UMass Memorial Health
UMASS MEMORIAL MEDICAL CENTER

# Community Benefits Strategic Implementation Plan, 2025–2027

**An Affiliate of UMass Memorial Health**
A Community Health Improvement Approach
to Addressing Health Inequities

UMass Memorial Health
UMASS MEMORIAL MEDICAL CENTER

UMass Memorial Medical Center (Medical Center) located in Worcester, MA, is the three-campus (University Campus, Memorial Campus and Hahnemann Campus) academic medical center of UMass Memorial Health (UMass Memorial), the largest not-for-profit healthcare delivery system in Central Massachusetts with 2,400 physicians, 249,000 adult primary care patients, and 46,000 pediatric primary care patients. The Medical Center is a teaching hospital and the clinical partner of the University of Massachusetts Chan Medical School with access to the latest technology, research, and clinical trials.

UMass Memorial's Community Benefits Mission was developed and recommended by the Community Benefits Committee and approved by the UMass Memorial Board of Trustees. UMass Memorial recognizes that healthcare delivery represents only a portion of an individual's and a community's health and to totally transform our communities, we must use our full reach to more actively address the social, economic, and environmental factors that are the primary contributors to a healthy community.

Our Community Benefits Strategic Implementation Plan targets the social/health factors that are important in the delivery of care. Our public health approach centers anchor institutions including our school system, local health centers, programming focused on youth placed-at-risk, institutions of higher education and academia, maternal health, equitable access to care for marginalized communities, as well as collaborative efforts that include direct partnership with the City of Worcester's Public Health Department, and partners like the Coalition for a Healthy Greater Worcester to leverage unique opportunities to address social factors and improve the health of the Greater Worcester community.

# UMass Memorial has Adopted the Following Mission, Vision, and Values:

### UMASS MEMORIAL MISSION
### – A STATEMENT ABOUT OUR PRESENT AND WHY OUR ORGANIZATION EXISTS

UMass Memorial Health is committed to improving the health of the people of our diverse communities of Central New England through culturally sensitive excellence in clinical care, service, teaching, and research.

### UMASS MEMORIAL VISION
### – A STATEMENT ABOUT OUR FUTURE AND WHAT WE WANT TO BE

As one of the nation's most distinguished academic healthcare systems, UMass Memorial will provide leadership and innovation in seamless healthcare delivery, education, and research, all of which are designed to provide exceptional value to our patients.

### UMASS MEMORIAL VALUES
### – A GUIDE TO OUR DECISION-MAKING AS WE MOVE TO OUR FUTURE

- Consistently excelling at patient–centered care
- Acting with personal integrity and accountability
- Respecting one another
- Effecting change through teamwork and system thinking
- Supporting our diverse communities

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# Summary: Community Benefits Strategic Implementation Plan

This Community Benefits Strategic Implementation Plan is based on the findings of the 2024 Community Health Assessment (CHA) published by insert UMass Memorial Medical Center (Medical Center) in September of 2024 and aligns with the 2021-2026 Greater Worcester Community Health Improvement Plan (CHIP – revised in the fall of 2024) to maximize collective impact.

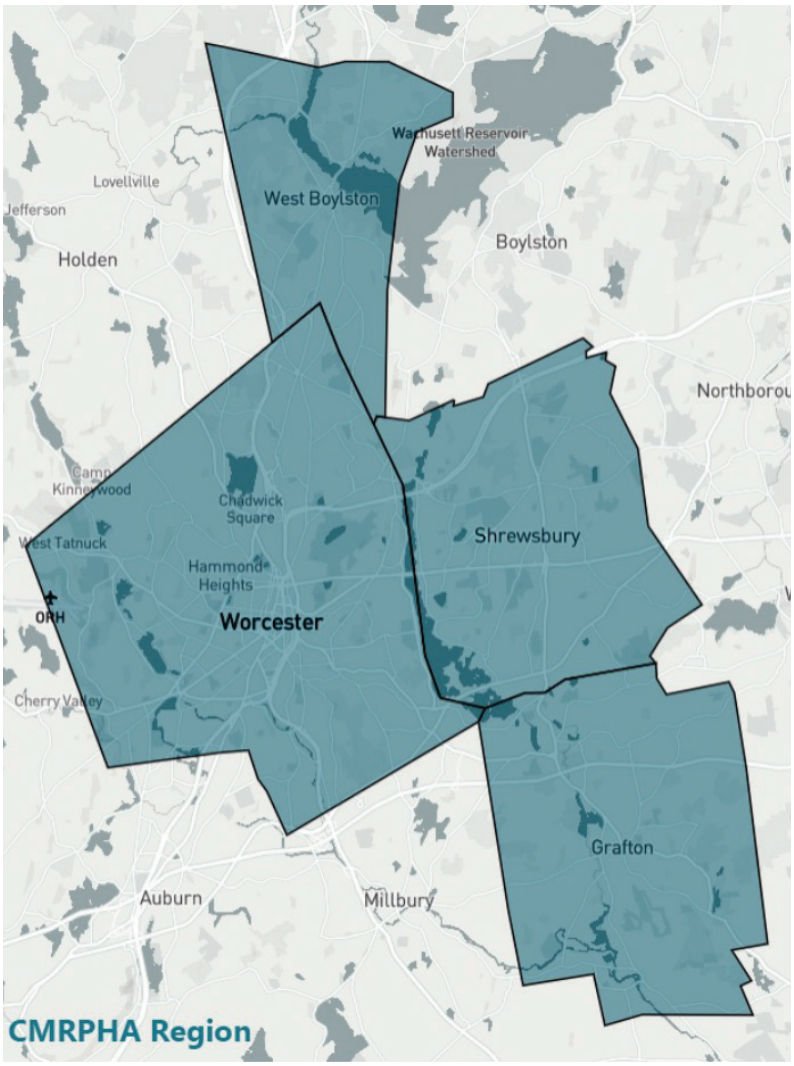
The CHA's aim was to gain a greater understanding of the unmet health and social services needs of residents of greater Worcester and Central Massachusetts as well as how those needs are currently being addressed and where there are gaps and opportunities to address those needs in the future.

The study was a collaborative effort with the City of Worcester Health and Human Services Department, the Medical Center, Fallon Health, Central Massachusetts Regional Health Alliance, and the Coalition for a Healthy Greater Worcester. Various other organizations and individuals also contributed to this effort, including community-based organizations, hospital stakeholders and residents of the service area.

## DEFINITION OF THE COMMUNITY SERVED

The City of Worcester, the second largest city in New England, is very ethnically diverse, with a high poverty rate and many social-economic challenges. The 2024 CHA focuses on the City of Worcester and the outlying towns of the Central Massachusetts Regional Public Health Alliance (CMRPHA), which include Grafton, Shrewsbury, and West Boylston, sub-sections of its primary service area. This specific geographic area is the focus for the City of Worcester Division of Public Health's regionalization initiative and overlaps with UMass Memorial Medical Center's service area and of many other local organizations. Focusing on this geographic area facilitates the alignment of the hospital's efforts with community and governmental partners, specifically the city public health department, the area's Federally Qualified Health Centers, and multiple community-based organizations.

The CHA process synthesized statistics from secondary sources like the United States Census Bureau, the Massachusetts Department of Public Health, Worcester Division of Public Health, and the participating hospital systems with qualitative information gathered through pre-existing surveys of residents and focus groups of stakeholders from across the partner hospitals' service areas. This comprehensive, integrative process resulted in the identification of specific "Priority Populations" and "Priority Issues" for the hospitals to address through their Community Benefits work. Throughout the CHA

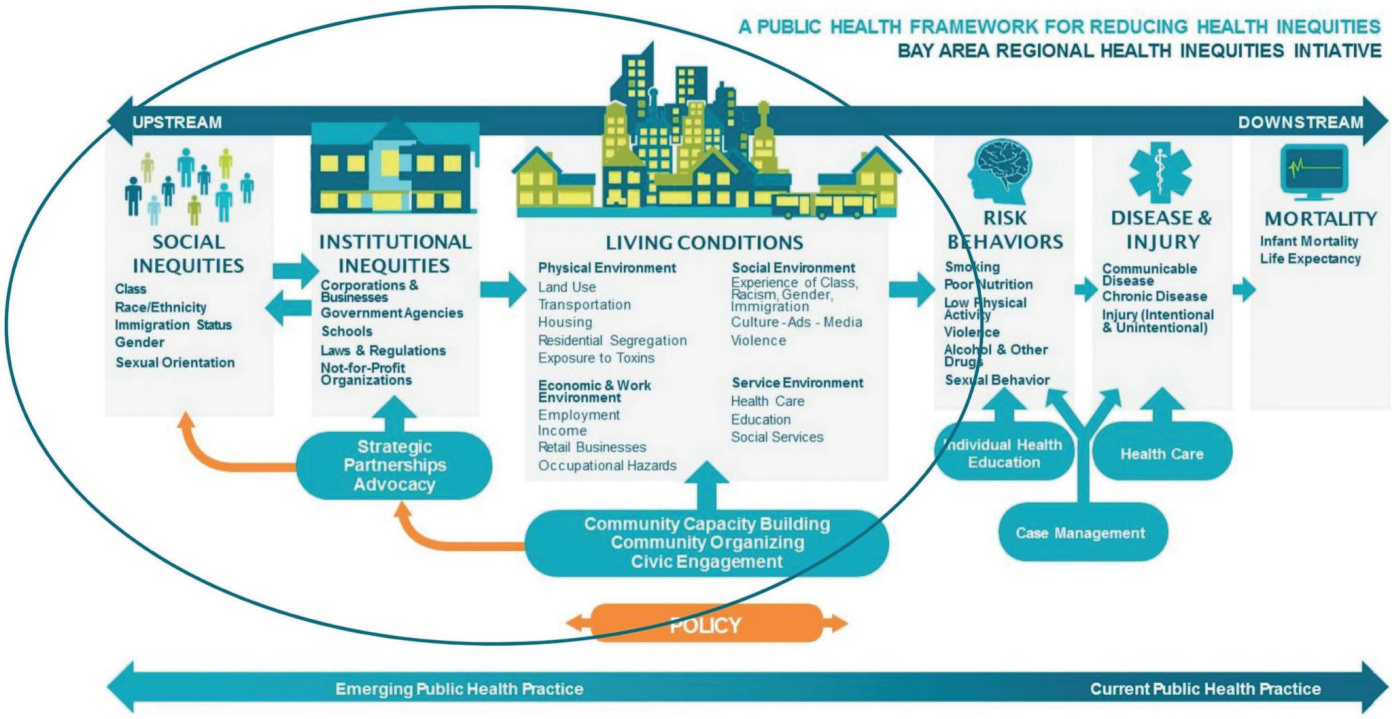


process, special attention was paid to issues of health-related social needs or social drivers of health (SDOH) and their impact on health disparities and health equity.

Health-related social needs are conditions in the places where people live, learn, work, and play that affect a wide range of health outcomes. According to the World Health Organization [1], research has shown up to half of all health outcomes are influenced by non-clinical factors like access to nutritious food, reliable transportation, quality housing, and financial stability. As a result, and in keeping with the Centers for Medicare & Medicaid Services' (CMS's) new guidelines mandating that hospitals screen for SDOH, the Medical Center is increasingly recognizing the critical role of addressing Health-Related Social Needs in community health, particularly for members of traditionally marginalized communities.

While hospitals have always focused on caring for their communities both inside the hospital and through Community Benefits work, the new CMS requirements mandate that hospitals better connect patients with community-based resources and participate in "upstream" and "midstream" efforts to reduce negative health outcomes.

The Bay Area Regional Public Health Framework for Reducing Health Inequities (the BARHII framework) [2] (see graphic below) is a pathway for health that involves people and communities. The far right of the graphic represents the "downstream" part of the health pathway, where the traditional medical model of treating disease focuses. While interventions here are crucial, the Medical Center recognizes the importance of involving our communities in health improvement efforts further "upstream" to prevent disease. Some strategies, often called "midstream" strategies, include prevention efforts focusing on individual risk and supporting behavior change. Other strategies move further upstream and address the policy, systems, and environments impacting health outcomes for entire populations exposed to them. All the way upstream, on the far left, are the structural drivers of health: institutional and social inequities like structural racism and the inequitable distribution of power, money, opportunity, and resources. The farthest left is the "groundwater," referring to the policies and interconnected systems perpetuating inequities.




*Source: Bay Area Regional Health Inequities Initiative. BARHII Framework. Accessed July 2024 at: https://barhii.org/framework*

With the BARHII framework and the Public Health Institute's Five Core Principles for Advancing the State of the Art in Community Benefit [3] as our guides, the Medical Center's Community Benefits Program strives to meet and exceed the Schedule H/Form 990 IRS mandate to "promote health for a class of persons sufficiently large so the community as a whole benefits."

# Identifying Priority Populations and Priority Areas

Between July and September 2024, the Community Health Assessment (CHA) planning committee, along with hospital leaders and their Community Benefits and Patient & Family Advisory Committees, reviewed the findings of the CHA. In addition, the Medical Center Community Benefits' leadership also considered the hospital's strategic priorities, health equity plan, and existing community health efforts. The goal of this review process was to develop and elevate Priority Populations and Priority Areas on which to focus Community Benefits' investments over the next several years though this Strategic Implementation Plan.

## PRIORITY POPULATIONS

The Medical Center's Community Benefit Strategic Implementation Plan (SIP) includes strategies and activities that will support residents throughout its service area and from all segments of the population. However, based on the 2024 Community Health Assessment's (CHA's) quantitative and qualitative findings, including discussions with a broad range of community participants, the Medical Center's SIP will prioritize certain demographic and socio-economic segments of the population that have complex needs or face particular barriers to care, service gaps, or adverse social drivers of health that can put them at greater risk.

Specifically, the assessment identified the following groups of community members as the Priority Populations for the SIP:

### PRIORITY POPULATIONS OVERVIEW

#### People Living in Poverty/Low-income Individuals and Families

People with low socio-economic status who struggle to afford basic household items (healthy food, utilities, weather, and appropriate clothing).

#### Non-English Speakers and Recent Immigrants

Undocumented persons, migrants, immigrants, and refugees.

#### BIPOC/Black, Indigenous, and People of Color

Black, indigenous, and other people of color, people of historically marginalized ethnic groups, including in our area: Hispanic/Latinos; Portuguese/Brazilians; Arabic; Haitian-Creole; Hmong; and West and East Africans.

#### People Experiencing Homelessness

Both individuals and families who lack a fixed, regular, and adequate night-time residence.

#### People Living with Substance Use Disorder

Both individuals and families.

#### People in Reentry from Incarceration

People who need reinsertion into society and their communities after jail time.

#### Older Adults (75+)

The aging population (75+) whose concerns center around transportation, isolation, mental health, and substance use.

#### Women and Girls/Birthing People

Someone who gives birth, regardless of their gender identity, which may be female, male, nonbinary, or other.

#### Veterans

Persons who served in the active military, Naval or Air Service, and who were discharged or released.

## PRIORITY AREAS

The Medical Center's Community Benefits' SIP includes strategies and activities that will have a broad impact on the health and well-being of residents of the Greater Worcester area and Central Massachusetts. However, based on the 2024 Community Health Assessment, the 2021 Community Health Implementation Plan (CHIP,) and the 2024 revised CHIP findings, including discussions with a broad range of community participants, the Medical Center's SIP will prioritize certain areas:

## PRIORITY AREA OVERVIEW

### #1: BUILT ENVIRONMENT

- Location, quality, and cultural sensitivity of food access points
- Supporting of local and regional food system – buying local

### #2: AFFORDABLE, SAFE HOUSING

- Affordable, safe housing
- Addressing risk of housing insecurity
- Transitional housing

### #3: HEALTHCARE & PUBLIC SYSTEMS NAVIGATION

- Navigating public benefits
- SNAP/HIP/TANF enrollment
- Alternative, accessible clinical options for vulnerable populations

### #4: HEALTHCARE WORKFORCE

- Allied Health career pathway and workforce development opportunities

### #5: CULTURALLY RESPONSIVE HEALTHCARE

- Black maternal and birther health
- Culturally proficient/congruent care

Recognizing the value of diverse voices in planning, and with the above Priority Populations and Priority Areas identified, the Medical Center Community Benefits' leadership facilitated a process by which key stakeholders, including healthcare providers, administrators, and frontline caregivers; community-based organizations; and patients proposed various strategies and activities to serve as the foundation for Community Benefits work over the next three years. In addition, proposed strategies and activities were reviewed alongside UMass Memorial Health's Community Benefits Mission, Anchor Mission, and Health Equity Mission as well as the corresponding strategic plans to ensure system's level alignment and allow for the leveraging of resources.

## UMASS MEMORIAL COMMUNITY BENEFITS MISSION

UMass Memorial Health is committed to improving the health status of all those it serves and to addressing the health problems of the poor and other medically underserved populations. In addition, nonmedical conditions that negatively impact the health and wellness of our community are addressed.

## UMASS MEMORIAL ANCHOR MISSION

A commitment to use our business and economic power and our human and intellectual resources to better the long-term health and economic well-being of Central Massachusetts communities.

## UMASS MEMORIAL COMMUNITY HEALTH EQUITY MISSION

Align our resources, power, and privilege to effectively partner with, invest in, and remove barriers to thriving, beginning with supporting a just regional food system in Central Massachusetts.

# Levers Framework

Finally, proposed strategies and activities were overlaid on UMass Memorial Health's Levers Framework. The Levers Framework is a system-wide structure that guides overarching strategy formation as well as initiatives at the community hospital level. The interconnected levers of Policy & Advocacy, Infrastructure Development, Investing and Purchasing, and Clinical & Social Care Integration enable the health system to address social drivers of health (SDOH), reduce disparities, and achieve both clinical and community goals. Specifically:

**POLICY AND ADVOCACY** focuses on systemic change by developing strategies and advocating for initiatives like expanded healthcare access, affordable housing, and improved nutrition programs. By educating and collaborating with policymakers, stakeholders, and the public, hospitals drive regulations and investments that improve Population Health and address root causes of inequity.

**INFRASTRUCTURE DEVELOPMENT** strengthens the foundation for care delivery through investments in infrastructure, advanced data systems, and workforce development. Hospitals use patient data to inform decisions, address disparities, and optimize resource distribution. Recruiting, training, and retaining a skilled and diverse workforce also ensures responsive, equitable care while addressing critical staffing shortages. Capacity building can also include supporting community-based organizations with training, board members, and volunteers, helping to expand their capacity and enhance service delivery in local communities.

**INVESTING AND PURCHASING** focuses on systemic change by developing strategies and advocating for initiatives like expanded healthcare access, affordable housing, and improved nutrition programs. By educating and collaborating with policymakers, stakeholders, and the public, hospitals drive regulations and investments that improve Population Health and address root causes of inequity.

**CLINICAL AND SOCIAL CARE INTEGRATION** bridges the gap between medical and social care, ensuring holistic patient support. Hospitals assess and address SDOH alongside clinical needs by leveraging non-traditional health services, delivering care in non-traditional settings, and providing case management and navigation services. These approaches connect patients with resources that tackle disparities and improve overall well-being.

Together, these Levers reflect UMass Memorial's commitment to a system-wide approach that aligns with and amplifies efforts at community hospitals, creating a unified strategy to improve health outcomes, reduce inequities, and support the diverse needs of the populations served.

## LEVERS FRAMEWORK OVERVIEW

### Policy and Advocacy

Policy involves developing and supporting strategies or regulations that address SDOH and promote community well-being, including initiatives like advocating for improved healthcare access, affordable housing, and nutrition programs. Advocacy focuses on educating and collaborating with policy makers, stakeholders, and the public to drive systemic changes that improve populations health.

### Infrastructure Development

Infrastructure Development involves enhancing infrastructure, data systems, and work force capacity. This includes using robust patient data to guide decision-making, identify disparities, and allocate resources effectively while addressing critical staffing shortages through recruiting, training, and retaining a skilled and diverse work force. It also includes supporting community-based organizations with training to expand capacity and enhance service delivery.

### Funding and Investing

Funding and Investing involves the strategic distribution of financial, human, and material resources, including prioritizing local purchasing to support the regional economy and investing in community-based programs that align with the hospital's mission, such as initiates addressing SDOH and promoting equity. These efforts ensure resources maximize community impact while advancing the hospital's objectives.

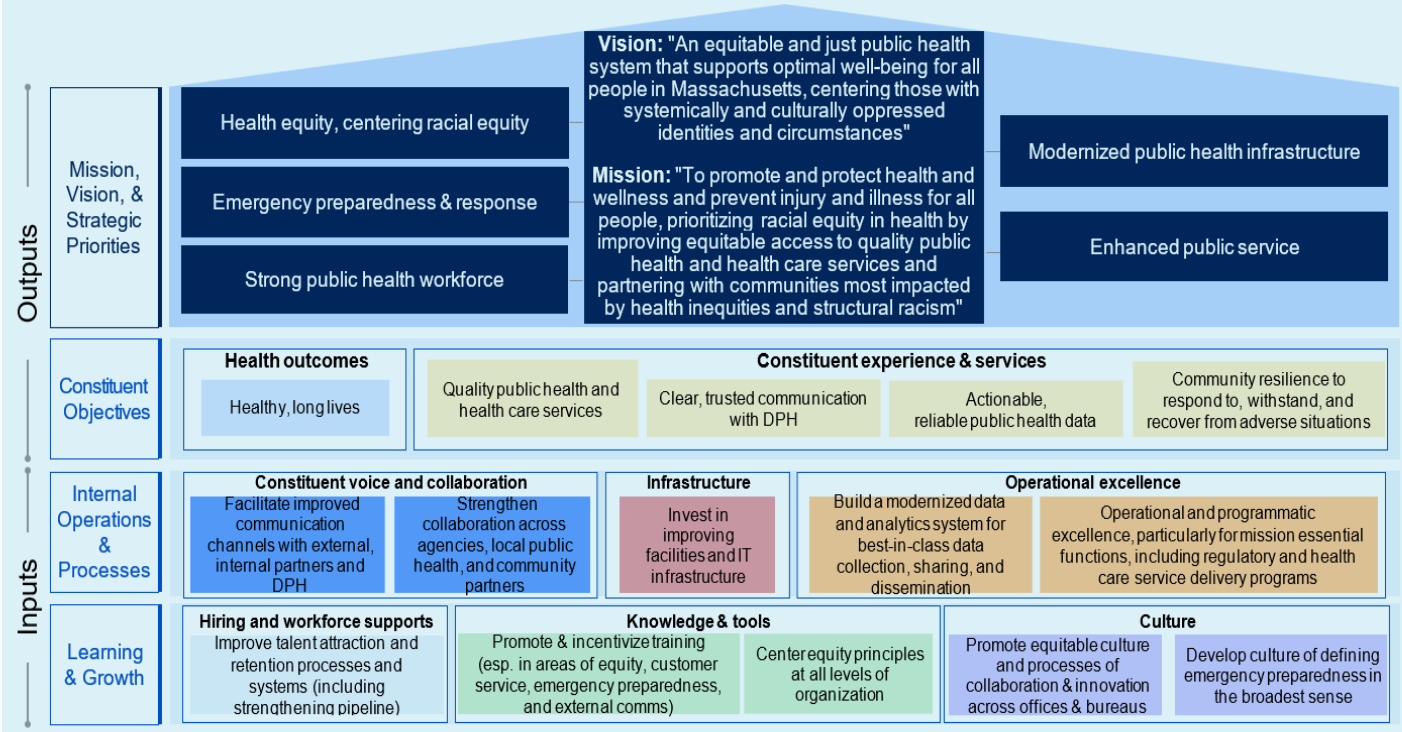
### Social and Clinical Care Integration

Social and Clinical Care Integration is the coordination of medical care and social support services. It involves assessing and addressing SDOH alongside clinical needs. It includes leveraging non-traditional locations and providing case management and care navigation to connect patients with essential resources to address the root causes of health disparities and enhance patient well-being.

# The Community Benefits Strategic Implementation Plan 2025–2027

UMass Memorial Health is committed to improving the health status of all those it serves and to addressing the health problems of the poor and other medically underserved populations. In addition, nonmedical conditions that negatively impact the health and wellness of our community are addressed. The summary of the Medical Center's Community Benefits Priority Areas and Goals are listed below, followed by the detailed Community Benefits Strategic Implementation Plan (SIP). As mentioned previously, the Medical Center's plan aligns with findings of the Community Health Assessment and the Greater Worcester Community Health Improvement Plan. The SIP will be tracked and updated annually. In addition, the SIP takes into consideration the Massachusetts Department of Public Health (DPH) Strategic Priorities:

## DPH STRATEGY MAP



# Priority Plans

PLEASE NOTE: The 2024-2027 Greater Worcester Community Health Assessment identified six priority areas. The Medical Center has identified five of the six as specific areas of focus except for Access to Quality, Reliable Broadband. Although Medical Center leaders have engaged with digital equity efforts by the City of Worcester including local qualitative and quantitative assessments to inform grant application efforts and will continue to be a thought-partner in the developing work, we would have a greater impact in the priority areas listed below:

| CHA PRIORITY AREAS | PRIORITY GOALS |
|---|---|
| **#1: Food Access**<br>**SDOH: Built Environment**<br>*Improve food security and access to a just food system.* | Align community health improvement activities by utilizing the resources, power, and privilege of the Medical Center to effectively partner with community to invest in a just, equitable, sustainable, and coordinated local food system. |
| **#2: Affordable, Safe Housing**<br>**SDOH: Housing**<br>*Support efforts to address the growing housing crisis disparately affecting our diverse communities.* | Leverage the Medical Center, and Community Benefits resources to support internal and community efforts that focus on affordable and safe housing. |
| **#3: Healthcare and Public Systems Navigation**<br>**SDOH: Healthcare Access**<br>*Improve health equity and health literacy for our most vulnerable.* | Develop and sustain community/clinical linkages with community stakeholders to address health disparities including accessing public benefits, navigation of the healthcare system, alternative care options, and social care coordination and provision. |
| **#4: Healthcare Workforce**<br>**SDOH: Economic Stability and Employment**<br>*Improve the economic well-being of our communities through equitable and accessible workforce opportunities.* | Develop, support, and sustain efforts internally, and by community partners that improve career pathway opportunities that disrupt generational poverty, promote a livable wage, and utilize the strengths of our diverse communities. |
| **#5: Culturally Responsive Healthcare**<br>**SDOH: Social and Community Environment**<br>*Address racialized health disparities to improve the health of our diverse communities and close the life expectancy gap for people of color.* | Develop and support strategies, structures, and practices to effect policy, systems, and environmental change in our communities. |

*Note: Measures of success/metrics (intended impact) are identified for the above Priority Areas at the Objective and Strategy levels outlined later in this document.*

PRIORITY 1:

# Food Access

**Goal:** Align community health improvement activities by utilizing the resources, power, and privilege of the Medical Center to effectively partner with community to invest in a just, equitable, sustainable, and coordinated local food system.

| Objective 1.1: Improved healthy food security and access in the UMass Memorial Health service area. | | |
|---|---|---|
| **Outcome Indicators: (Medical Center Community Health Equity Team)** | **Intended Annual Impact** | **Actual Outcomes** |
| Patients who screened positive for food insecurity are connected to appropriate food resources and engaged to inform and enhance UMass Memorial Community Health Equity Team (CHET) initiatives to develop a just, regional food system. | 100 patients | Year 1:<br>Year 2:<br>Year 3: |
| Number of patients accessing healthy food through the Food is Medicine Fresh Connect Program. | Provide 250 enrolled patients gift cards to purchase produce | Year 1:<br>Year 2:<br>Year 3: |
| Grant support of local efforts that address food access/security. | At least 10 local mobile markets by the Regional Environmental Council (DoN/CHI 3-Year Project) | Year 1:<br>Year 2:<br>Year 3: |
| In-kind community health support to assist local community-based organization's capacity in community outreach efforts. | 100 hours of support provided to El Buen Samaritano Food Pantry by Outreach Liaison | Year 1:<br>Year 2:<br>Year 3: |

| Objective 1.2: Align UMMH resources and investment to drive impact based on community food system priorities. | | |
|---|---|---|
| Food purchasing from hubs of small-, local-, and minority-owned businesses (e.g., small farmers, CBOs, freight farms, etc.) | 10% increase in the purchasing of local food producers and utilization of local distributors | Year 1:<br>Year 2:<br>Year 3: |
| Number of efforts supported through a range of means including oral and written testimony and support of other Worcester Food Policy Council, Worcester Together, MA Food Action Plan, and others. | Participation in a minimum of three community coalition-based efforts annually | Year 1:<br>Year 2:<br>Year 3: |
| Anchor Mission investment decisions will prioritize projects with food system impact. | 40% of all Anchor Mission investments | Year 1:<br>Year 2:<br>Year 3: |

| Strategies | Timeline |
|---|---|
| **1.1.1** Leverage programs that connect patients to fresh, healthy food (e.g., Food is Medicine) to contribute to a just and inclusive food system. Development of the UMass Memorial system strategy to contribute to a just and equitable regional food system for all service areas and aligned resources for aligned needs specific to each service area leveraging CHET. | Years 1, 2, 3 |

*Continued on following page.*

PRIORITY 1:

# Food Access

| Strategies | Timeline |
|---|---|
| **1.1.2** Leverage programs that connect patients to fresh, healthy food (e.g., Food is Medicine) to contribute to a just and inclusive food system. | Years 1, 2, 3 |
| **1.1.3** Through the social needs screening, invest in platforms and processes that support the coordination of food resources to improve awareness and access to food-related programs (SNAP/HIP). | Years 1, 2, 3 |
| **1.1.4** Provide support to local partners through equitable grant making, and in-kind contributions. | Years 1, 2, 3 |
| **1.2.1** Increase the proportion of UMass Memorial food purchasing and composting to support local producers and distributors with a concerted effort toward small and disadvantaged businesses. | Years 1, 2, 3 |
| **1.2.2** Support a range of efforts to address food insecurity and healthy nutrition among vulnerable populations through continued active participation as a member of the Worcester Food Policy Council Steering Committee, the Coalition for a Healthy Greater Worcester's Steering Committee and other community coalitions including Worcester Together. | Years 1, 2, 3 |
| **1.2.3** Align Anchor Mission Impact Purchasing and Community Benefits to support local, fresh food systems in the Medical Center service area. | Years 1, 2, 3 |
| **1.2.4** Memorialize food access as priority for Anchor Mission investments. | Years 1, 2, 3 |
| **1.2.5** Collaborate and support community-based efforts of the Food Policy Council focus including: SNAP benefits and range of issues to improve access in underserved, food insecure areas including healthy food retailers, SNAP (food stamp) and expanding urban agriculture opportunities. | Years 1, 2, 3 |

## MONITORING/EVALUATION APPROACH

- End of year reports (Community Benefits Annual Report, North Pavilion DoN/CHI).
- Number of Farmer's Markets by the Regional Environmental Council.
- % and total amount of spend to diverse and local food vendors reported Anchor Mission Purchasing Pillar.
- Amount of the Medical Center service area Anchor Investment.
- Policies influenced to address access to healthy foods.

PRIORITY 2:

# Affordable, Safe Housing

**Goal:** Leverage the Medical Center, and Community Benefits resources to support internal and community efforts that focus on affordable and safe housing.

| Objective 2.1: Improved access to safe, affordable housing in the UMMMC service area. | | |
|---|---|---|
| **Outcome Indicators: (UMMMC, various partners)** | **Intended Annual Impact** | **Actual Outcomes** |
| Number of affordable housing projects via Anchor Mission place-based investing. | 10 Units Developed | Year 1:<br>Year 2:<br>Year 3: |
| Number of individuals that received assistance to prevent housing loss in partnership with Central MA Housing Alliance (CMHA). | # of individuals identified in the CMHA DoN project scope | Year 1:<br>Year 2:<br>Year 3: |
| Participation in safe, affordable housing meetings/convenings. | Participation in 75% of related meetings/convenings | Year 1:<br>Year 2:<br>Year 3: |

| Objective 2.2: Improve the behavioral, mental, and physical health of individuals with housing needs through coordinated clinical and social care efforts. | | |
|---|---|---|
| Number of individuals served through the Medical Respite Program in partnership with the Medical Center and the South Middlesex Opportunity Council for patients with complex chronic illness and/or mobility issues. | 10 unduplicated patients served | Year 1:<br>Year 2:<br>Year 3: |
| Assist community-based organizations with infrastructure development for supportive housing that address housing needs and associated behavioral health in partnership with the Latin American Health Alliance and Zach's House. | At least 30 individuals served | Year 1:<br>Year 2:<br>Year 3: |

| Strategies | Timeline |
|---|---|
| **2.1.1** Anchor Mission investment decisions will prioritize housing projects. | Years 1, 2, 3 |
| **2.1.2** Support local and regional efforts to assist individuals experiencing housing insecurity in the Medical Center service area through equitable grant making opportunities. | Years 1, 2, 3 |
| **2.1.3** UMass Memorial will align and engage with City of Worcester's Housing Department's strategic housing planning efforts including the City's Housing Production Plan (pending City Council approval in March, 2025); Affordable Housing Trust Fund Strategic Plan; and the City of Worcester, Worcester Housing Authority and Worcester Continuum of Care's 5-year Strategic Plan. | Years 1, 2, 3 |

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PRIORITY 2:

# Affordable, Safe Housing

| Strategies | Timeline |
|---|---|
| **2.2.1** The Medical Center Community Benefits Department's Medical Director will continue to lead the Medical Respite Program in partnership with South Middlesex Opportunity Council. | Years 1, 2, 3 |
| **2.2.2** The North Pavilion DoN/CHI grant administration process will provide ongoing technical assistance to 3-year project grantees offered through Radiant Legacy, LLC in the areas of leadership coaching, organizational development, and a community of practice. | Years 1, 2, 3 |
| **2.2.3** The North Pavilion DoN/CHI grant administration process will provide ongoing technical assistance to 1-year project grantees offered through Radiant Legacy, LLC in the areas of leadership coaching, organizational development, and a community of practice. | Years 1, 2, 3 |
| **2.2.4** The North Pavilion DoN/CHI grant administration process includes provision of evaluative services by Health Resources in Action (HRiA) for 3-year and 1-year project grantees. | Years 1, 2, 3 |

## MONITORING/EVALUATION APPROACH

- End of year reports (Community Benefits Annual Report, North Pavilion DoN/CHI).
- Amount of the Medical Center service area Anchor Investment for housing-related projects.
- HRiA evaluation reports for identified partners.
- Year-end funding reports for all housing related Community Benefits activities.
- Medical Respite Program year-end report and analysis.
- SDOH screener data positive for housing.

PRIORITY 3:

# Healthcare and Public Systems Navigation

**Goal:** Develop and sustain community/clinical linkages with community stakeholders to address health disparities including accessing public benefits, navigation of the healthcare system, alternative care options, and social care coordination and provision.

## UMASS MEMORIAL RONALD MCDONALD CARE MOBILE

**Objective 3.1: Deliver neighborhood-based medical and preventive dental mobile services at 11 sites and 28 schools as a means of decreasing access to care barriers and connecting underserved populations to on-going care.**

| Outcome Indicators: (UMass Memorial Care Mobile) | Intended Annual Impact | Actual Outcomes |
|---|---|---|
| Number of patients seen at neighborhood sites through the Care Mobile program. | A minimum of 1,000 total patients | Year 1:<br>Year 2:<br>Year 3: |
| Number of people vaccinated at Care Mobile clinics. | A minimum of 250 people | Year 1:<br>Year 2:<br>Year 3: |
| Reduce the proportion of children with dental caries experience in their primary and permanent teeth in the City of Worcester by providing the following preventive services through the UMass Memorial Care Mobile school-based program, which includes:<br>· Screenings<br>· Sealants<br>· Fluoride varnishes<br>· Dental prophylaxis<br>· Oral Health education | A minimum of 2,500 total visits | Year 1:<br>Year 2:<br>Year 3: |
| Coordination of Oral Health Providers Task Force to ensure preventive services are delivered in schools in the City of Worcester due to the lack of fluoridation in the water supply. | Meets a minimum of three times annually | Year 1:<br>Year 2:<br>Year 3: |

| Strategies | Timeline |
|---|---|
| **3.1.1** Sustain neighborhood-based medical and dental services at a minimum of 11 sites through the Care Mobile program. | Years 1, 2, 3 |
| **3.1.2** Sustain preventive dental services for underserved children at a minimum of 28 schools through the Care Mobile program. | Years 1, 2, 3 |
| **3.1.3** Provide health education and vaccines through the Care Mobile and participate at a minimum of three community-based events. (screenings: BMI, hypertension, blood glucose, dental, and other). | Years 1, 2, 3 |
| **3.1.4** Coordinate the Oral Health Providers Task Force to ensure dental services are offered to Worcester school-aged children. | Years 1, 2, 3 |

## MONITORING/EVALUATION APPROACH

- Tracking patients served.
- Number of community events participated in.
- Number of school-based dental visits.
- Number of vaccinations delivered.

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PRIORITY 3:

# Healthcare and Public Systems Navigation

## ROAD TO CARE MOBILE ADDICTION SERVICE

**Objective 3.2: Reduce the rates of morbidity and mortality caused by opioids and other substance misuse, particularly among the unhoused or those experiencing homelessness. Note: The mobile clinic offers medical and behavioral health services and is designed to mitigate barriers such as lack of transportation or mistrust in healthcare systems.**

| Outcome Indicators: (Road to Care Mobile Clinic) | Intended Annual Impact | Actual Outcomes |
|---|---|---|
| · Number of patients served.<br>· Number of patients connected to wrap-around services. | A minimum of 500 patients annually | Year 1:<br>Year 2:<br>Year 3: |

| Strategies | Timeline |
|---|---|
| **3.2.1** Reduce opioid–related morbidity and mortality by mitigating barriers such as lack of transportation or mistrust in healthcare and meeting people where they are — in shelters or on the street. | Years 1, 2, 3 |

### MONITORING/EVALUATION APPROACH

- Tracking and reporting patient services.
- End of year reports.

## HEALTH INSURANCE ENROLLMENT

**Objective 3.3: Continue insurance enrollments conducted by UMass Memorial Benefits Advisors for uninsured/underinsured individuals.**

| Outcome Indicators: (Road to Care Mobile Clinic) | Intended Annual Impact | Actual Outcomes |
|---|---|---|
| Number of UMass Memorial Insurance applications. | Number of patients needing service — variable, depending on state prerequisites and need | Year 1:<br>Year 2:<br>Year 3: |

| Strategies | Timeline |
|---|---|
| **3.3.1** Financial Benefit Advisors assist with insurance enrollment, education, and advocacy. | Years 1, 2, 3 |

### MONITORING/EVALUATION APPROACH

- Tracking of people served.
- End of year report.

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PRIORITY 3:

# Healthcare and Public Systems Navigation

## UMASS MEMORIAL/MEDICAL LEGAL PARTNERSHIP

**Objective 3.4: Establish/continue Medical Legal Partnership (MLP) between the Medical Center and Community Legal Aid to integrate legal services into clinical sites to address underlying social/economic factors among socially complex populations.**

| Outcome Indicators: (Medical Center, MLP) | Intended Annual Impact | Actual Outcomes |
|---|---|---|
| Number of cases resolved. | A minimum of 180 patients will receive legal intervention at four primary care clinics | Year 1:<br>Year 2:<br>Year 3: |
| Produce program evaluation document that measures impact of medical/legal intervention. | Completed Evaluation Plan that is updated annually | Year 1:<br>Year 2:<br>Year 3: |

| Strategies | Timeline |
|---|---|
| **3.4.1** Serve patients at four Medical Center clinical sites: 1) Hahnemann Family Health Center; 2) Benedict Family Medicine; 3) Benedict Internal Medicine; 4) and Benedict Pediatric Primary Care; 5) Tri River Family Health Center; and 6) Charlton MOB Family Practice. | Years 1, 2, 3 |
| **3.4.1** Continued Medical Center presence for the MLP Steering Committee. | Years 1, 2, 3 |
| **3.2.1** Sustain a panel of 120 lawyers to do pro bono work. | Years 1, 2, 3 |

### MONITORING/EVALUATION APPROACH

- Tracking of people served.
- End of year report.

## SOCIAL DRIVERS OF HEALTH (SDOH) SCREENINGS — CLINICAL AND SOCIAL CARE INTEGRATION

**Objective 3.5: Implement SDOH screenings in various hospital settings using the EPIC EMR, the CommunityHELP resource repository and GetWell platforms to assist in social care coordination for patients.**

| Outcome Indicators: (OCI, CHET, Medical Center) | Intended Annual Impact | Actual Outcomes |
|---|---|---|
| · Number of "claimed" participating organizations and programs in the CommunityHELP platform.<br>· Number of monthly usage searches in the system. | A minimum of 120 new participating organizations and a minimum of 10,000 monthly searches in the system | Year 1:<br>Year 2:<br>Year 3: |
| Number of patients screened and recorded in EPIC/EMR. | 10,000 | Year 1:<br>Year 2:<br>Year 3: |
| Number of points of contact made with patients by GetWell. | 2,000 (10% of patients screened) | Year 1:<br>Year 2:<br>Year 3: |

*Continued on following page.*

PRIORITY 3:

# Healthcare and Public Systems Navigation

| Strategies | Timeline |
|---|---|
| **3.5.1** Increase the number of closed-loop referrals with Community Health Worker's at various locations. | Years 1, 2, 3 |
| **3.5.2** Increase general knowledge of CommunityHELP across Central Massachusetts entities. | Years 1, 2, 3 |
| **3.5.3** Ensure continuous improvement process to enhance the alignment of CommunityHELP and GetWell. | Years 1, 2, 3 |
| **3.5.4** Community Benefits staff to continue to serve on the CommunityHELP governance committee structure for ongoing integration, and innovation utilizing CommunityHELP. | Years 1, 2, 3 |

## MONITORING/EVALUATION APPROACH

- End of year reports documenting efficiency and use.

## YOUTH COMMUNITY PROGRAMMING TO PROMOTE HEALTH AND ACCESS

**Objective 3.6: In collaboration with the City of Worcester, implement summer programs that promote physical activity and active living, summer learning loss prevention programming and healthy meals for at-risk children (Recreation Worcester).**

| Outcome Indicators: (Medical Center, City of Worcester's Division of Youth Services) | Intended Annual Impact | Actual Outcomes |
|---|---|---|
| Number of children/youth participating in programming. | A minimum of 1,020 youth participating in (Recreation Worcester summer program) | Year 1:<br>Year 2:<br>Year 3: |
| Number of meals provided. | A minimum of 1,020 children receives two meals a day (Recreation Worcester summer program) | Year 1:<br>Year 2:<br>Year 3: |
| Number of youth employed in the program. | A minimum of 100 youth | Year 1:<br>Year 2:<br>Year 3: |

| Strategies | Timeline |
|---|---|
| **3.6.1** Collaborate with the City of Worcester Youth Division, Worcester Public Schools, and other community-based agencies to increase access to physical activity opportunities. | Years 1, 2, 3 |

## MONITORING/EVALUATION APPROACH

- End of year reports.

*Continued on following page.*

PRIORITY 3:

# Healthcare and Public Systems Navigation

## ENHANCE THE PUBLIC HEALTH INFRASTRUCTURE OF THE COMMUNITY

**Objective 3.7: Enhance the capacity of the City of Worcester Public Health Division (WDPH) to deliver high-quality prevention and promote equity to the residents in Worcester and the Alliance towns through regionalization and accreditation efforts.**

| Outcome Indicators: (Medical Center, WDPH, Coalition for a Healthy Greater Worcester, Fallon Health) | Intended Annual Impact | Actual Outcomes |
|---|---|---|
| Co-lead and support efforts by the WDPH, Medical Center, and Fallon Health for the 2027-2029 Community Health Assessment. | CHA planning will commence in 2026 | Year 1:<br>Year 2:<br>Year 3: |
| WDPH and Coalition for a Healthy Greater Worcester completion of the Community Health Improvement Plan (CHIP) including strategies, measurable outcomes for each Domain Area and regular convening of CHIP Work Groups, ensuring collection of epidemiological data for each CHIP Domain, dissemination of meeting minutes; identification of new policies. | Ongoing CHIP Work Group meetings, distribution of data and Meeting Minutes for each CHIP Work Group and annual report to the community | Year 1:<br>Year 2:<br>Year 3: |
| Support the Coalition for a Healthy Greater Worcester to successfully implement CHIP strategies. | Active participation in Steering Committee, Research and Evaluation Sub-committee | Year 1:<br>Year 2:<br>Year 3: |
| Utilize CHA/CHIP to inform grant making processes that align to identified priority areas. | Community Benefits contributions and grants to local partners | Year 1:<br>Year 2:<br>Year 3: |

| Strategies | Timeline |
|---|---|
| **3.7.1** Support the WDPH foster collaboration between WDPH, UMass Memorial Health, and academic partners to improve community health and develop public health researchers and practice leaders. | Years 1, 2, 3 |
| **3.7.2** Support the Public Health Infrastructure and work. | Years 1, 2, 3 |
| **3.7.3** Active participants in the update of the CHIP and annual updates and planning of 2027 Community Health Needs Assessment. | Years 1, 2, 3 |
| **3.7.4** Engagement in the Coalition for a Healthy Greater Worcester. | Years 1, 2, 3 |
| **3.7.5** Ensure continuous alignment to infrastructure development through North Pavilion DoN/CHI grants including the Coalition for a Healthy Greater Worcester award. | Years 1, 2, 3 |
| **3.7.6** Provision of grant funding to support the Medical Director of the WDPH, who provides medical supervision and guidance for the city and alliance towns. | Years 1, 2, 3 |

## MONITORING/EVALUATION APPROACH

- End of year reports.
- Number of policies implemented.
- Public health/CHIP activities completed.
- Activities that support regionalization and accreditation of the WDPH and regional alliance.

PRIORITY 4:

# Healthcare Workforce

**Goal:** Develop, support, and sustain efforts internally, and by community partners that improve career pathway opportunities that disrupt generational poverty, promote a livable wage, and utilize the strengths of our diverse communities.

## WORKFORCE DEVELOPMENT AND CAREER PATHWAY PROGRAMS

**Objective 4.1: Support workforce development opportunities for UMass Memorial caregivers that focus on equitable access, and community career pathway programs that focus on diverse populations.**

| Outcome Indicators: (Medical Center, UMass Chan, Patients R Waiting, Regional Environmental Council) | Intended Annual Impact | Actual Outcomes |
|---|---|---|
| Number of patients seen at neighborhood sites through the Care Mobile program. | 50 Caregivers enrolled | Year 1:<br>Year 2:<br>Year 3: |
| · Anchor Mission Hiring/Workforce Development Committee<br>· Development and implementation of "Outside-In and Inside-Up" approaches and pathways to employment and career opportunities within the UMass Memorial system for vulnerable populations facing barriers.<br>· Identify potential training avenues/programs for existing and incoming employees.<br>· Continue to partner and work closely with key Community stakeholder partners for on-going employee candidate pipeline facilitation and development; identify and alignment of needs between Community partner organizations and hospital system needs and opportunities<br>· Data analytics of internal workforce and highest poverty census tracts. | Restructuring of Committee | Year 1:<br>Year 2:<br>Year 3: |
| Support the partnership between the Medical Center and Regional Environmental Council's YouthGrow program through grants and sponsorships. | Number of students served | Year 1:<br>Year 2:<br>Year 3: |
| Support the Pipeline Dreams Scholar's Program (Patients R Waiting, UMass Chan Medical School's Collaborative for Health Equity) through the Office of Workforce Development. | FY2025 Baseline Year | Year 1:<br>Year 2:<br>Year 3: |

| Strategies | Timeline |
|---|---|
| **4.1.1** Support the Anchor Mission Hiring and Workforce Development Pillar infrastructure to ensure fidelity of implementation for career pathway programs. | Years 1, 2, 3 |
| **4.1.2** Actively engage with the Healthcare Anchor Network (HAN) to ensure data reporting and data analysis to enhance continuous improvement processes to inform workforce development strategies. | Years 1, 2, 3 |

*Continued on following page.*

PRIORITY 4:

# Healthcare Workforce

| Strategies | Timeline |
|---|---|
| **4.1.3** Provide in-kind support of the UMass Chan Collaborative for Health Equity efforts for workforce development and community outreach via in-kind thought partnership and collaboration opportunities including, but not limited to, speaking engagements, participation in meetings, and governance opportunities. | Years 1, 2, 3 |
| **4.1.4** Support the Patients R Waiting Pipeline Dreams Scholars Program. | Years 1, 2, 3 |

## MONITORING/EVALUATION APPROACH

- End of year HAN reports.
- Number of UMass Memorial Caregivers enrolled in career pathway programs.
- Number of students enrolled in Pipeline Dreams Scholars Program.

PRIORITY 5:

# Culturally Responsive Healthcare

**Goal:** Goal: Develop and support strategies, structures, and practices to effect policy, systems, and environmental change in our communities.

## PEDIATRIC ASTHMA INTERVENTION

**Objective 5.1: Pediatric Pulmonology will sustain an intervention with Pediatric Pulmonary and ED in-patient departments that targets patients most at risk.**

| Outcome Indicators: (Pedi-Pulmonology, Pedi-ED, Pedi-Primary Care) | Intended Annual Impact | Actual Outcomes |
|---|---|---|
| Number of unduplicated patients served per year. | 20 unduplicated patients/families enrolled in program | Year 1:<br>Year 2:<br>Year 3: |
| Number of home visits provided. | Reduce # of pediatric asthma related hospital admissions | Year 1:<br>Year 2:<br>Year 3: |
| Self-management education for all persistent pediatric patients (medications, Asthma Action Plan, flu shot, triggers). | 90% | Year 1:<br>Year 2:<br>Year 3: |
| Asthma control: Asthma Control Test in last 12 months; conducted in the clinical setting and administered by Community Health Workers at each intervention visit. | 90% | Year 1:<br>Year 2:<br>Year 3: |
| Referral for home visits among identified high-risk patients for education, assessment of environmental asthma triggers, medication usage, and trigger mitigation (bed casings, etc.) by a Community Health Worker. | 70% | Year 1:<br>Year 2:<br>Year 3: |

| Strategies | Timeline |
|---|---|
| **5.1.1** Sustain linkage with ED/Pediatrics, Pedi-Pulmonology and Provider Champions. | Years 1, 2, 3 |
| **5.1.2** Develop a continuous improvement process for progress monitoring of program data and fidelity of intervention. | Years 1, 2, 3 |
| **5.1.3** Identify training and development opportunities for Outreach Liaison providing intervention including best practices, and local, regional, and state collaboratives and coalitions. | Years 1, 2, 3 |
| **5.2.1** Ensure fidelity of implementation to program model. | Years 1, 2, 3 |

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PRIORITY 5:

# Culturally Responsive Healthcare

| Strategies | Timeline |
|---|---|
| **5.2.2** Allocation of financial resources to assist patients in need with necessary materials to assist in their treatment. | Years 1, 2, 3 |
| **5.2.3** Provide SDOH screenings and referrals as part of program model. | Years 1, 2, 3 |

## MONITORING/EVALUATION APPROACH

- Tracking home visits by a Community Health Worker.
- Tracking number of children receiving meds at school.
- Tracking number of ED visits for children in the Meds at School Program.

| Objective 5.3: Identify high risk populations and improve care for pediatric asthma patients served by Pedi-Primary Care to decrease asthma-related health disparities. | | |
|---|---|---|
| Completion of Home Visits for enrolled. | 60% | Year 1:<br>Year 2:<br>Year 3: |

| Strategies | Timeline |
|---|---|
| **5.3.1** Utilize EMR to identify all pediatric patients with asthma and assess severity. | Years 1, 2, 3 |
| **5.3.2** Provide Champion to develop office workflow, train personnel, and managed care. | Years 1, 2, 3 |
| **5.3.3** Utilize Community Health Workers to provide case management and implement home visit program contact patient, schedule and provide home visits, follow-up, communicate with schools and Community Legal Aid referrals. | Years 1, 2, 3 |
| **5.3.4** Utilize Community Health Workers to follow-up on ER visits and hospitalizations of all pediatric persistent asthma patients through EPIC. | Years 1, 2, 3 |
| **5.3.5** On-going participation and communication with the City-Wide Pediatric Asthma Task Force. | Years 1, 2, 3 |

## MONITORING/EVALUATION APPROACH

- Monitor patient registry monthly, follow up ED visits and hospitalizations.
- Individual children identified as high risk will be monitored at least quarterly through a combination of clinic visits, home visits, and/or contact with a Community Health Worker.

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PRIORITY 5:

# Culturally Responsive Healthcare

## HECTOR REYES SUBSTANCE USE TREATMENT FACILITY

**Objective 5.4 Execute the delivery of a medical model that treats Latino males with substance use disorders in a culturally sensitive way in a residential treatment program while emphasizing opiate addiction.**

| Outcome Indicators | Intended Annual Impact | Actual Outcomes |
|---|---|---|
| Number of Latino men receiving medical services at the Hector Reyes House residential substance use treatment program. | 80 men annually | Year 1:<br>Year 2:<br>Year 3: |

| Strategies | Timeline |
|---|---|
| **5.4.1** UMass Memorial physician provides medical care for Latino men who have/or are at risk for developing chronic diseases due to substance use at the Hector Reyes House. | Years 1, 2, 3 |

## MONITORING/EVALUATION APPROACH

- Tracking and replacing patient services.
- End of year reports.

## CULTURALLY RESPONSIVE AND ALTERNATIVE CARE FOR FOCUS POPULATIONS

**Objective 5.5 Grant support for projects and initiatives that focus on vulnerable populations including, but not limited to, migrants, refugees, undocumented immigrants, and those that offer culturally congruent care.**

| Outcome Indicators: (Medical Center, Worcester RISE, Worcester State Foundation, Southeast Asian Coalition, Center for Health Impact) | Intended Annual Impact | Actual Outcomes |
|---|---|---|
| · Number of individuals served by 2024 DoN/CHI 3-yer project grants:<br>- Worcester RISE for Health (refugee assistance)<br>- Southeast Asian Coalition (Community Health Workers)<br>· Worcester State Foundation (Promotoras de Salud). | FY2025 Baseline Year | Year 1:<br>Year 2:<br>Year 3: |
| Number of patients served by a Community Health Worker at Worcester RISE partially funded by the Medical Center Community Benefits grant funds. | FY2025 Baseline Year | Year 1:<br>Year 2:<br>Year 3: |
| Number of trainings facilitated by the Center for Health Impact to build capacity of Community Health Worker's and Promotoras de Salud as part of a collaborative project effort. | FY2025 Baseline Year | Year 1:<br>Year 2:<br>Year 3: |

*Continued on following page.*

PRIORITY 5:

# Culturally Responsive Healthcare

| Strategies | Timeline |
|---|---|
| **5.5.1** The Medical Center's to provide grant administration for all relevant projects including TA and evaluation. | Years 1, 2, 3 |
| **5.5.2** Support of projects via the Medical Center's presence at coalition and collaborative meetings. | Years 1, 2, 3 |
| **5.5.3** Support of policy and advocacy efforts to support vulnerable communities served by projects. | Years 1, 2, 3 |

## MONITORING/EVALUATION APPROACH

- End of year reports.

## MATERNAL AND INFANT HEALTH

**Objective 5.6 Support the City of Worcester Division of Public Health's (WDPH's) efforts to address Infant Mortality disparities and promote equity in practices among maternal/child health population.**

| Outcome Indicators: (Medical Center, WDPH) | Intended Annual Impact | Actual Outcomes |
|---|---|---|
| · Assist in the development of WDPH Maternal and Infant Health 2025 work plan with the following priorities:<br>- Improve Black and Brown maternal health.<br>- Improve Black and Brown infant health.<br>- Create a Data Dashboard.<br>- Allocation of resources.<br>· Build capacity. | FY2025 Baseline Year | Year 1:<br>Year 2:<br>Year 3: |

| Strategies | Timeline |
|---|---|
| **5.6.1** Support the WDPH through in-kind thought partnership in the development of their action plan. | Years 1, 2, 3 |
| **5.6.2** Participate in collaborative convenings of relevant partners. | Years 1, 2, 3 |
| **5.6.3** Support the data collection and analysis with the assistance of UMass Memorial's Office of Clinical Integration. | Years 1, 2, 3 |
| **5.6.4** Support policy and advocacy efforts at the local, regional, and state level. | Years 1, 2, 3 |

## MONITORING/EVALUATION APPROACH

- Tracking of patients served and virtual/home visits conducted by Community Health Workers.
- Number of patients receiving virtual/home visits.
- Number of patients connected to community resources addressing SDOH needs and number of resources referred to.

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PRIORITY 5:

# Culturally Responsive Healthcare

**Objective 5.7 Support the UMass Memorial Doula Program to improve the experience of Black birthing patients.**

| Outcome Indicators: (UMass Memorial, UMass Chan Medical School) | Intended Annual Impact | Actual Outcomes |
|---|---|---|
| Number of Black birthing patients who received Doula services. | FY2025 Baseline Year | Year 1:<br>Year 2:<br>Year 3: |

| Strategies | Timeline |
|---|---|
| **5.7.1** Support the implementation of the UMass Memorial Doula Program via thought partnership and community outreach efforts. | Years 1, 2, 3 |
| **5.7.2** Collaborate with efforts of OB/GYN Department as requested. | Years 1, 2, 3 |
| **5.7.3** Identify opportunities for cross collaboration efforts with CHET, i.e. Food is Medicine. | Years 1, 2, 3 |
| **5.7.4** Support policy and advocacy efforts at the local, regional, and state level. | Years 1, 2, 3 |

## MONITORING/EVALUATION APPROACH

- Tracking of patients served.
- Data analytics of patient outcomes via developed Data Dashboard with the Worcester Department of Public Health.