FULL-TEXT ANNUAL REPORT

WINCHESTER HOSPITAL
WINCHESTER, MASSACHUSETTS
WWW.WINHOSP.ORG

Region Served: Northwest
Report for Fiscal Year 2004

I. Winchester Hospital Mission Statement

To ensure that the highest quality health care continues to be delivered through the coordination of available resources for the purpose of improving the health of the communities we serve

A. Summary

The focus of Winchester Hospital's community benefit efforts is on secondary prevention (early detection and treatment of preventable and treatable health problems) while offering an array of social encounters tailored to provide continued group/community interaction, in an effort to promote social well-being.

The Hospital's specific preventable health focus for this year is osteoporosis, the Department of Public Health declared this a public health problem in the Commonwealth. The mission of the Winchester Hospital Community Benefit Program is to:

- Raise awareness of osteoporosis as a preventable disease
- Identify community members at risk for osteoporosis
- Provide screenings for osteoporosis
- Teach community members how to identify risk factors and how to prevent osteoporosis

B. Approval of Governing Body

The current mission statement was approved and adopted by the Winchester Hospital Board of Directors on February 28, 1995.

II. Internal Oversight and Management of Community Benefits Program

A. Management Structure

Winchester Hospital's senior management is involved in the planning and execution of the Community Benefit Program.

For the Osteoporosis Community Benefit Program, a Registered Nurse Community Benefit Specialist and an Administrative Assistant report to the Associate Director of the Community Health Institute of Winchester Hospital, where the Program is housed. The Associate Director reports to the Director of the Community Health Institute who then reports to the Vice President for Human Resources/Legal, who reports to the President and CEO of the hospital, who reports to the Winchester Hospital Board of Directors.

A seven member Osteoporosis Community Benefit Program Advisory Board was developed and convened for the first time on October 21, 2002. This group is comprised of intergenerational women who come from the communities that Winchester Hospital serves. The Board met two times this year and provides input on the various aspects of the Program.

Another Program, the Senior Outreach Plan "Aging On Your Own Terms", is housed under the Department of Marketing and Business Development. A Senior Outreach Coordinator is responsible for the event implementation and reports to the Manager of Marketing and Business Development. This manager reports to the Director of Strategy, Communications and External Affairs, who reports to the Vice President of Planning and Business Development, who reports to the President and CEO, who then reports to the Winchester Hospital Board of Directors. The Senior Outreach Program is revised and reviewed bi-annually as well as monitored quarterly by the Hospital's Senior Management team and CEO.

B. Method of Sharing Information with Staff

The Community Benefits Mission/programs are shared with staff at all levels through hospital orientation, hospital staff newsletters, electronic mail (MOX), intranet site, and at staff and board meetings. All employees are encouraged to participate in program opportunities for the community whether in a volunteer capacity or as an actual participant.

III. Community Health Needs Assessment

A. Process

Community needs were identified through use of a variety of formal assessment avenues. Yankee Alliance, Miser, the Department of Public Health and its Division of Health Care Policy and Finance, as well as hospital data related to admission rates and diagnoses were utilized. Social needs of the various communities were identified through local Senior Center Directors, community residents, surveys and meetings.

The process began with the creation of a Health Mapping Report of the area we serve using the above assessment tools. The created report provided demographic information that included the age groups and economic backgrounds of our communities. Chronic disease prevalence was also identified. Once the report was completed, all of the Boards of Health in the Winchester service area were provided with the Health Mapping Report and a forum was held to share the information, answer any questions and receive any comments. Next, community forums were held comprised of invited seniors, community organizations, and community leaders. They were also open to the public for interested parties. Participation in these forums averaged around 50 – 60 participants.

B. Information Sources

Yankee Alliance, Winchester Hospital Planning and Development, the Department of Public Health, senior centers, community forums, community employees, community leaders, our large senior population, and the resulting Health Mapping Report for the Winchester Hospital service area

C. Summary of Findings

Meeting the needs of the senior population that Winchester Hospital serves was the priority finding of the assessment process. Specific areas identified were:

- Educational information regarding legislation, HMO's, and new medical technology
- Social encounters
- Flu immunizations
- Education and assistance around chronic disease management
- Education and screenings to decrease the high incidence of osteoporosis and fractures
- Home services for the elderly
- Availability of alternative therapies which are not covered by insurance as well as for those without insurance

Although the senior population was the priority area identified, Winchester Hospital is totally committed to meeting the needs of its younger population through existing and new programs.

IV. Community Participation

A. Process and Mechanism

Brainstorming sessions were held with community residents, senior populations in the various communities, the Council on Aging in each community, Executive Office of Elder Affairs advisors, school nurses, local Boards of Health, service organizations, and senior residential housing representatives. At the sessions, information was provided then the participants divided into small groups and discussed their perceived needs for the community and improvements needed in quality of life issues. The Health Mapping Report was also presented with the statistical needs of the communities.

Currently, monthly senior health initiatives are held at which time individuals are asked to fill out surveys and can also verbally bring forth needs. A senior hotline is available that allows seniors to call with questions, concerns and needs. There are also disease specific groups (i.e. breast cancer, diabetes, and prostate cancer) which meet regularly and can also identify their immediate needs.

The Department of Marketing and Business Development held a Community Leaders Forum on March 24, 2004 with the focus on Children's Health. The goal of the meeting was to take a step towards enhancing the coordination between all of the community organizations focused on children's health. More than 50 community leaders from the area attended including representatives from local board of education, school nurses, board of health departments, local businesses, YMCA, municipal and legislative offices.

B. Identification of Community Participants

Seniors, Senior Planning Committee with key senior advisors, school age youth, community residents, and church members

C. Community Role in Development, Implementation and Review of Community Benefits Plan and Annual Reports

The seniors have played a big part in the development of our plans by providing direction on what they need and want. Each program has its own planning mechanism and evaluation process.

V. Community Benefits Plan

A. Process of Development of the Plan

We have looked at several approaches to address the medically under-served and disadvantaged populations, as well as specific health problems. There have been many different ongoing community benefit programs. Each of our present programs has had a different focus, population and level of activity. This year we are again focusing on one major identified problem – osteoporosis.

B. Choice of Target Population

The senior population has been chosen as the target population based on demographics. The overall population in our patient care service area is not expected to grow significantly from 2000 - 2005 (1.95%). However, the senior population (65+) is projected to increase by 4%, the adult population 18 – 29 will decrease by 4%, the adult population 30 – 44 will decrease by 6%, but the adult population 45 – 64 will increase 14%. Based on these statistics, the main thrust of this year's activities will be the Osteoporosis Screening and Prevention Initiative as well as the Senior Outreach Initiative.

Osteoporosis has been declared a public emergency by the Massachusetts Department of Public Health as well as being a preventable health disease. It occurs most frequently in the population aged 50 and above but is found in younger people. Winchester Hospital statistics also highlight the presence of this disease in its older population with many fractures attributed to its cause. The Osteoporosis Prevention and Early Detection Program will focus on the early detection of this disease through public screenings. Those participants testing positive for either osteopenia or

osteoporosis will have a follow-up plan involving their physician. The goal is to screen 6,000 community participants and then do data analysis on the population screened in order to describe the participants. Since the chosen testing device can screen women starting at age 20, a younger population will also be served beside the senior population.

The Senior Outreach Program works with both the socially active and inactive senior. Five events are held monthly at various community locations with topics ranging from Luncheon Socials to Internet Training. Each event is coordinated in a manner that allows for attendees to participate at various levels. On a monthly basis, the Program connects socially with more than 400 seniors.

As one of the outreach initiatives to homebound seniors, the Winchester Hospital laboratory goes into homes to do blood draws.

A new Outpatient Heart Failure Program was launched this year. Heart failure is a chronic, progressive syndrome whereby the heart is unable to deliver sufficient blood and nutrients to meet the body's metabolic needs. Heart failure is the most rapidly growing cardiovascular disorder in the U.S., affecting 4.9 million people, and is responsible for 555,000 new cases annually (American Heart Association, 2002). It is, and will continue to be, a clinical and public health challenge as the baby boomer population ages (Redmond, 2002).

C. Short-term (1 year) and long-term 3 – 5 years) strategies and goals
Our main strategy is to continue meeting with community leaders, community advisory groups, and key legislative and organizational leaders to promote open and honest discussion about community needs and how Winchester Hospital can assist in meeting these needs.

Short-term (1 year) Goal
The Osteoporosis Early Detection and Prevention Program will continue its screenings and education.

The Pediatric Asthma Program will continue to see referred children.

The Senior Outreach Initiative will continue with its programming.

The Outpatient Heart Failure Program will continue to do telephonic callbacks of enrolled participants.

Long-term (3 – 5 years) Strategies
The continual meetings with our community advisory groups will identify health needs for the Community Benefit Programs in the upcoming years.

D. Process for Measuring Outcomes
The number of participants, as well as screening results, will be monitored in the Osteoporosis Early Detection and Prevention Program.

The Senior Outreach Program, Pediatric Asthma Program, and the Outpatient Heart Failure Program will also monitor the number of participants as well as detail vital information on the overall program.

E. Process and Consideration for Determining a Budget
The budget for the noted programs were created to fit the program needs. Appropriate staff, supplies and equipment was identified to run the programs. Each budget was submitted to senior management and approved.

F. Process for Reviewing, Evaluation and Updating the Plan

The Osteoporosis Early Detection and Prevention Program will be reviewed bi-annually with its Advisory Committee and changes made as needed. The Senior Outreach Program, Pediatric Asthma Program, and Outpatient Heart Failure Program will also be evaluated as appropriate and changes made as needed.

VI. Progress Report: Activity During Reporting Year

A. Expenditures

See Expenditures Chart in Attachment 2

B. Major Programs and Initiatives provided in 2004

Osteoporosis Early Detection and Prevention Program

A Community Benefit Specialist (a Masters prepared RN) and an administrative assistant were hired to develop and launch this program. Screenings are held in the communities that Winchester Hospital serves. Screening sites range from senior centers to faculty of community schools, from pharmacies to department stores, and from physician offices to local YMCA's. Participants are interested in their bone health and voluntarily come to the screening. The ultrasound machine used can test women from age 20 on with the actually screening protocol taking approximately eight minutes.

There are three major components to this program:

- A screening through the use of the Achilles Express ultrasound bone density machine
- Assessment of personal risk factors
- Provision of education based on the screening results and personal risk factors

If the participant has a reading that falls into the osteopenia or osteoporosis range, a letter which includes the results is sent to their primary care provider. The participant also comes away from the screening with information on osteoporosis and their personal calcium intake need as well as A symbolic gift of a lace ribbon with an explanation of its purpose.

An Osteoporosis Advisory Board, comprised of intergenerational women, met for the first time on October 21, 2002 with representation from the various communities in Winchester Hospital's service area. The Board will meet two times a year and provide guidance to the program as necessary.

This year Mystic Valley Elder Services awarded this program a grant for community education and free screenings on osteoporosis. One lecture and screening have been completed for this year of the grant. Another similar grant by Minuteman Senior Services was completed in September after three lectures and screenings were provided.

Senior Outreach Initiative "Aging On Your Own Terms"

The "Aging on Your Own Terms" Senior Outreach Program provides a multi-faceted series designed to provide a wide range of social programs and educational services to seniors throughout the communities Winchester Hospital serves. The goal of the program is to work collaboratively with area organization to offer a variety of programs and services that meet the needs of area seniors at no cost to the attendee.

Adult Vaccination Initiative

This was the seventh year of the Community Health Institute's Adult Immunization Initiative. The target populations were the middle-aged caregiver population, seniors, and people with medical problems or whom had family members with medical problems jeopardized by having the flu (i.e. lack of spleen).

Unfortunately, after initial planning was completed with sites interested in having this program, the Community Health Institute had to cancel this year's initiative based on insufficient vaccine, which was a national health crisis.

Home Blood Draws
The Winchester Hospital laboratory provides free phlebotomy services to the community for those residents unable to get to the laboratory. There is no additional charge to the patient for this service.

Winchester Town Day
In June, the Winchester Hospital, in collaboration with the Winchester Fire Fighters and the Board of Health, offered a Health Fair during the annual Town Day. The following screenings were provided free of charge – cholesterol, blood sugar, blood pressure, lung capacity, osteoporosis and podiatry screening. Over 600 individuals were screened. Massages and nutrition counseling were offered free.

There was health education information on skin cancer, breast cancer, smoking cessation, organ donation, Lifeline, violence prevention, nutrition/dietary counseling, lactation product and services, preventative dental care, senior outreach and seat belt safety. During the fair there was a demonstration on Healthy Heart Cooking. During the fair, we identified several with elevated blood sugars and cholesterol. These individuals were followed up to see that they had received the appropriate health care. Resources and physicians were made available as needed.

Elizabeth and George Sanborn Foundation Grant
Winchester Hospital has continued to service the residents of Arlington living with cancer through the Sanborn Grant. This year, residents received acupuncture, herbs, hypnotherapy and massage therapy with a small co-pay. In 2004, 8 residents received alternative therapies for the following symptoms: pain, stress, anxiety and nausea. We continue to receive positive comments from the participants.

Mt. Vernon House Grant
Mt. Vernon House, a residential home for seniors in Winchester, has given Winchester Hospital a grant to provide acupuncture; hypnotherapy, massage therapy and chiropractic care to the residents of Mt. Vernon House and residents of Winchester over 65. There is a small co-pay for the residents of Winchester.

There are seven residents receiving therapy at Mt. Vernon House (MVHR). The massage therapist and acupuncturist visit the home weekly to provide treatments to the residents. The chiropractor provides adjustments monthly. Reported results include improved flexibility; relief of sciatica, neck, hip, low back and arthritis pain; and improved balance.

Five hundred seventy six treatments were provided to 60 Winchester residents. The following issues were treated: arthritis, back problems, hip pain, post-surgical pain, torn meniscus, Parkinson's disease symptoms, insomnia, neck pain, osteoarthritis, sciatica, GI problems and torticollis.

Lactation Counseling
The Outpatient Lactation Center offers breastfeeding support to all breastfeeding mothers and babies in the community. This service is given by a registered nurse who is an internationally board certified consultant (IBCLC). Clients are referred to the lactation consultant by hospital staff, pediatricians, obstetricians, Boston hospitals, other breastfeeding clients, and through telephone triage. The lactation consultant meets with the breastfeeding couplet for a private consultation of about 1 ½ hours. During the consultation breastfeeding issues are resolved and questions are answered. Most issues are resolved with one visit; however, follow-up visits are scheduled on an as needed basis. There were 256 lactation consults during the 2004 calendar year.

The Nursing Mothers' Group is also part of the Outpatient Lactation Center services. It is a weekly walk-in breastfeeding support group where mothers and babies can come together for one hour. Here they receive the support of the lactation consultant and other breastfeeding mothers. Through this support group we have seen mothers and babies who are breastfeeding beyond two years. There are on average 10 mother-baby couplets per week.

Diabetes Counseling

Winchester Hospital's Diabetes Program is recognized by the American Diabetes Association. The Association's Education Recognition Certificate assures that education programs meet the National Standards for Diabetes Self-Management Education Programs. Patients with diabetes receive individual education and consultation from the Certified Diabetes Nurse Educator and a Registered Dietician. Patients with Type 1, Type 2, and Gestational Diabetes are seen at the center (most of the patients are 18 years of age and older). The patients learn self-management skills that include blood glucose monitoring, rapid continuous glucose monitoring, medication management, insulin administration, insulin pump therapy, personal exercise program and meal planning. With proper knowledge and support, people with diabetes can improve their glycemic control and reduce the risk of complications.

Mothers to be with gestational diabetes learn daily self-management skills that include blood glucose monitoring, meal planning and information that lead to a positive pregnancy outcome.

Four monthly support groups are offered with a yearly attendance of approximately 900 participants. Day-to-Day Diabetes Support Group was created to provide a place for people to meet others who are living with or may have a friend or family member who is living with diabetes. Parents Helping Parents is a support group for parents of children with diabetes who wish a warm non-judgmental atmosphere where parents can share similar concern, needs, knowledge and information with each other. Insulin Pumpers group is for those who wear an insulin pump or are interested in learning about insulin pump therapy. And the last group meets in the Medford Senior Center.

This year Minuteman Senior Services awarded this program a grant for community education and free blood sugar screenings. One lecture and screening have been completed for this year of the grant.

Chiropractic Arthritis Research Grant

Winchester Hospital received a grant from the Farrington Foundation to conduct a research study on the efficacy of chiropractic care for the patient with osteoarthritis of the back. Two hundred and forty participants have completed the study. The study is in its last phase of statistical analysis and will then be ready for publication.

Town of Winchester Worksite Wellness Program

Winchester Hospital has had a relationship with the Town of Winchester since 1995 when the Worksite Wellness program was initiated. Since then the program has consistently exceeded participation goals and expectations for identifying and reducing health risks. All town employees participated in some health program provided. There were more than 2,000 employee encounters.

The fitness programs continue to be the most popular. We offer yoga, strength training and personal fitness. There were four mini health fairs held in the different town buildings. The goal was to bring the program to the employee, improve quality of life and improve moral.

New England School of Acupuncture

The New England School of Acupuncture uses the Winchester Hospital Family Medical Center and Baldwin Park 1 for their clinical rotations. Students see patients' one day a week at the two different sites. The students are observed by their instructor. Patients pay a reduced rate of $25 per one-hour treatment. Currently, there are 36 patients participating in the program. The program is using four examination rooms and conference room areas at each site. Linen services,

maintenance of site and supplies, scheduling are all-free of charge as part of the use of the space. This has been a successful program to help those in chronic pain who would other wise be unable to pay for these services. The space, utilities, supplies, staff, management and advertising are provided by the hospital.

Support Groups and Activities

The following six groups were created for those participants with cancer.

(1.) A Touch of Strength

A support group for those newly diagnosed with breast cancer. This is a 7-week session and offered four times throughout the year. Sessions are comprised of group support and an educational component. Educational topics include nutrition, fitness, family night, complementary therapies, make-up for those going through treatments which have caused hair loss and changes in self-image. A Social Worker and a Registered Nurse facilitate this group from the Breast Care Center.

(2.) Survivor Support Group

A follow-up program for breast cancer survivors is offered five times a year. This program offers continued education regarding complimentary therapies as well as support to breast cancer survivors. This program has also offered three retreats for survivors. The group facilitator is a Social Worker and a Registered Nurse from the Breast Care Center.

(3.) Metastatic Support Group

A support group for patients who have advanced cancer or a reoccurrence. A Social Worker from the Oncology Clinic facilitates this group.

(4.) Men's Spousal Support Group

A support group designed to assist the spouses of women undergoing cancer treatment. The Social Worker for the units facilitates this group which helps guide spouses to a better understanding of their loved ones cancer experience and gives them an opportunity to address relevant issues within their relationship. This group meets on an as needed basis.

(5.) A Sharing Caring Experience

A support group that is a general cancer support group consisting of patient and their family member. Patients, with any type of cancer, and their family members are invited to participate in an 8-week support group offered 3 – 4 times a year. There is an educational component, as well as, group support for both patients and their loved ones.

On-going general cancer support groups consisting of the patient and family members meet bi-monthly to offer on-going support after patients have finished the 8-week support group.

(6.) Prostate Cancer Support Group

This is a monthly support group that is facilitated by a survivor.

New Support Group

A new support group was added this year at the request of a woman who needed support around the care of her severely disabled husband. This new group is entitled Support Group for the Caregivers of Spouses or Partners.

The "Read to Me" Program

The "Read to Me" Program started seven years ago by the Friends of Winchester Hospital. The Program is based on the research of Jim Trelease, Reading Specialist, and promotes the concept that listening comprehension comes before reading comprehension. Because of this, it is very important to start reading to children from birth on so that they hear the language in an organized way. Studies have shown that children who are read to early on become better readers and if better readers they become better students and typically feel better about themselves.

At Winchester Hospital, a volunteer went into every ChildBirth class and gave a 10 minute presentation to the new parents on the importance of reading to children from the time you bring them home from the hospital. There were 4 to 7 classes every month with 10 – 12 couples in attendance. This approximates 1,500 new parents.

As a follow-up to this effort, a copy of The Pooh Story Book was given to every new baby born at the hospital. It is estimated that 2,400 copies of this book were provided free.

Pediatric Asthma Program

Asthma is a chronic inflammatory disease of the airways and can be life-threatening if not properly managed. Asthma is the most common chronic illness of childhood affecting 5 million children nationally. Approximately 4.3% of all households include a child with asthma. The annual cost of treating children with asthma is estimate at $1.9 billion.

Winchester Hospital's cost in 1999 for members with the primary diagnosis of asthma was $555,315.00. These figures are from the claims data for Tufts HMO, HPHC, First Seniority, HMO Blue and Blue Care 65 for IPA members.

The Pediatric Asthma Program was developed in 2003 and its goals are:

- Raise awareness of patients, health care professionals, and the public that asthma is a serious life-threatening, chronic disease
- Ensure the recognition of the symptoms of asthma by patients, families, and the public, and the appropriate diagnosis by health professionals
- Ensure the effective control of asthma by encouraging a partnership among patients and family, physicians, and other health professionals through modern treatment and education programs.

The Program recognizes that the continuum of Winchester Hospital's quality care of the child with asthma needed to include a collaborative effort of a team of members in the child's community. The Team includes appropriate Winchester Hospital personnel, the child's pediatrician/Primary Care physician, school nurse/child care facility personnel, classroom teachers, and anyone else who may be in a position to advise the child about their asthma medications and their asthma symptoms (scouting leaders, athletic coaches, music coaches…). The Program is designed to involve that community of people in helping the child with asthma and his/her caregivers manage their asthma more effectively.

The Program consists of up to 3 home or office visits where an asthma nurse teaches the child and/or caregiver about asthma medications, evaluates medication device techniques, reviews warning signs and symptoms of asthma, performs a home environment evaluation for triggers, and develops an Asthma Action Plan. Each child receives an individualized Asthma Notebook, which contains educational information, as well as, two Peak Flow Meters and two InspirEase spacers (one each for home and school use). The child is encouraged to bring the Asthma Notebook (containing peak flow diaries, their Asthma Action Plan and the most current list of their asthma medications) to the doctor's office, ED, or school nurse if they have any questions about asthma.

Beyond the home/office visits, the nurse personally files the completed Asthma Action Plan with the school nurse/child care provider. The nurse also visits the classroom to teach the classroom teacher(s) about warning signs and symptoms of asthma and perform a classroom environmental evaluation for triggers. Other appropriate school personnel and community members are also visited and make aware of the child's needs.

Outpatient Heart Failure Program

Research has shown that elderly patients with heart failure who receive inpatient heart failure education along with follow-up home care visits and telephone contact by the heart failure team had a significant reduction in readmission rate, cost of care and improved quality of life (Rich et al, 1995). The goals of Winchester Hospital's Heart Failure Program are to reduce readmissions for heart failure patients, enhance quality of care and patient satisfaction while encouraging self-management.

Patients referred into the program will receive written educational materials, a digital scale if needed, a one-time home visit from a Winchester Home Care Heart Failure Team Nurse and periodic, scheduled telephone follow-up by the outpatient Heart Failure Nurse. If, at the home visit, the nurse feels the patient needs further home care, then the patient can be referred to the Heart Failure Program when they are discharged from home care. The physician may also refer patients into the program by calling the Outpatient Heart Failure nurse. Patients will be followed in this program indefinitely.

Magnet Hospital Mentoring

In November of 2003, Winchester Hospital became the first community hospital in the state of Massachusetts to be awarded Magnet status. This prestigious award was earned through the Magnet Recognition Program sponsored by the American Nurses Credentialing Center (ANCC), the nation's largest and foremost nursing accrediting and credentialing organization. Magnet hospitals must meet stringent quantitative and qualitative standards that define the highest quality of nursing practice and patient care. Currently, there are approximately one hundred hospitals worldwide that have this recognition.

Once a hospital achieves this status, mentoring other hospitals in their quest for magnet status is a must. Winchester Hospital has happily compiled and has mentored over 18 hospitals. Local hospitals include Dana Farber Cancer Center, Beth Israel Hospital, Beverly Hospital, Jordan Hospital, Emerson Hospital, Lahey Clinic, Milford Regional Hospital, Elliot Hospital, Boston Medical Center, Anna Jacques Hospital, Saints Memorial Medical Center, Norwood Hospital, and South Shore Hospital. Hospitals out of state include San Diego Naval Hospital; Baptiste Hospital, Louisville, KT; Martha Jefferson Hospital, Charlottesville, VA; Maine Medical Center, and Newport Hospital, Newport, RI.

Community education on magnet status was also done with presentations to the Rotaries of Winchester, Woburn, Burlington, Wilmington, and Stoneham.

Community Education Resource

Winchester Hospital is frequently asked by local cable access stations to provide experts on selected topics. Personnel presented three programs over the course of this year. Topics covered were diabetes awareness and prevention, diabetic complications, and hypnosis to combat the fear of flying.

C. HMO'S

Not applicable

D. Notable Challenges, Accomplishments and Outcomes

(1.) Osteoporosis Early Detection and Prevention Program

Statistics for the calendar year of 2004 are as follows:

Screening sites: 97
Participants: 1,461 (Since program inception, 4,806 women have been screened)

Results:

Osteopenia	30%
Osteoporosis	7%

(2.) Senior Outreach Initiative "Aging On Your Own Terms"

Program Highlights:

- In 2004 there were 60 events held, reaching 9,000 seniors from Winchester Hospital's primary and secondary service area.

- The most popular events this year have been:
  - Nutrition Seminars
  - Holiday Socials
  - Osteoporosis Screenings

- The average age of the Senior Program participant was 71.

- The leading towns for participation in 2004 were:

Woburn (20%)	Winchester (20%)	Medford (16%)
Burlington (12%)	Reading (12%)	Wilmington (10%)
Stoneham (4%)	Malden (2%)	Other (4%)

- As a result of the "Aging on Your Own Terms" Program, new relationships have been developed with members of Massachusetts Council on Aging offices, Senior Centers, state and local government agencies, elder service providers, police and fire departments, and local businesses.

- Community Outreach Events

Winchester Town Day	Billerica Health Fair
Burlington Senior Health Fair	North Reading Senior Health Fair
Woburn Senior Fall Fest	Wilmington Senior Health Fair
State House Health Fair	YMCA Community Unity Day
Medford Senior Health Day	National Active Older Adults Day
YMCA Annual Road Race	Winchester Savvy Senior Symposium

(3.) Home Blood Draws

The number of patients with community blood draws this year was 4,560. This number is up by approximately 200 patients from last year's statistics.

(4.) Pediatric Asthma Program

In 2004, the CHAMP Program experienced a great deal of growth demonstrated by the following statistics:

- 126 participants
- 134 home visits
- 71 visits to schools, pre-schools, childcare facilities and camps
- 129 Asthma Action Plans (AAP) filed (The higher number of AAP's filed than participants in the program is reflective of the difference between the calendar year and the academic year)

The success of the program is reflected in the following statistics. Of the 126 participants, there were only 3 Winchester Hospital Emergency Department re-visits and only 2 Winchester Hospital admissions. Also, the hospital is going to hire another RN to assist with the program.

The RN Asthma Educator has become an educational resource to school nurses and pediatric office nurses. In addition, CHAMP has identified an educational need in those schools, pre-schools and childcare facilities where there is no health care professional on staff. CHAMP has

just begun to offer a one-hour EpiPen Educational Session and a two-hour Asthma Educational Session.

(5.) Outpatient Heart Failure Program
The free Outpatient Heart Failure Program was developed and launched on March 1, 2004.

By December 2004, there were 82 participants in the program. During this time, only one patient was readmitted to the hospital within 31 days of the initial discharge.

VII. Next Reporting Year

A. Approved budget/projected expenditures
All of the previously noted programs have had their budget approved for the coming year.

Anticipated goals and program initiatives
All of the previously noted programs will continue on as designated.

B. Projected outcomes
(1.) The Osteoporosis Early Detection and Prevention Program
This program will continue until the completion of the assessment of 6000 women. Upon completion, the results of the research will be shared with appropriate resources.

(2) The Pediatric Asthma Program
The outcomes of this program will be based on four major components:

- Decreased ED visits
- Decreased hospital admissions
- Decreased days missed from school
- Decreased days missed from work by caregivers

A second RN will be added to the program due to the high volume of patients.

(3.) The Outpatient Heart Failure Program
The outcomes of this program will be based on the following objectives:

- Reduce or prevent the 31 day readmission rate for the population receiving intervention
- Determine that patient and/or family will perform daily weight
- Determine that the patient and/or family are able to state signs and symptoms of heart failure exacerbation
- Determine that patient and/or family will seek and secure appropriate medical assistance for their heart failure
- Determine that patient and/or family has a system for and follows the patient's medication schedule

VIII. Contact Information

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