurance counselors located at the Winchester Center for Cancer Care, participating in the Mystic Valley Public Health Coalition, and supporting an on-site farmer's market at Winchester Housing Authority. Additionally, Winchester Hospital collaborates with many community partners to own, catalyze and/or support total population and community-wide interventions including Boys and Girls Club of Stoneham & Wakefield, Council of Social Concern, Mystic Valley Elder Services, Metro Housing Boston, Network for Social Justice, North Reading Community IMPACT Team, and Mission of Deeds.

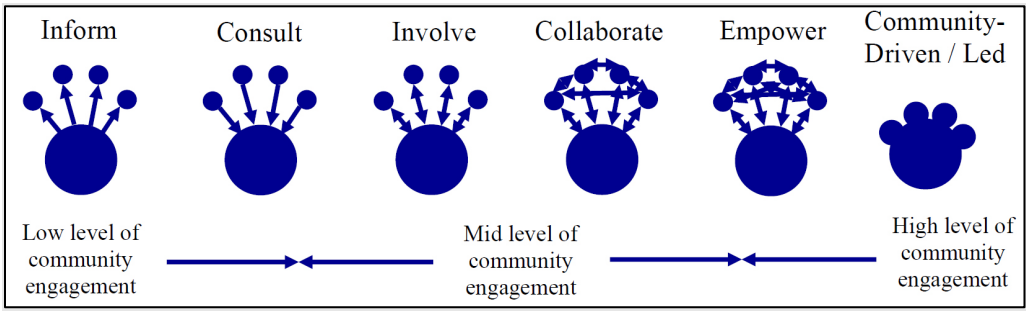
II. Community Engagement

1. Organizations Engaged in CHNA and/or Implementation Strategy
   Use the table below to list the key partners with whom the hospital collaborated in assessing community health needs and/or implementing its plan to address those needs and provide a brief description of collaborative activities with each partner. Note that the hospital is not obligated to list every group involved in its Community Benefits process, but rather should focus on groups that have been significantly involved. Please feel free to add rows as needed.

Organization	**Name and Title of Key Contact**	**Organization Focus Area**	**Brief Description of Engagement** (including any decision-making power given to organization)
Boys and Girls Club of Stoneham and Wakefield	Adam Rogers, Executive Director	Other	Adam is a member of the CBAC, and provided input throughout the CHNA process and development of the IS. The BGC works collaboratively with Winchester Hospital in implementing programs that meet the priority needs identified in WH's FY19 CHNA and in engaging youth in the FY22 CHNA process. In addition, the BGC provided programs and services to address the urgent needs in the

			community in response to COVID-19, focusing on youth mental health.
Council of Social Concern (COSC)	Jessie Bencosme, Executive Director	Social service organizations	As a member of the CBAC, Jessie provided input throughout the CHNA process, development of the IS, and provides ongoing input on community benefits programs and services. In addition, Winchester Hospital works collaboratively with the COSC to increase access to food for members of the community.
Metro Hosing Boston	Carla Beaudoin, Director of Development	Housing organizations	As a member of the CBAC, Carla provided input throughout the CHNA process, development of the IS, and provides ongoing input on community benefits programs and services. Carla also served on our 2023-2025 grant selection committee. In addition, Winchester Hospital works collaboratively with the Metro Housing Boston to increase housing stability and security for people in the Winchester Hospital CBSA
Mystic Valley Elder Services	Lauren Reid, Director of Community Programs	Social service organizations	BIDMC engages with MVES on the Mobile Mental Health Program, which meets mental health needs of older adults in the Winchester Hospital CBSA. Lauren serves on the Winchester Hospital CBAC and participated in the FY22 CHNA prioritization process.

2. Level of Engagement Across CHNA and Implementation Strategy
   Please use the spectrum below from the Massachusetts Department of Public Health[1] to assess the hospital's level of engagement with the community.



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

A. Community Health Needs Assessment
Please assess the hospital's level of engagement in developing its CHNA and the effectiveness of its community engagement process.

[1]

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in assessing community health needs	Empower	Goal was met.	Collaborate
Collecting data	Empower	Goal was met – Winchester Hospital built capacity for community residents to co-facilitate/facilitate focus groups and breakout sessions during listening sessions.	Collaborate
Defining the community to be served	Collaborate	Starting several months before launching the CHNA, Winchester Hospital worked with its CBAC to identify the community, those to be engaged and ways to engage them.	Collaborate
Establishing priorities	Empower	Working with BILH, Winchester Hospital actively engaged with the CBAC and the community to identify and select priorities.	Collaborate

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

  BILH and Winchester Hospital are committed to continuing to build our capacity to engage with the community and to foster community member capacity for facilitation and evaluation.

B. Implementation Strategy

Please assess the hospital's level of engagement in developing and implementing its plan to address the significant needs documented in its CHNA and the effectiveness of its community engagement process.

Category	Level of Engagement	Did Engagement Meet Hospital's Goals?	Goal(s) for Engagement in Upcoming Year(s)
Overall engagement in developing and implementing filer's plan to address significant needs documented in CHNA	Collaborate	Goal met – community listening sessions with breakout sessions facilitated by community members, with active CBAC engagement in prioritization discussions and decisions.	Collaborate
Determining allocation of hospital Community Benefits resources/selecting Community Benefits programs	Collaborate	Goal met – FY 2022 was the last year of Winchester Hospital's FY 2020 – 2022 Implementation Strategy (IS) and its CBAC was informed regarding how CB resources were allocated. Winchester Hospital will	Collaborate

		collaborate with its CBAC to select programs to invest its resources in for the FY 2023 – 2025 IS.	
Implementing Community Benefits programs	Collaborate	Goal met – FY 2022 was the last year of Winchester Hospital's FY 2020-2022 Implementation Strategy (IS). Winchester Hospital will be collaborating with the community on new and existing programs for its FY 2023-2025 IS.	Collaborate
Evaluating progress in executing Implementation Strategy	Involve	Goal met - BILH and Winchester Hospital held multiple evaluation workshops to build evaluation and data capacity of community organizations, CBAC members and community residents.	Collaborate
Updating Implementation Strategy annually	Inform	Goal met – FY 2022 was the last year of the current FY2020-2022 IS. BILH and Winchester Hospital are working to develop, track and share data on a routine basis with the CBAC.	Collaborate

- For categories where community engagement did not meet the hospital's goal(s), please provide specific examples of planned improvement for next year:
  Click or tap here to enter text.

3. Opportunity for Public Feedback
   Did the hospital hold a meeting open to the public (either independently or in conjunction with its CBAC or a community partner) at least once in the last year to solicit community feedback on its Community Benefits programs? If so, please provide the date and location of the event. If not, please explain why not.

   The Winchester Hospital Annual Community Benefits Public Meeting was held June 30, 2022 via Zoom.

   Winchester Hospital has a comprehensive Implementation Strategy (IS) to respond to identified community health priorities. Winchester Hospital engaged with the leadership team and the community to identify and select priorities for the new (FY2023-2025) IS. The IS was shared with the CBAC, the leadership team, adopted by the Board of Trustees and widely distributed.

4. Best Practices/Lessons Learned
   The AGO seeks to continually improve the quality of community engagement.

   - What community engagement practices are you most proud of? (150-word limit)

Winchester Hospital is most proud of its committed CBAC and the long-standing relationships it has with many community-based organizations, the public health department, and other government partners. Winchester Hospital is proud of their collaboration with these and other organizations that Winchester Hospital to engage with hard-to-reach cohorts. Winchester Hospital is particularly proud of how it was able to reach community members who had not previously been engaged.

- What lessons have you learned from your community engagement experience? (150-word limit) Working collaboratively with other hospitals, community-based organizations, public health agencies, and area coalitions enhances the level and quality of Winchester Hospital's community engagement efforts.

III. Regional Collaboration

1. Is the hospital part of a larger community health improvement planning process?

   ☒Yes ☐No

- If so, briefly describe it. If not, why?

  For its FY 2022 CHNA, Beth Israel Lahey Health (BILH) took the unique approach of designing and implementing a system-wide, highly coordinated CHNA and prioritization process across each of the system's 10 licensed hospitals, including Winchester Hospital, encompassing 49 municipalities and six Boston neighborhoods. While Winchester Hospital focuses its Community Benefits resources on improving the health status of those in its CBSA experiencing the significant health disparities and barriers to care, this system-wide approach enhances opportunities for collaboration and alignment with respect to addressing unmet need and maximizing impact on community health priorities. Together, BILH hospitals are identifying efficient ways to share information, address health needs, and identify common indicators to measure programmatic impact.

2. If the hospital collaborates with any other filer(s) in conducting its CHNA, Implementation Strategy, or other component of its Community Benefits process (e.g., as part of a regional collaboration), please provide information about the collaboration below.

- Collaboration:
  Winchester Hospital worked collaboratively with each of the 9 other hospitals in the BILH system to design and implement a system-wide, highly coordinated CHNA and prioritization process across each of the system's 10 licensed hospitals.

- Institutions involved:
  - Anna Jaques Hospital
  - Beth Israel Deaconess Hospital - Milton
  - Beth Israel Deaconess Hospital - Needham
  - Beth Israel Deaconess Hospital - Plymouth
  - Beth Israel Deaconess Medical Center
  - Beverly and Addison Gilbert Hospitals
  - Lahey Hospital and Medical Center
  - Mount Auburn Hospital
  - New England Baptist Hospital
  - Winchester Hospital
- Brief description of goals of the collaboration:
  Winchester Hospital collaborated with the other 9 hospitals in the BILH system to add rigor to the hospitals' assessments and planning processes, promoting alignment across hospital efforts and strengthening relationships between and among BILH hospitals, community partners and the community-at-large.

- Key communities engaged through collaboration:
  Winchester Hospital collaborated with the other 9 hospitals in the BILH system to engage the 49 municipalities and six Boston neighborhoods who were part of the individual Community Benefits Service Areas from each of the licensed hospitals.

- If you did not participate in a collaboration, please explain why not:
  Click or tap here to enter text.