2. Project Description

Beth Israel Lahey Health, Inc. (the "Applicant" or BILH), with a principal place of business at 20 University Road, Suite 700, Cambridge, MA 02138, is filing a Notice of Determination of Need (DoN) ("Application") with the Department of Public Health (DPH) for the expansion of endoscopy services by Winchester Hospital (the "Hospital") at its satellite, Winchester Endoscopy Center, located at 10P Commerce Way, Woburn, Massachusetts 01801 (the "Endoscopy Center"). The Proposed Project includes the addition of three (3) procedure rooms and seven (7) pre/post procedure bays for a total of eight (8) procedure rooms and 22 pre/post procedure bays (the "Proposed Project").

BILH is a Massachusetts, non-profit, tax-exempt corporation that operates an integrated health care delivery system comprised of teaching and community hospitals, physician groups, behavioral health providers, post-acute care providers and other caregivers serving patients in Greater Boston and the surrounding communities in Eastern Massachusetts and Southeastern New Hampshire. Its member hospitals include Addison Gilbert Hospital; Anna Jaques Hospital; BayRidge Hospital, Beth Israel Deaconess Medical Center; Beth Israel Deaconess Hospital-Milton; Beth Israel Deaconess Hospital-Needham, Beth Israel Deaconess Hospital-Plymouth; Beverly Hospital; Exeter Hospital, Lahey Hospital & Medical Center; Mount Auburn Hospital; New England Baptist Hospital; and Winchester Hospital (collectively known as "BILH Hospitals").

Winchester Hospital is a leading regional provider of comprehensive healthcare services in northwest suburban Boston serving the communities of Medford, North Reading, Reading, Stoneham, Tewksbury, Wakefield, Wilmington, Winchester, and Woburn. The Hospital has 229 licensed inpatient beds with more than 2,400 employees and over 850 clinicians on active medical staff. Winchester Hospital offers acute care inpatient services and an extensive range of outpatient services.

As cancer rates, particularly rates of colorectal cancer, continue to rise both nationally and within Massachusetts, the demand for timely, high-quality screening and diagnostic procedures has significantly increased. Colorectal cancer rates are increasing at a concerning rate even among younger adults, underscoring the need for expanded access to endoscopy services. The Endoscopy Center's procedure volume has tripled over the past three years, resulting in extended wait times and a backlog of patients awaiting endoscopy services. The demand for endoscopy services is not limited to the Hospital; wait times for endoscopy at BILH Hospitals averages between six (6) and 12 months. The Endoscopy Center's utilization was 89% is FY25and cannot accommodate additional patients.

To address these access limitations, the Applicant proposes to expand its Endoscopy Center through the addition of three (3) new procedure rooms and seven (7) new pre/post-procedure bays. This expansion will enable the Endoscopy Center to accommodate current and projected demand for endoscopy. By increasing procedural capacity, the Proposed Project aims to significantly reduce wait times to less than 40 days for all patients, ensuring that patients receive timely and effective care. The expanded facility will allow more patients to access screening and diagnostic services in a dedicated outpatient setting, improving convenience and patient experience.

Expanding the Endoscopy Center will support greater care coordination and efficiency, leveraging existing infrastructure, experienced staff, and established clinical pathways to streamline patient flow and optimize patient health outcomes. By meeting the increasing demand for endoscopy services within the community, the Proposed Project will advance early cancer detection, improve overall health outcomes, and support the Commonwealth's goals of cost containment and equitable access to high-quality healthcare.

Factor 1: Applicant Patient Panel Need, Public Health Values and Operational Objectives

F1.a.i Patient Panel:

Describe your existing Patient Panel, including incidence or prevalence of disease or behavioral risk factors, acuity mix, noted health disparities, geographic breakdown expressed in zip codes or other appropriate measure, demographics including age, gender and sexual identity, race, ethnicity, socioeconomic status and other priority populations relevant to the Applicant's existing patient panel and payer mix.

Overall Patient Panel

A. Beth Israel Lahey Health

BILH is an integrated health care delivery system of teaching and community hospitals, physician groups, behavioral health providers, and post-acute care providers serving patients in Greater Boston[1] and the surrounding communities in Eastern Massachusetts and Southeastern New Hampshire. BILH aims to have a broader impact on the health care industry and patient populations in Massachusetts by sharing best practices, investing in foundational infrastructure to support population health management, and encouraging competition based on value.

BILH also operates Beth Israel Lahey Health Performance Network, LLC (BILHPN), a clinically integrated network of physicians, clinicians, and hospitals. BILHPN is a Health Policy Commission (HPC) certified Accountable Care Organization (ACO) committed to providing high-quality, cost-effective care to the patients and communities they serve, while effectively managing medical expenditures. By leveraging best practices in population health management and data analytics, BILHPN seeks to improve care quality and patient health outcomes across the system through population health initiatives.

Patient Panel

In FY25, 60% of BILH's Patient Panel was predominantly composed of individuals aged 18 to 64, who represented the largest age cohort. Patients aged 65 and older made up the second largest group, followed by those aged 0 to 17. Approximately 58% of patients were female, compared to 42% male, with gender distribution remaining consistent from FY23 through FY25. About 73% of patients self-identified as White, and 93% identified as Not Hispanic/Latino in FY25, which remained largely unchanged from FY23. Data shows that in FY25, commercial insurance was the primary payer source for approximately 50% of patients, followed by Medicare at around 29%, Medicaid at 15%, and 6% had another type of insurance.

[1] Greater Boston includes the following cities/towns: Acton, Arlington, Ashland, Bedford, Belmont, Boston, Boxborough, Braintree, Brighton, Brookline, Burlington, Cambridge, Canton, Carlisle, Chelsea, Cohasset, Concord, Dedham, Dorchester, Dover, Foxboro, Framingham, Hingham, Holbrook, Holliston, Hopkinton, Hudson, Hull, Lexington, Lincoln, Littleton, Marlborough, Maynard, Medfield, Millis, Milton, Natick, Needham, Newton, Norfolk, Northborough, Norwell, Norwood, Quincy, Randolph, Revere, Roslindale, Scituate, Sharon, Sherborn, Somerville, Southborough, Stow, Sudbury, Walpole, Waltham, Watertown, Wayland, Wellesley, Westborough, Weston, Westwood, Weymouth, Wilmington, Winchester, Winthrop, Woburn, and Wrentham.

Table 1: BILH Patient Panel Demographics

Demographic	FY23 *(#)*	FY23 *(%)*	FY24 *(#)*	FY24 *(%)*	FY25*(#)*	FY25 *(%)*
Total	**995,640**	**100%**	**1,097,931**	**100%**	**1,251,364**	**100%**
Age: 0 to 17	67,632	7%	72,280	7%	79,390	6%
Age: 18 to 64	600,125	60%	657,034	60%	748,361	60%
Age: 65+	327,883	33%	368,617	34%	423,613	34%
Gender: Male	418,638	42%	457,517	46%	526,467	42%
Gender: Female	576,512	58%	638,844	58%	723,051	58%
Gender: Other[2]	490	0%	1,570	0%	1,846	0%
Race: White	750,501	75%	811,890	74%	912,924	73%
Race: Black or African American	62,678	6%	69,994	6%	78,461	6%
Race: American Indian or Alaska Native	1,293	0%	1,541	0%	1,837	0%
Race: Asian	77,450	8%	85,723	8%	96,989	8%
Race: Native Hawaiian or Other Pacific Islander	671	0%	674	0%	828	0%
Race: Other	59,061	6%	74,544	7%	90,229	7%
Race: Unknown	29,480	3%	35,294	3%	45,599	4%
Race: Patient Declined	14,506	1%	18,271	2%	24,497	2%
Ethnicity: Hispanic or Latino	64,965	7%	77,311	7%	91,290	7%
Ethnicity: Not Hispanic or Latino	901,208	91%	995,359	91%	1,158,869	93%
Ethnicity: Other	24,990	3%	20,203	2%	<11	0%
Ethnicity: Unknown	749	0%	1,974	0%	1,205	0%
Ethnicity: Patient Declined	3,728	0%	3,084	0%	<11	0%
Payer: Commercial	480,609	48%	529,840	48%	622,147	50%
Payer: Medicare	190,394	19%	210,334	19%	238,059	19%
Payer: Medicare Managed Care	119,336	12%	122,456	11%	126,164	10%
Payer: Medicaid	82,491	8%	98,845	9%	109,191	9%
Payer: Medicaid Managed Care	73,848	7%	73,507	7%	77,624	6%
Payer: Other[3]	48,962	5%	62,949	6%	78,179	6%

[2] Includes genders other than male/female, as well as patients for whom a gender is not specified, and whose gender varies across visits over the time period.
[3] Includes self-pay, health safety net, and liability coverage other than worker's compensation for an injury event.

B. Winchester Hospital

Overall Patient Population

In FY25, Winchester Hospital's overall patient population included 163,740 unique patients. Patients aged 18-64 were the largest patient cohort, making up 58% of unique patients. An additional 28% of patients were aged 65 and older. Approximately 58% of patients were female, compared to 42% male in FY25. In FY25, 85% of the Hospital's patients self-identified as White, 3% of patients self-identified as Black/African American and 6% of patients self-identified as Asian. Lastly, approximately 62% of patients were covered by a commercial insurance plan in FY25, compared to 23% who were insured through Medicare, 11% through Medicaid, and 4% who had another source of coverage.

Table 2: Winchester Hospital Patient Panel Demographics

Demographic	**FY23** *(#)*	**FY23** *(%)*	**FY24** *(#)*	**FY24** *(%)*	**FY25***(#)*	**FY25** *(%)*
Total	**154,014**	**100%**	**158,383**	**100%**	**163,740**	**100%**
Age: 0 to 17	23,944	16%	24,348	15%	23,327	14%
Age: 18-64	88,813	58%	91,045	58%	94,618	58%
Age: 65+	41,257	27%	42,990	27%	45,795	28%
Gender: Male	65,344	42%	67,096	42%	69,265	42%
Gender: Female	88,615	58%	91,249	58%	94,433	58%
Gender: Other	55	0%	38	0%	42	0%
Race: American Indian or Alaska Native	159	0.1%	229	0.1%	278	0.2%
Race: Asian	8,662	5.6%	9,243	5.8%	9,963	6.1%
Race: Black or African American	4,229	2.7%	4,768	3.0%	5,093	3.1%
Race: Native Hawaiian or Other Pacific Islander	55	0.0%	58	0.0%	57	0.0%
Race: Other	5,382	3.5%	5902	3.7%	6,404	3.9%
Race: White	133,038	86.4%	135,650	85.6%	139,095	84.9%
Race: Unknown	1,473	1.0%	1,486	0.9%	1,675	1.0%
Race: Patient Declined	1,016	0.7%	1,047	0.7%	1,175	0.7%
Ethnicity: Hispanic or Latino	7,128	5%	7,725	5%	8,221	5%
Ethnicity: Not Hispanic or Latino	146,859	95%	150,642	95%	155,511	95%
Ethnicity: Unknown	27	0%	16	0%	<11	0%
Payer: Commercial	96,545	63%	98,585	62%	101,477	62%
Payer: Medicare	24,266	16%	24,474	16%	25,831	16%
Payer: Medicare Managed Care	11,045	7%	11,968	8%	12,844	8%
Payer: Medicaid	12,562	8%	9,030	6%	8,939	6%
Payer: Medicaid Managed Care	4,638	3%	8,328	5%	8,535	5%
Payer: Other[4] / Unknown	4,958	3%	5,998	4%	6,114	4%

4 Includes self-pay, health safety net, and liability coverage other than worker's compensation for an injury event.

C. Winchester Hospital Endoscopy Patients

In FY25, slightly less than half of the Hospital's endoscopy patients were between the ages of 46 and 64 (46%). 30% of the Hospital's endoscopy patients were age 65 and older, and 24% of patients were under the age of 45. Approximately 53% of these patients were female while 47% were male. These numbers are largely unchanged from FY24. Most of the Hospital's endoscopy patients self-identified as White and Not Hispanic or Latino in FY25. Commercial payers were the primary payer in FY25 (58%), followed by Medicare, inclusive of Managed Medicare (approximately 27%).

Table 3: Winchester Hospital Endoscopy Patient Panel Demographics

Demographic	FY23 *(#)*	FY23 *(%)*	FY24 *(#)*	FY24 *(%)*	FY25*(#)*	FY25 *(%)*
Total	**6,452**	**100%**	**8,614**	**100%**	**10,944**	**100%**
Age: 0 to 27	212	3%	318	4%	410	4%
Age: 28-45	980	15%	1,439	17%	2,233	20%
Age: 46-54	1,689	26%	2,002	23%	2,506	23%
Age: 55-64	1,615	25%	2,175	25%	2,507	23%
Age: 65+	1,956	30%	2,680	31%	3,288	30%
Gender: Male	3,040	47%	4,005	46%	5,163	47%
Gender: Female/Other	3,412	53%	4,609	54%	5,781	53%
Race: White	5,551	86%	7,310	85%	9,274	85%
Race: Black or African American	197	3%	239	3%	311	3%
Race: Asian	330	5%	571	7%	655	6%
Race: Other	171	3%	233	3%	356	3%
Race: Unknown	108	2%	161	2%	212	2%
Race: Patient Declined	95	1%	100	1%	136	1%
Ethnicity: Hispanic or Latino	<11	0%	19	0%	28	0%
Ethnicity: Not Hispanic or Latino	6,073	94%	8,101	94%	10,286	93%
Ethnicity: Other	171	3%	233	3%	310	3%
Ethnicity: Unknown	108	2%	161	2%	207	2%
Ethnicity: Patient Declined	95	1%	100	1%	141	1%
Payer: Commercial	3,709	57%	4,864	56%	6,400	58%
Payer: Medicare	1,717	27%	2,406	28%	2,944	27%
Payer: Medicaid	420	7%	517	6%	540	5%
Payer: Low Income State Payer[5]	292	4%	390	4%	425	4%
Payer: Other[6] / Unknown	314	5%	437	5%	635	6%

[5] Includes Connector Care and Health Safety Net.

6 Includes self-pay, health safety net, and liability coverage other than worker's compensation for an injury event.

F1.a.ii Need by Patient Panel:

Provide supporting data to demonstrate the need for the Proposed Project. Such data should demonstrate the disease burden, behavioral risk factors, acuity mix, health disparities, or other objective Patient Panel measures as noted in your response to Question F1.a.i that demonstrates the need that the Proposed Project is attempting to address. If an inequity or disparity is not identified as relating to the Proposed Project, provide information justifying the need. In your description of Need, consider the principles underlying Public Health Value (see instructions) and ensure that Need is addressed in that context as well.

Colorectal cancer is a significant public health risk throughout the United States, including Massachusetts. In 2025, an estimated 154,200 adults will be diagnosed with colorectal cancer nationally, with over 50,000 expected deaths.[7] Notably, while cancer rates historically have increased with age, recent trends reveal a concerning 2% annual rise in colorectal cancer rates among younger adults aged 20-39 since the 1990s.[8] Massachusetts is not immune to the public health burden of colorectal cancer; in 2025 alone, the Commonwealth anticipates 2,770 new cases and 820 related deaths.[9] Early detection through screening is the most effective strategy to reduce both incidence and mortality, as well as overall costs of colorectal cancer.

Colonoscopy remains the gold standard for colorectal cancer screening and prevention, associated with a 69% decrease in new colorectal cancer cases and an 88% reduction in colorectal cancer mortality.[10] However, access barriers, including limited procedural capacity and increasing wait times, threaten to undermine the benefits of widespread colonoscopy. As demand for endoscopic procedures, including colonoscopy, grows, timely access is critical to ensure early detection and intervention, ultimately improving patient outcomes and reducing healthcare costs.

The Applicant has seen a significant increase in the need for colonoscopy and endoscopy services by its Patient Panel, resulting in a substantial backlog and wait times up to 12 months across the system. The Endoscopy Center, which opened in 2006, currently operates five procedure rooms. As further detailed below, endoscopy procedure volume at the Endoscopy Center has tripled from FY22 to FY25, demonstrating the need for expanded capacity to meet current and future demand for high-quality, timely access to endoscopy. To meet this need, the Applicant proposes to expand capacity at the Endoscopy Center by adding three (3) procedure rooms for a total of eight (8) procedure rooms for outpatient endoscopy.

A. Historical Utilization

The increasing need for endoscopy is reflected in historical volume. In FY25, Winchester Hospital performed 13,799 endoscopy procedures, representing a 183% increase since FY22. Of those procedures, 80% were performed at the Hospital's Endoscopy Center, highlighting the important role the Endoscopy Center plays in providing outpatient diagnostic and preventive care. The Endoscopy Center alone saw its annual procedure volume grow from 3,674 in FY22 to 11,079 in FY25, while volume at the main campus also increased from 1,194 procedures in FY22 to 2,720 procedures in FY25.

The table below breaks down the Hospital's outpatient endoscopy utilization by location.

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7 Colorectal Cancer Rates Are Skyrocketing In Young Adults – Is Your Lifestyle Putting You At Risk?, Cancer Research Institute (Mar. 5, 2025), https://www.cancerresearch.org/blog/colorectal-cancer-awareness-month.

8 *Id*.

9 Cancer Facts & Figures, American Cancer Society (last accessed Oct. 17, 2025), www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2025/2025-cancer-facts-and-figures-acs.pdf.

10 Trisha Pasricha and Lawrence S. Friedman, How Well Do Colonoscopies Prevent Colorectal Cancer? What You Need to Know, Harvard Health Publishing (Oct. 18, 2022), https://www.health.harvard.edu/blog/how-well-do-colonoscopies-prevent-colorectal-cancer-what-you-need-to-know-202210182834.

Table 4: Winchester Hospital Total Endoscopy Volume

Location	FY22	FY23	FY24	FY25	4-Year Change
Endoscopy Center	3,674	6,634	8,671	11,079	202%
Main Campus	1,194	1,622	2,456	2,720	128%
Percent Performed at Endoscopy Center	75%	80%	78%	80%	183%

Over the past four years, the Endoscopy Center had significant growth in procedure volume and utilization. In FY25, diagnostic procedures accounted for the overwhelming majority (83%) of the Endoscopy Center's volume, reflecting a 199% increase from FY22.[11] Screening procedures also increased substantially, with a 216% increase over the same period, highlighting the Endoscopy Center's pivotal role in providing preventive care to the Hospital's patient population. Most notably, overall utilization of the Endoscopy Center reached 92% in FY25, up from just 31% in FY22, demonstrating the growing demand for the Center's services and the need for the Proposed Project. Moreover, the Endoscopy Center's current utilization is nine (9) percentage points above the Hospital's target utilization of 80%.

The Endoscopy Center's utilization from FY22 through FY25 is detailed in Table 5 below.

Table 5: Endoscopy Center Utilization

Procedure Type	FY22	FY23	FY24	FY25	4-Year Change
Diagnostic	3,102	5,579	7,311	9,270	199%
Screening	572	1,055	1,360	1,809	216%
Upper	974	1,444	1,998	2,444	151%
Lower	2,700	5,190	6,673	8,635	220%
Utilization	29%	53%	69%	89%	202%

The rapid increase in procedure volume has outpaced existing capacity, leading to increased wait times for outpatients. Current wait times for endoscopy procedures at the Endoscopy Center are between six weeks and six months.[12] Moreover, approximately 2,700 patients have an outstanding order from their primary care physician and are waiting for their screening colonoscopy to be scheduled. As more fully detailed in F2.b, extended wait times have serious clinical implications: delays in screening and diagnostic evaluation can result in later-stage cancer diagnoses, reducing the likelihood of curative treatment and worsening patient outcomes. Currently, less than 33% of colorectal cancers are detected at an early stage,[13] underscoring the need for timely access to colonoscopy as the most effective method for reducing colorectal cancer risk and mortality.

In addition to the growing need for endoscopy services by patients of the Hospital, there is significant need for expanded access by patients across the BILH system. In particular, patients of Lahey Primary

[11] Diagnostic procedures represent procedures that were billed with a diagnostic finding and may have been scheduled as a screening procedure. This further highlights the clinical necessity of screening procedures and screening adherence.

[12] The average wait times for patients of Winchester's GI group and Digestive Health Associates is one to two months, which accounts for 65% of the Endoscopy Center's volume. The remaining 35% of volume comes from Atrius GI providers, whose patients are waiting an average of 6 months due to limited block time at the Endoscopy Center.

[13] U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute. Updated June 2025. Accessed October 6, 2025. www.cdc.gov/cancer/dataviz.

U.S. Preventive Services Task Force; Davidson KW, Barry MJ, Mangione CM, et al. Screening for colorectal cancer: US Preventive Services Task Force recommendation statement. JAMA. 2021;325(19):1965–1977. doi:10.1001/jama.2021.6238.

Care ("Lahey") in the communities of Burlington up through Peabody are currently waiting 12 months on average to be scheduled for endoscopy. Lahey's practices are located within a 12-mile radius, and some as close as few miles from the Endoscopy Center, making expanded access a convenient option for patients. Similarly, patients of BIDMC Gastroenterology ("BIDMC") in Boston are waiting five months on average. To address both the Hospital's growing need for outpatient endoscopy as well as the Applicant's, the Endoscopy Center was selected as the best location for expansion for several reasons.

B. The Proposed Project

To address the access issues detailed above, as well as to accommodate the growing population in the Hospital's service area[14], the Applicant proposes to expand capacity at the Endoscopy Center through the addition of three (3) new procedure rooms, bringing the total number of procedure rooms to eight (8). The Proposed Project will also add seven (7) new pre/post-procedure bays, for a total of 22 bays, increasing the Endoscopy Center's ability to efficiently manage patient flow and recovery. First, the Endoscopy Center offers a unique opportunity for expansion without disrupting ongoing patient care, as its design and operational flow allow for renovations to be carried out with minimal impact to clinical services. Importantly, the renovations required to increase capacity are not expected to be significant, allowing both a cost-effective and time-sensitive opportunity to expand services. Moreover, the Endoscopy Center's central location makes it easily accessible for both Lahey and BIDMC patients, helping to alleviate system-wide wait times. Additionally, as a freestanding building, the Endoscopy Center provides added convenience for patients, with dedicated parking and streamlined access, further supporting its role as an ideal site for expanded endoscopy capacity for the Patient Panel. The Applicant anticipates additional capacity at the Endoscopy Center will improve access across the system, providing a system-wide solution addressing the Patient Panel's need for expanded access to outpatient endoscopy. Through the Proposed Project, the Endoscopy Center will be able to accommodate the growing need for endoscopy services, in turn ensuring more patients have timely access to screening and diagnostic endoscopy.

The Applicant projects additional volume following the Proposed Project's implementation based on several factors. Expanded capacity at the Endoscopy Center will ensure the Applicant's Patient Panel has timely access to endoscopy by reducing wait times for patients of the Hospital, as well as for Lahey and BIDMC patients who are waiting up to 12 months for an appointment. In addition, there currently are 4,100 Hospital patients eligible for colonoscopy screening but do not yet have an order from their PCP. Combined with patients with active orders, this represents more than 6,800 patients who should be screened this year. Factoring in a target screening compliance rate of 80%, almost 6,000 more patients should have be seen at the Endoscopy Center, but could not have been accommodated because of limited capacity. Lastly, based on historical utilization, the Endoscopy Center expects non-colonoscopy procedures will continue to account for roughly 20% of total procedures. In six years, non-colonoscopy procedures are projected to total 3,356 cases annually.

The projected increased volume also is based on population increases. In 2030, the towns closest to the Endoscopy Center, including Arlington, Burlington, Lynnfield, Medford, North Reading, Peabody, Reading, Stoneham, Tewksbury, Winchester and Woburn are projected to have more than 130,000 residents ages 45-75. With recommended colorectal cancer screening at least every 10 years[15], this amounts to approximately 13,000 patients annually who will need some form of screening colonoscopy

[14] Based on UMass Donahue Institute projections, the 40-69 age cohort in the city/towns of Burlington, Lynnfield, Winchester, Stoneham are collectively projected to increase by 19% between 2025 and 2050. Within the towns of Burlington, Lynnfield, Medford, Stoneham, and Woburn, the 45-49 age cohort alone projected to grow 22% by 2030. https://donahue.umass.edu/business-groups/economic-public-policy-research/massachusetts-population-estimates-program/population-projections

[15] American Cancer Society Guideline for Colorectal Cancer Screening, AMERICAN CANCER SOCIETY, https://www.cancer.org/cancer/types/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html (last visited September 24, 2025). Individuals at a higher risk of colorectal cancer may need to receive more frequent screening, up to every three years rather than every ten (10) years.

and would result in 10,400 procedures if just 80% of those residents followed the recommended screening guidance.[16] These calculations do not account for patients who are at a higher risk and require more frequent screenings, or follow-up screenings, which would result in increased volume. Moreover, almost a quarter of the Hospital's endoscopy patients were under the age of 45 who are not represented in these projections.

Based on these assumptions, the Applicant anticipates the Endoscopy Center will perform 16,779 procedures within five years of the new rooms opening, with utilization increasing from 72% in Year 1[17] to 84% in Year 5. This additional capacity will directly translate into shorter wait times, with the goal of reducing the average scheduling interval from 90 days to 40 days or less within 5 years. The expansion also will enable more patients to access timely care, helping to alleviate the system-wide backlog experienced across BILH.

The Endoscopy Center's proposed utilization is set forth in Table 6 below.

Table 6: Endoscopy Center Projected Volume

Projections	Year 1	Year 2	Year 3	Year 4	Year 5
New Volume	3,420	3,800	4,370	5,130	5,700
Total Volume	14,499	14,879	15,449	16,209	16,779
Utilization	72%	74%	77%	81%	84%

The Proposed Project is a necessary and timely response to the growing need for colorectal cancer screening and diagnostic and preventive endoscopy by the Applicant's Patient Panel. By increasing procedural capacity, reducing wait times, and improving access at the Endoscopy Center, the Proposed Project will play a critical role in advancing early detection, improving clinical outcomes, and containing healthcare costs. As colorectal cancer rates continue to rise, particularly among younger adults, timely and equitable access to high-quality endoscopy is essential. The Proposed Project ensures that Winchester Hospital remains at the forefront of cancer prevention and care for years to come.

F1.a.iii Competition:

Provide evidence that the Proposed Project will compete on the basis of price, total medical expenses, provider costs, and other recognized measures of health care spending. When responding to this question, please consider Factor 4, Financial Feasibility and Reasonable of Costs.

The Proposed Project will improve access to high-quality, patient-centered endoscopy by expanding procedural capacity at an existing provider. Rather than expanding hours of operation to the inconvenience of patients or allowing wait times to increase, the Proposed Project will improve access for current and future patients. This approach allows the Applicant to build upon proven operational efficiencies, staff expertise, and established care pathways in place to quickly expand access to preventative and diagnostic endoscopy which will contribute to limiting total medical expenses (TME).

By leveraging the Endoscopy Center's infrastructure and available resources, the Proposed Project will support seamless care coordination and maintain high standards of quality and safety. The integration of additional procedure rooms within the current facility ensures that patients will continue to benefit from streamlined scheduling, experienced care teams, and efficient workflows that minimize delays and enhance the overall patient experience. Expanding services at the Endoscopy Center offers distinct advantages to patients, who will be able to continue to access endoscopy services in a dedicated outpatient environment located within their community and within BILH's network of providers. The

[16] National Colorectal Cancer Round Table, "80% in Every Community", https://nccrt.org/our-impact/80-in-every-community/
[17] The Hospital anticipates the additional endoscopy rooms will open Summer 2027.

Endoscopy Center is specifically designed for outpatient endoscopy care, resulting in greater ease of access, reliable scheduling, and better patient experience.

Moreover, expanding access to timely screening and diagnostic endoscopy will directly contribute to lowering TME through the provision of preventative care. Early detection of colorectal and other gastrointestinal cancers via routine endoscopic screening enables the identification and removal of precancerous polyps, significantly reducing the incidence of advanced-stage cancers that are far more costly to treat.[18] Preventative endoscopy not only improves patient outcomes and survival rates but also reduces the need for later expensive interventions, potential hospital admissions, and complex oncologic treatments associated with late-stage disease.[19] Increasing procedural capacity at the Endoscopy Center will support earlier, less invasive, and more cost-effective care, ultimately decreasing the overall financial burden on patients, payers, and the Commonwealth's healthcare system. As an existing provider of endoscopy services, there will be no change in price as a result of the Proposed Project.

To that end, expanding capacity at the Endoscopy Center will meet growing community needs efficiently and effectively, without duplicating resources or disrupting established care delivery. This approach not only supports optimal patient outcomes and satisfaction but also aligns with the Commonwealth's goals of ensuring timely, accessible, and high-quality care for all residents.

F1.b.i Public Health Value/Evidence-Based:

Provide information on the evidence-base for the Proposed Project. That is, how does the Proposed Project address the Need that Applicant has identified.

A. Clinical Overview of Endoscopy

Endoscopy involves a slender, flexible tube with a camera, called an endoscope, to examine internal organs with minimal invasiveness.[20] Common procedures like colonoscopies and esophagogastroduodenoscopies (EGD) are frequently used to screen, diagnose, and manage conditions such as cancer, gastrointestinal issues, and inflammatory diseases without the creation of a large incision, making it safer than traditional surgery.[21] These procedures permit physicians to conduct biopsies and collect abnormal tissue for further analysis.[22] Studies reveal that a single endoscopy can detect cancer in up to 99% of cases,[23] making endoscopy a highly effective and reliable clinical tool.[24] It also allows doctors to close wounds, administer medication, drain fluids, stop internal bleeding, and remove tumors or damaged tissues.[25]

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[18] *See, e.g.,* Mehak Gul Mastoi et al., *Advances In Endoscopic Techniques For Early Detection And Treatment of Gastrointestinal Cancers: A Systematic Review*, MEDICINE (Oct. 2025), https://pmc.ncbi.nlm.nih.gov/articles/PMC12537103/.

[19] Goede SL, Kuntz KM, van Ballegooijen M, et al. Cost Savings to Medicare from Pre-Medicare Colorectal Cancer Screening. MEDICAL CARE. 2015;53(7):630–638.

[20] Endoscopy, CLEVELAND CLINIC, https://my.clevelandclinic.org/health/diagnostics/25126-endoscopy (last visited September 24, 2025).

[21] Upper Endoscopy, MAYO CLINIC, https://www.mayoclinic.org/tests-procedures/endoscopy/about/pac-20395197 (last visited September 24, 2025).

[22] Johnathan Y Xia and Aziz Aadam, Advances in Screening and Detection of Gastric Cancer, J Surg Oncol. 125(7) (2022), available at https://pmc.ncbi.nlm.nih.gov/articles/PMC9322671/.

[23] Schreuders, E. H., Ruco, A., Rabeneck, L., Schoen, R. E., Sung, J. J., Young, G. P., & Kuipers, E. J. (2015). Colorectal cancer screening: a global overview of existing programmes. *Gut*, *64*(10), 1637-1649.

[24] Upper Endoscopy, American Cancer Society, https://www.cancer.org/cancer/diagnosis-staging/tests/endoscopy/upperendoscopy.html (last visited June 4, 2025).

[25] EGD Procedure (Upper Endoscopy), CLEVELAND CLINIC, https://my.clevelandclinic.org/health/procedures/22549-egd-procedureupper-endoscopy (last visited September 24, 2025).

Lower endoscopies allow providers to view the lower gastrointestinal tract, including the colon and rectum.[26] The endoscope is able to obtain tissue samples, remove polyps, detect cancer including colorectal cancer, and diagnose causes of bleeding or inflammation.[27] Upper endoscopies are used to examine the upper digestive system including esophagus, stomach, and beginning of the small intestine.[28] As further detailed below, colorectal cancer is the second leading cause of cancer-related deaths in the United States.[29] Screening colonoscopies are able to find polyps and early signs of colorectal cancer before symptoms present.[30] Upon a positive screening test, a diagnostic colonoscopy is used allowing for a closer examination and potential removal of abnormalities.[31]

B. Colorectal Cancer and Screening

The growing prevalence of cancer nationwide underscores a critical gap in healthcare infrastructure, particularly the need to broaden the availability of endoscopic procedures that play a key role in early detection and treatment. The American Cancer Society estimates that about 154,270 of colorectal cancer have been diagnosed in the United States so far this year.[32] In Massachusetts alone, it is estimated that 2,770 new cases of colorectal cancer have been diagnosed along with 820 deaths.[33]

Since the 1990s, cases of colorectal cancer among adults aged 20-39[34] have consistently increased 2% annually making it the most common cancer among this population.[35] Information from the U.S. Centers for Disease Control and Prevention Database show that since 1999, rates of colorectal cancer have grown 500% among children ages 10 to 14 and 333% among teens ages 15-19.[36] Despite this prevalence, colorectal cancer screening protocols advise individuals without a family history to begin regular screenings at age 45 and continue every decade until age 75.[37] Because early screening isn't recommended for this age group, younger adults often depend on endoscopic procedures not for prevention, but as a means of diagnosing and managing symptoms once they arise.[38] Adults within the 45 to 75 age range are increasingly following these guidelines. Between 2012 and 2020, the proportion of U.S. adults, ages 50-75 who had never undergone colorectal cancer screening dropped from 27.4% to 21.6%.[39] This 5.8-point decline translates to nearly 3.9 million more individuals being screened in 2020 compared

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[26] Lower GI Endoscopy, Veterans Health Library, https://www.veteranshealthlibrary.va.gov/Encyclopedia/3,82149 (last visited September 24, 2025).
[27] Stauffer, C. M., & Pfeifer, C., *Colonoscopy*, StatPearls Publishing (2023), https://europepmc.org/article/NBK/nbk559274.
[28] Upper Endoscopy, MAYO CLINIC, *supra* note 21.
[29] Key Statistics for Colorectal Cancer, American Cancer Society, https://www.cancer.org/cancer/types/colon-rectal-cancer/about/key-statistics.html. (last accessed September 24, 2025).
[30] Colorectal Cancer Screening Tests, American Cancer Society, https://www.cancer.org/cancer/types/colon-rectal-cancer/detection-diagnosis-staging/screening-tests-used.html#:~:text=The%20most%20important%20thing%20is,before%20they%20turn%20into%20cancer. (last visited September 24, 2025).
[31] Screening Tests to Detect Colorectal Cancer and Polyps, National Cancer Institute, https://www.cancer.gov/types/colorectal/screening-fact-sheet#:~:text=A%20colonoscopy%20to%20follow%20up%20on%20a,covered%20as%20fully%20as%20a%20screening%20colonoscopy). (last accessed September 24, 2025).
[32] Key Statistics for Colorectal Cancer, American Cancer Society, *supra* note 29.
[33] Cancers by State 2025, American Cancer Society, https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2025/sd3-21-cancers-by-state-2025.pdf (last accessed September 24, 2025).
[34] Colorectal Cancer Rates Are Skyrocketing in Young Adults—Is Your Lifestyle Putting You at Risk?, *supra* note 7.
[35] Can Cancers in Young Adults Be Prevented?, AMERICAN CANCER SOCIETY, https://www.cancer.org/cancer/types/cancer-in-youngadults/prevention.html (last visited September 19, 2025).
[36] Colorectal Cancer Cases have Tripled in Teens—and Jumped by 500% in Kids. What you Need to Know. (2024). American Association of Naturopathic Physicians. https://naturopathic.org/news/672625/Colorectal-Cancer-Cases-have-Tripled-in-Teensand-Jumped-by-500-in-Kids.-What-you-Need-to-Know.htm (last accessed September 19, 2025).
[37] American Cancer Society Guideline for Colorectal Cancer Screening, AMERICAN CANCER SOCIETY, https://www.cancer.org/cancer/types/colon-rectal-cancer/detection-diagnosis-staging/acs-recommendations.html (last visited September 24, 2025).
[38] Key Statistics for Cancers in Young Adults, AMERICAN CANCER SOCIETY, https://www.cancer.org/cancer/types/cancer-in-youngadults/key-statistics.html (last visited September 19, 2025).
[39] Adults Who Have Never Been Screened for Colorectal Cancer, Behavioral Risk Factor Surveillance System, 2012 and 2020. (2022) CDC. https://www.cdc.gov/pcd/issues/2022/22_0001.htm (last accessed September 24, 2025).

to 2012.[40] Despite increases in screening adherence, Massachusetts is still falling short of the national target for 80% of eligible adults to be screening as recommended.[41] As the rate of screening continues increase among older adults as well as younger adults' reliance on endoscopy, wait times for endoscopy will continue to increase without additional capacity in the Commonwealth.

Colonoscopies are the gold standard when it comes to colorectal screenings and routine access to endoscopies is the key to reduction of mortality and improving patient outcomes.[42] When asymptomatic adults are tested, a colonoscopy's sensitivity percentage for detecting colorectal cancer is 92 to 99% while detecting advanced neoplasia is 88 to 98%.[43] Meanwhile, the greatest success rate of any of the fecal exams were 79% for colorectal cancer and 32 to 53% for advanced neoplasia.[44] Even if the fecal exam detects an abnormality, the patient is then referred for a colonoscopy.[45] This creates risk because studies show that patients are more likely to take a second fecal exam or delay their colonoscopy beyond one year[46], which leads to a higher incidence of colorectal cancer.[47] In fact, only 41% of patients who had two positive fecal tests had a colonoscopy within a year of their initial results.[48] Delays in scheduling colonoscopies, especially wait times exceeding six months, are associated with worse clinical outcomes.[49] Studies have shown that a time interval longer than six months between a fecal immunochemical test and the patient's colonoscopy is a significant predictor of colorectal cancer detection in high-risk populations.[50] Extended wait times for procedure scheduling may also increase rates of missed appointments and/or cancellation.[51]

C. Role of Hospital-Based Departments in Endoscopy

While recent trends show an increasing number of ambulatory surgery centers, hospital-based procedure rooms play a crucial role in healthcare delivery. For example, patients treated in hospital-based procedure rooms had lower odds of unexpected hospitalization after undergoing colonoscopy.[52] Research also indicates that for screening and non-screening colonoscopy, the rates for unplanned hospital visits for "adverse events of surgical procedures or medical care" were actually numerically higher in ASCs versus hospital-based departments in the matched cohort despite the hospital-based cohort having more comorbidities (13.4% vs 8.7%, screening colonoscopy; 11.1% vs 7.6%, non-screening colonoscopy).[53]

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[40] *Id*.
[41] National Colorectal Cancer Roundtable*, supra* note 15.
[42] Michael Bretthauer et al, Effect of Colonoscopy Screening on Risks of Colorectal Cancer and Related Death, THE NEW ENGLAND JOURNAL OF MEDICINE (2022), available at https://www.nejm.org/doi/full/10.1056/NEJMoa2208375.
[43] Schreuders, E. H., Ruco, A., Rabeneck, L., Schoen, R. E., Sung, J. J., Young, G. P., & Kuipers, E. J., *supra* note 23.
[44] *Id*.
[45] Ben-Ari, Elia (2022). Colonoscopy after Positive FIT Test Cuts Risk of Colorectal Cancer Death. National Cancer Institute. https://www.cancer.gov/news-events/cancer-currents-blog/2022/positive-fit-stool-test-colonoscopy. (last accessed September 24, 2025).
[46] *Id*.
[47] Forbes, N., Hilsden, R. J., Martel, M., Ruan, Y., Dube, C., Rostom, A., ... & Heitman, S. J. (2021). Association between time to colonoscopy after positive fecal testing and colorectal cancer outcomes: a systematic review. *Clinical Gastroenterology and Hepatology*, *19*(7), 1344-1354.
[48] Rochman, S. (2024). Some patients delay colonoscopy after positive fecal test. Kaiser Permanente. https://divisionofresearch.kaiserpermanente.org/delay-after-positive-fecal-test/ (last accessed September 24, 2025).
[49] Megan A. Adams et al.*, Trends In Wait Time For Outpatient Colonoscopy In the Veterans Health Administration, 2008-2015*, JOURNAL OF GENERAL INTERNAL MEDICINE (June 2020), https://pubmed.ncbi.nlm.nih.gov/32212093/.
[50] Mingqing Zhang et al., *Postponing Colonoscopy For 6 Months In High-Risk Population Increases Colorectal Cancer Detection In China*, CANCER MEDICINE (Mar. 2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC10242305/.
[51] Reema Alnasser et al., *Factors Associated With Missed And Cancelled Appointments In The Endoscopy Unit: Descriptive Study*, CUREUS (Mar. 2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC7153807/.
[52] Chukmaitov, A. S., Menachemi, N., Brown, L. S., Saunders, C., & Brooks, R. G. (2008). A comparative study of quality outcomes in freestanding ambulatory surgery centers and hospital-based outpatient departments: 1997–2004. *Health services research*, *43*(5p1), 1485-1504.
[53] Rostom, A., Dubé, C., & Hilsden, R. (2022). Outcomes after outpatient endoscopy: Can administrative data tell the whole story?. *Gastrointestinal Endoscopy*, *95*(6), 1098-1100.

A comparative study found that differences in outcomes may be due to policies adopted, finding benefit to having a hospital affiliate. [54] Specifically, hospital-based departments are more likely to have implemented broader hospital-level safety strategies, clinical protocols, or evidence-based guidelines that contribute to lowering the risk of complications that would otherwise lead to inpatient admissions.[55] Expanding access to endoscopy in existing hospital-based facilities will ensure timely access to high-quality care.

F1.b.ii **Public Health Value /Outcome-Oriented:**

Describe the impact of the Proposed Project and how the Applicant will assess such impact. Provide projections demonstrating how the Proposed Project will improve health outcomes, quality of life, or health equity. Only measures that can be tracked and reported over time should be utilized.

The Proposed Project will provide public health value by improving access to high-quality outpatient endoscopy in Winchester, thereby improving health outcomes and patient satisfaction for the Applicant's Patient Panel. To assess the impact of the Proposed Project, the Applicant will monitor and report following quality metrics.

1. **Wait Time to Scheduled Procedure:** Timely access to endoscopic procedures is critical for early diagnosis and treatment, contributing to improved health outcomes and patient satisfaction.[56] Extended wait times for scheduling procedures delays care and negatively impacts patient outcomes. The Applicant will monitor and report the average time patients wait from the date the procedure is ordered to the date it is scheduled. Data will be tracked to identify trends, barriers, and opportunities for improvement.

   Measure: Average number of days between the date a procedure is ordered and the date the procedure is scheduled to be performed.

   Numerator: Total number of days waited by all patients from order to scheduled procedure date.

   Denominator: Total number of scheduled procedures.

   Baseline and Goal: Patients currently wait between 3 to 6 months between scheduling and their procedure date, depending on their provider's availability. The Proposed Project aims to reduce wait times by 15% per year, with a target goal of 40 days (less than 6 weeks) by Year 5.

2. **Delayed Procedure Start Times:** Delays in starting scheduled endoscopic procedures can disrupt patient care and impact overall operational efficiency. Monitoring the frequency and duration of delayed procedure start times will enable the Endoscopy Center to identify causes of delays and implement process improvements.

   Measure: Percentage of procedures that start more than 30 minutes after the scheduled start time.

   Numerator: The number of procedures that began more than 30 minutes after the scheduled start time.

   Denominator: Total number of scheduled procedures.

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[54] Chukmaitov, A. S., *supra* note 52.
[55] *Id*.
[56] *See, e.g.*, Megan A. Adams et al., *supra* note 49.

Baseline and Goal: The current baseline delayed start rate is 44%. The goal with the Proposed Project is to achieve a 15% reduction each year until less than 20% of scheduled procedures are delayed by Year 5.

3. **Patient Satisfaction:** Patients who are satisfied with their care are more likely to seek additional treatment when needed. The Applicant will continue to review patient satisfaction levels of the Endoscopy Center's patients and compare it across similar facilities and regional benchmarks.

   Measure: A Press Ganey Patient Satisfaction survey is provided to all eligible patients following their procedure at the Endoscopy Center. This survey focuses on the patient's experience in multiple areas, including net promoter score (NPS), wait times, facility operations, care communication, nurse/physician treatment, and discharge. The survey also allows for anonymous comments from patients to further provide insight into potential areas of improvements as well as patient concerns or commendations.

F1.b.iii **Public Health Value /Health Equity-Focused**

For Proposed Projects addressing health inequities identified within the Applicant's description of the Proposed Project's needbase, please justify how the Proposed Project will reduce the health inequity, including the operational components (e.g., culturally competent staffing). For Proposed Projects not specifically addressing a health disparity or inequity, please provide information about specific actions the Applicant is and will take to ensure equal access to the health benefits created by the Proposed Project and how these actions will promote health equity.

The Proposed Project will meaningfully address health equity by increasing access to endoscopy services to all patients, regardless of age, race, ethnicity, gender/gender-identity, physical ability, sensory or speech limitations, or religious, spiritual and cultural beliefs, nor a patient's ability to pay or payer source. The Hospital has implemented the following initiatives to facilitate equitable access to its services.

A. Ensuring Language Accessibility

Ensuring healthcare providers and staff have the opportunity to establish direct relationships with all patients is essential for high-quality, equitable care. Accordingly, the Hospital offers language services across various modes of patient interaction, including in-person, remote video, and telephonically, at no cost to patients to allow meaningful and accurate communication between staff and patients. Interpreter services are available for more than 100 languages, including American Sign Language, and can be used 24 hours a day 7 days a week. Trained medical interpreters act as a conduit to facilitate communication between patients, families, staff, and healthcare providers, informing patients and families about procedures, medications, social services, financial topics, and other important information.

As its patient population grows in both size and diversity, the Hospital's Interpreter Services Department has expanded to meet its patients' needs. In FY23, the number of requested and completed language services encounters was 7,109. The Hospital provides in-person and video remote interpreting (VRI) to all patients in order to ensure communication is available in the patient's preferred language by a qualified medical translator. The Hospital also is contracted with several vendors to meet language needs 24/7 including VRI, over the phone language services, and in person/on-site interpreters. In addition, assistive listening devices, such as PocketTalkers and telephone volume amplifiers, are available to assist deaf and hard of hearing patients and family members.

B. Social Determinants of Health

The Hospital actively promotes health equity by addressing social determinants of health that impact patient care. During the initial consultation, nursing staff screen all patients to assess their living situation, smoking status, substance use, available support systems, and any transportation challenges. Mental

health concerns are also evaluated during this visit. Based on these findings, referrals to social work or other appropriate services are made as needed via the BILH Find Help platform.

Following these assessments, the Hospital coordinates necessary interventions. Social work referrals may help connect patients with resources such as financial counseling, community mental health services, transportation assistance programs, and physical therapy for eligible patients.

C. RELD/SOGI Data Collection

BILH has implemented an initiative aimed at systematically collecting more comprehensive and accurate demographic information from patients, supporting the organization's commitment to fostering a culture of diversity, equity, and inclusion. Gathering detailed information on patient demographics, including race, ethnicity, language, disability, sexual orientation, and gender identity ("RELD/SOGI") is essential for identifying and addressing health disparities within the community. To achieve this, BILH collects RELD/SOGI data during patient registration and via MyChart self-reporting. This allows BILH to identify and monitor any disparities in health outcomes.

BILH assembled a multidisciplinary team with members from across the System, including representatives from patient access services, information services, nursing, social work, community benefits, and community relations. In collaboration with patient representatives, this team developed a standardized set of demographic data elements and established best practices and processes to ensure consistent and reliable data collection within the electronic medical record system. Staff also receive ongoing training on health equity, disability, interpreter services, and social determinants of health through department meetings and online learning modules.

F1.b.iv Provide additional information to demonstrate that the Proposed Project will result in improved health outcomes and quality of life of the Applicant's existing Patient Panel, while providing reasonable assurances of health equity.

The Proposed Project will enhance health outcomes and quality of life for the Applicant's Patient Panel by ensuring timely access to both routine and diagnostic endoscopy services in the region. Expanding capacity at the Endoscopy Center will play a critical role in improving prompt access to endoscopy services, encouraging greater adherence to recommended screenings and allowing patients to be diagnosed sooner. Patients are more likely to follow through with screening guidelines when services are available in a convenient setting without significant wait times. Increasing colorectal cancer screening rates for all patients, regardless of financial means, ensures more cancers are detected at an earlier stage when treatment is less invasive and more successful. To that end, the Proposed Project will provide for better health outcomes, improved quality of life, and reduced healthcare expenditure.

F1.c Provide evidence that the Proposed Project will operate efficiently and effectively by furthering and improving continuity and coordination of care for the Applicant's Patient Panel, including, how the Proposed Project will create or ensure appropriate linkages to patients' primary care services.

Expanding capacity at the Endoscopy Center will further continuity and coordination of care through the shared EMR system used by the Hospital and BILH. The EMR seamlessly connects clinical information from the patient's endoscopy services to their Hospital profile, allowing coordination of care between endoscopy providers and the rest of the patient's care team. All BILH-affiliated providers receive case notes following the patient's procedures at the Endoscopy Center, and the information uploaded to the EMR system can be quickly shared to the patient's portal. Furthermore, notes and results in the EMR system can be easily shared with providers in other networks, ensuring the patient receives comprehensive care across care teams.

Finally, the Hospital participates in the MassHealth ACO Program through Beth Israel Deaconess Care Organization (BIDCO), which is part of BILHPN and its clinically integrated network. In support of the MassHealth ACO Program's objectives, BIDCO is committed to expanding access to high-quality care for members who are more likely to experience unmet social determinants of health needs compared to the commercially insured population. Much of BIDCO's progress in advancing health care is achieved through robust care coordination efforts. In particular, BIDCO provides data analysis and risk management tools to BILH providers, including a Population Health Management Tool that assists primary care physicians in monitoring patient health and managing chronic conditions. The strong connections between BILH gastroenterologists and primary care providers are essential for delivering high-quality care and ensuring effective care coordination. These primary care linkages will continue to improve care for BILH patients, including timely access to screening endoscopy that will be further supported by the Proposed Project.

F1.d **Provide evidence of consultation, both prior to and after the Filing Date, with all Government Agencies with relevant licensure, certification, or other regulatory oversight of the Applicant or the Proposed Project**.

The Applicant consulted with the following agencies regarding the Proposed Project:

- Massachusetts Department of Public Health
- Massachusetts Executive Office of Health and Human Services
- Health Policy Commission
- Center for Health Information and Analysis
- The Centers for Medicare & Medicaid Services

F1.e.i **Process for Determining Need/Evidence of Community Engagement:**

For assistance in responding to this portion of the Application, Applicant is encouraged to review Community Engagement Standards for Community Health Planning Guideline. With respect to the existing Patient Panel, please describe the process through which Applicant determined the need for the Proposed Project.

In addition to relying on the data described throughout this application that demonstrates the need for the Proposed Project, the Applicant also sought to engage the community to elicit feedback from patients and families regarding the Proposed Project. The Applicant presented the Proposed Project to the community via a meeting with the Community Benefits Advisory Committee on October 7, 2025. This meeting was attended by seventeen (17) total members of the Committee, who expressed strong support for the expansion.

The Proposed Project was also presented to the Patient and Family Advisory Council on November 5, 2025. Six (6) members were present and were provided detailed information about the Proposed Project including the current backlog of patients with endoscopy orders and how additional endoscopy capacity will improve health outcomes by expanding access. Following the presentation, the members present voiced their support for the Proposed Project.

F1.e.ii **Please provide evidence of sound Community Engagement and consultation throughout the development of the Proposed Project. A successful Applicant will, at a minimum, describe the process whereby the "Public Health Value" of the Proposed Project was considered, and will describe the Community Engagement process as it occurred and is occurring currently in, at least, the following contexts: Identification of Patient Panel Need; Design/selection of DoN Project in response to "Patient Panel" need; and Linking the Proposed Project to "Public Health Value".**

To ensure sound community engagement throughout the development of the Proposed Project, the Applicant took the actions detailed in Factor F1.e.i. In addition, the Applicant published a legal notice announcing the Proposed Project in the *Daily Times Chronicle* on October 16, 2025, and posted a copy of the legal notice prominently on the Hospital's website. Please refer to Appendix 7 for copies of the legal notices.

Factor 2: Health Priorities

Addresses the impact of the Proposed Project on health more broadly (that is, beyond the Patient Panel) requiring that the Applicant demonstrate that the Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation.

F2.a. **Cost Containment**

Using objective data, please describe, for each new or expanded service, how the Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment.

The Proposed Project will meaningfully contribute to the Commonwealth's goals for cost containment by expanding access to high-quality endoscopy services in the community hospital setting. By increasing access to timely screening and diagnostic endoscopy procedures, the Applicant will contribute to a greater number of Massachusetts residents receiving high-quality screening and diagnostic endoscopy services, ultimately improving public health outcomes. As discussed throughout this application, timely access to treatment not only improves health outcomes but also minimizes avoidable costs incurred as a result of delays in treatment. According to the Centers for Disease Control and Prevention, less than 33% of colorectal cancers are found at an early stage.[57] The most effective method to reduce risk of colorectal cancer is routine screening, allowing for precancerous polyps to be removed before they can turn into cancer and detecting cancer early when treatment is most effective.[58] Despite the effectiveness of colonoscopy, screening adherence by Massachusetts residents is just 65.4% of adults between ages 45 and 75.[59] This figure is significantly below the National Colorectal Cancer Roundtable's goal of achieving 80% screening adherence across all communities.[60] Early colorectal screening also leads to significant cost savings; estimates show that increasing colorectal cancer screening rates to 70% among adults age 50 to 64 could reduce Medicare spending by $14 billion by 2050.[61] To that end, the Proposed Project will provide long-term financial benefit to its patients and the payers of healthcare.

[57] U.S. Cancer Statistics Working Group, *supra* note 13.
[58] U.S. Preventive Services Task Force, *supra* note 13.
[59] https://www.americashealthrankings.org/explore/measures/colorectal_cancer_screening/MA
[60] 80% in Every Community, *supra* note 16.
[61] Goede, *supra* note 19.

F2.b. Public Health Outcomes

Describe, as relevant, for each new or expanded service, how the Proposed Project will improve public health outcomes.

The Proposed Project will advance both public health and cost containment goals by delivering high-quality endoscopy services. In 2025, an estimated 154,200 adults will be diagnosed with colorectal cancer nationally, with over 50,000 expected deaths.[62] Access to endoscopy services can help reduce these numbers. Patients are much more likely to undergo timely cancer screenings when services are readily available and easier to access, leading to earlier detection of colorectal cancer and more effective treatment. As a stand-alone facility not on the main campus of the Hospital, the Endoscopy Center offers patients on-site parking and a designated waiting room inside the main entrance, reducing issues related to navigation and wayfinding that is prevalent for hospital-based services. The Applicant also anticipates that younger patients, who may be dissuaded by the inconvenience of screenings, will also benefit from improved outcomes through more timely and convenient access to diagnostic and preventative endoscopy services. By promoting earlier diagnostic and treatment opportunities, the Proposed Project will help close the gap to achieving better adherence to colorectal cancer screening guidelines in Massachusetts, in turn improving health outcomes for the Applicant's Patient Panel while contributing to the Commonwealth's broader efforts to reduce healthcare costs.

F2.c. Delivery System Transformation

Because the integration of social services and community-based expertise is central to goal of delivery system transformation, discuss how the needs of their patient panel have been assessed and linkages to social services organizations have been created and how the social determinants of health have been incorporated into care planning.

a. Social Determinants of Health (SDoH)

The Applicant integrates social services and community-based healthcare as a foundational aspect of its approach to delivering high-quality care. SDoH, such as food insecurity, housing instability, transportation barriers, and utility difficulties, play a critical role in the Patient Panel's health outcomes and overall well-being. To systematically assess the needs of the Patient Panel, SDoH screenings are conducted by the nursing staff for every patient upon hospital admission. Screenings include targeted questions addressing core social needs, such as food, housing, transportation, and interpersonal safety. The results are documented in the electronic medical record, ensuring that identified needs are tracked and addressed in a timely manner.

When a patient screens positive for a social need, the Applicant implements a two-pronged approach to intervention. First, a referral is placed to the social work team to provide individualized support and advocacy. Second, the BILH Find Help platform is utilized to offer patients a curated list of local resources or direct referrals based on their needs and preferences. This ensures that patients receive both immediate and longer-term assistance tailored to their personal circumstances.

b. Addressing Socioeconomic Barriers to Cancer Care

Timely access to cancer screening and treatment is essential for achieving better health outcomes. Unfortunately, socioeconomic challenges can significantly hinder patients' ability to access necessary cancer care.[63] Issues such as poverty, housing instability, and transportation problems often prevent

62 Colorectal Cancer Rates Are Skyrocketing in Young Adults—Is Your Lifestyle Putting You at Risk?, *supra* note 7.
63 Shen Li et al, *An Umbrella Review of Socioeconomic Status and Cancer*, NATURE COMMUNICATIONS (2024), available at https://www.nature.com/articles/s41467-024-54444-2.

patients from following best practice screening guidelines.[64] These same factors are associated with delays in starting treatment, receiving lower quality of care, and experiencing higher rates of missed treatments or early discontinuation, all of which negatively affect a patient's overall outcome.[65] By expanding access to high-quality endoscopy services, the Applicant seeks to address and reduce the barriers to treatment created by socioeconomic disadvantage. Expanding capacity at the Endoscopy improves access beyond procedural volume: patients will have more timely choices in scheduling their procedures at a convenient location within their community and within the BILH network. In addition, patients will continue to receive transportation assistance to ensure they can get to and from their procedure. As a result, the Proposed Project will promote health equity and align with the Commonwealth's broader efforts to reduce disparities and improve outcomes for all residents.

c. Patient Education

Additionally, BILH recently introduced a resource guide for newly arrived migrants, which is available in English, Spanish, and Haitian Creole. The guide, *Healthcare in Massachusetts: Important Information for Your First Few Months*, explains the types of care available in the state, how and when to access different levels of care, and provides valuable information on health insurance enrollment and payment assistance programs.

Factor 5: Relative Merit

F5.a.i **Describe the process of analysis and the conclusion that the Proposed Project, on balance, is superior to alternative and substitute methods for meeting the existing Patient Panel needs as those have been identified by the Applicant pursuant to 105 CMR 100.210(A)(1). When conducting this evaluation and articulating the relative merit determination, Applicant shall take into account, at a minimum, the quality, efficiency, and capital and operating costs of the Proposed Project relative to potential alternatives or substitutes, including alternative evidence-based strategies and public health interventions**.

Alternative Proposal 1: Extend operating hours at the Endoscopy Center.

Alternative Quality: Extending hours into the evenings and/or adding Saturday availability ignores the key factors that contribute to high-quality, patient-centered care. Endoscopy requires patients to prepare at home ahead of the procedure by fasting starting the night before. When procedures start in the late afternoon, patients must fast for an uncomfortably long period which increases the likelihood that the patient does not follow instructions and cannot have the procedure as scheduled. For similar reasons, patients are reluctant to schedule procedures following a holiday and the Hospital expects the same would be true for Saturdays. As a result, this alternative is unlikely to meaningfully increase access to endoscopy.

Alternative Efficiency: While using existing space for extended hours may seem efficient, this alternative introduces inefficiencies related to scheduling and staffing. Evening and weekend sessions are historically underutilized, leading to suboptimal use of resources. Scheduling outside of standard hours may result in increased cancellations or no-shows, as patients are less willing to undergo procedures at inconvenient times. Furthermore, overtime requirements for staff increases operating costs while ensuring physician availability adds operational complexity.

Alternative Capital Expenses: There are no capital expenses under this alternative.

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[64] *Id*.

[65] Amber Bourgeois et al, *Barriers to Cancer Treatment for People Experiencing Socioeconomic Disadvantage in High-Income Countries: A Scoping Review*, BMC HEALTH SERV RES, (2024), available at https://pmc.ncbi.nlm.nih.gov/articles/PMC11134650/.

Alternative Operating Costs: Operating costs would be higher due to overtime pay, shift differentials, and potential premium rates for physicians and ancillary staff as an incentive to work non-standard hours.

Alternative Proposal 2: Expand endoscopy space at the Hospital's main campus.

Alternative Quality: Expanding endoscopy services at the Hospital's main campus does not align with the goal of providing care in more convenient, stand-alone facility The hospital environment may be less comfortable and accessible for patients seeking routine outpatient procedures, potentially impacting patient satisfaction and adherence to recommended screenings. Furthermore, the main campus hospital lacks physical space for expanded endoscopy services.

Alternative Efficiency: The Hospital does not have any available physical space at the main campus to expand surgical capacity. As a result, any expansion of endoscopy services at the main campus would require the reduction of capacity for other surgical service lines. This process would not only be disruptive to patients but would require reducing the availability of block time for other surgical services, potentially creating wait times and backlogs for other needed services.

Alternative Capital Expenses: This alternative would require a substantial capital expenditure in order to create a dedicated space on the Hospital's main campus.

Alternative Operating Costs: Operating costs would be similar to the Proposed Project under this alternative if services were offered during standard hours.

Factor 6. Community Health Initiative

A. Community Health Initiative Monies

This Application requests approval for the expansion of Winchester Hospital Endoscopy Center (the "Proposed Project"). The Maximum Capital Expenditure (MCE) for the Proposed Project is $1,912,573. The breakdown of Community Health Initiative (CHI) monies for the Proposed Project is as follows, beginning with the MCE.

CHI Monies	Total	Description
MCE	$1,912,573.00	DoN Maximum Capital Expenditure
CHI Monies	$95,628.65	5% of Maximum Capital Expenditure
Administrative Fee	$3,825.15	4% of the CHI Monies, retained by Applicant
Remaining Monies	$91,803.50	CHI Monies minus the Administrative Fee
Statewide Initiative	$9,180.35	10% of remaining monies, paid to State-wide Fund
Local Initiative	$82,623.15	90% of remaining monies
Evaluation Monies	$8,262.31	10% of Local Initiative Monies, retained by Applicant
CHI Monies for Local Grants	**$73,360.84**	

B. Winchester Hospital's Community Health Needs Assessment

The CHI processes and community engagement for the Proposed Project will be conducted by Winchester Hospital (the "Hospital"), a community hospital primarily serving Medford, North Reading, Reading, Stoneham, Tewksbury, Wakefield, Wilmington, Winchester, and Woburn (*hereinafter referred to as the Community Benefits Service Area* (CBSA)*)*. Winchester Hospital provides inpatient and outpatient health services as well as 24-hour emergency services. Since 1912, Winchester has played a vital role in the lives of people who reside in its Service Area. Winchester Hospital is committed to helping improve the health and wellbeing of its community through a variety of ways. These include leveraging hospital

resources, creating and collaborating on programs with community organizations and stakeholders to address the unmet health needs for underserved populations. To understand the needs of the community, the Hospital conducts a Community Health Needs Assessment (CHNA) in the Hospital's CBSA every three years. The Winchester Hospital 2025 CHNA was approved by the Board of Trustees on September 9, 2025, findings were publicly shared on September 17, 2025, and published on Winchester Hospital's website on September 30, 2025, linked here Winchester 2025 Community Health Needs Assessment

The CHNA serves to:

- Assess community health need, defined broadly to include health status and disparities, social determinants, environmental factors, and service system strengths and weaknesses;
- Engage the community, including local health departments, service providers across sectors and community residents, as well as Winchester Hospital leadership and staff; and
- Identify the leading health issues and the population segment most at-risk based on a review of the quantitative and qualitative information gathered by the assessment.

Winchester Hospital utilizes a participatory, collaborative approach to carry out each CHNA and is committed to exploring health in its broadest context. The CHNA process includes a community listening session, a community health survey, focus groups and interviews. Winchester Hospital collects information from community residents with a special focus on those not typically engaged/included in such processes, hospital leadership, service providers, public health, public officials and other key stakeholders. Winchester Hospital also analyzes quantitative and qualitative data on demographics and various social determinants of health (e.g., income, employment, transportation, education, housing, food, etc.), as well as health status and access to care and services. Throughout the CHNA process, the hospital relies on the input and oversight of its Community Benefits Advisory Committee (CBAC) and key hospital leadership. The Winchester Hospital CBAC includes a diverse group of individuals and organizations, ensuring input and decision-making reflective of the community. Accordingly, the CHNA report illustrates key findings of the assessment process, which continues to explore a range of health behaviors and outcomes; social and economic issues; including the social determinants of health; health care access and gaps; and strengths of existing resources and services.

C. Advisory Committee Duties

Winchester Hospital is committed to a transparent and community-engaged process with respect to its CHNA, its Implementation Strategy and this CHI. The Hospital's CBAC membership intentionally reflects sector requirements outlined in the CHI guidelines and will serve as the decision-making body for this CHI. As outlined in the CBAC's Charter, its scope of work will include:

- Assisting Winchester Hospital staff with appropriate engagement with residents from focused communities and community partners around the CHI.
- Determining the Health Priority(ies) for CHI funding based upon the needs identified in the 2025 CHNA and in alignment with the Department of Public Health's Health Priorities and the Executive Office of Health and Human Services' Focus Areas.
- Selecting strategies to address the identified Health Priorities.
- Advising Winchester Hospital staff and leadership on the solicitation process and awardee selection.

D. Timeline for CHI Activities

The timeline for CHI activities is as follows:

- 6 weeks post-approval: The CBAC will begin meeting and reviewing the most recent CHNA to commence the process of selecting CHI Health Priorities for funding.
- 4 months post-approval: CBAC members select the CHI Health Priorities and Strategies and participate in a Conflict-of-Interest disclosure process; eligible CBAC members advise on the funding method to use, assist with the development of parameters for funding and evaluation and funding decisions are made.
- 9 months post-approval: Disbursement of funds begins.
- 9 months – 3 years post approval: Strategies are implemented; monitoring, evaluation and reporting with community partners is completed on an annual basis.
- 3 – 4 years post-approval: Final evaluation and reporting of funded projects to DPH.

E. Administrative Monies

Applicants submitting a Tier 1 CHI are eligible to retain a four percent (4%) administrative fee. Accordingly, Winchester Hospital is requesting $3,825.15 in administrative funding. These monies will support promotion of meetings, interpretation/translation, community engagement, stipends for community resident participation, additional staff time for these efforts.

F. Evaluation Overview

Winchester Hospital is seeking to use 10% of local CHI funding, $8,262.31, for evaluation efforts. These monies will allow Winchester Hospital to retain the expertise of the BILH Manager of Program Design and Evaluation to develop appropriate evaluation metrics of the CHI-funded project(s).