2025–2027
Community Benefits Strategic Plan

UMass Memorial Health
HEALTHALLIANCE-CLINTON HOSPITAL

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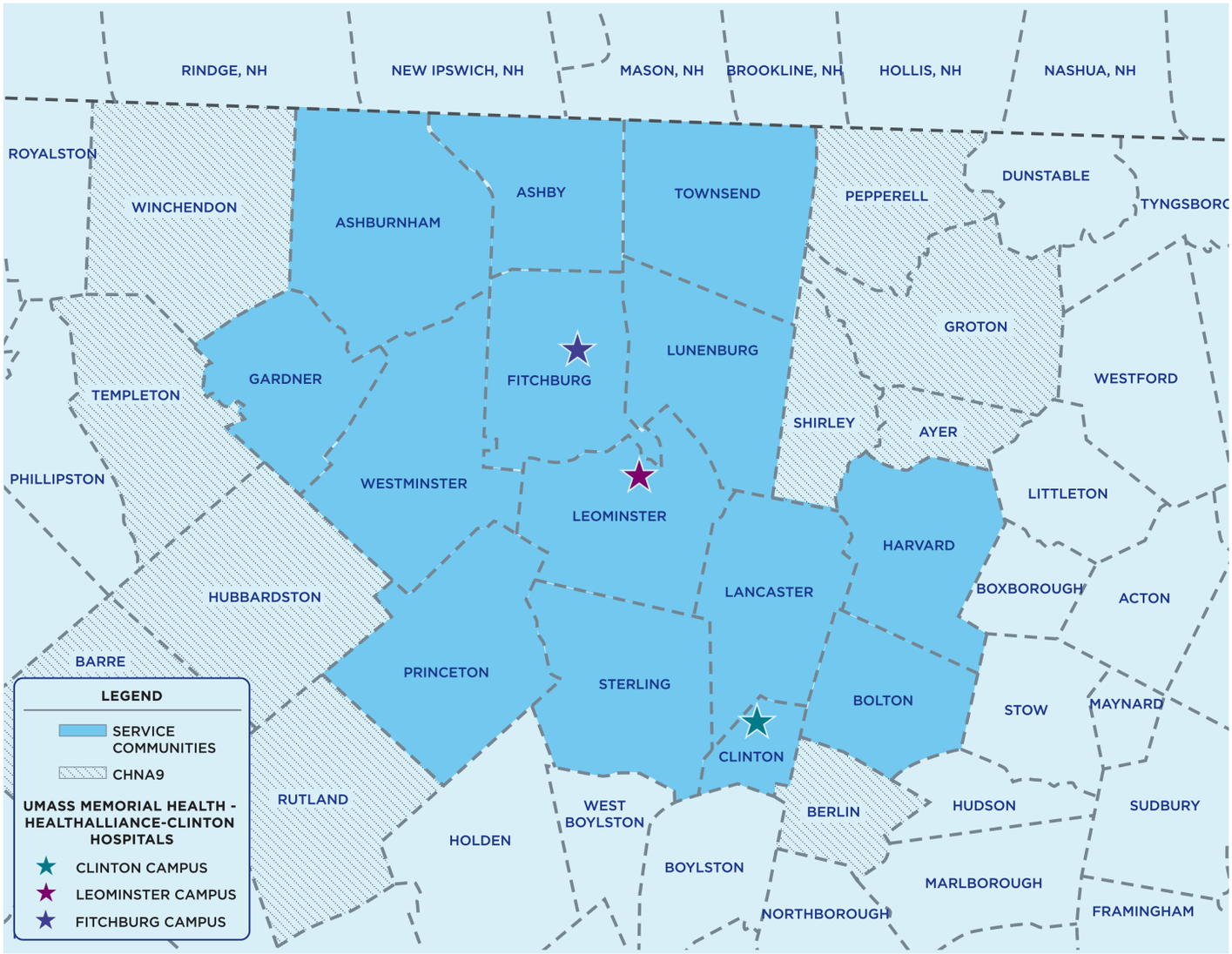
UMASS MEMORIAL HEALTH - HEALTHALLIANCE-CLINTON HOSPITAL COMMUNITY BENEFITS SERVICE AREA

UMass Memorial Health - HealthAlliance-Clinton Hospital (HA-C) is a full-service, not-for-profit, regional community hospital licensed for 138 beds. With campuses in Clinton, Fitchburg, and Leominster, HA-C's primary service area includes Ashburnham, Ashby, Bolton, Clinton, Fitchburg, Gardner, Harvard, Lancaster, Leominster, Lunenburg, Princeton, Sterling, Townsend, and Westminster.



HA-C has more than 550 physicians across nearly 50 healthcare specialties and offers a full complement of services, including two emergency departments and an urgent care, state-of-the-art diagnostic imaging, dialysis, laboratory, palliative care, surgery, and in-patient hospice care. In addition, HA-C operates the Simonds-Sinon Regional Cancer Center as well as HealthAlliance Home Health and Hospice.

HA-C is part of the UMass Memorial Health (UMMH) system, the largest health and wellness partner of the people of Central Massachusetts. As the clinical partner of the UMass Chan Medical School, the UMMH system has access to the latest technology, research and clinical trials.

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UMMH Has Adopted the Following Mission, Vision, and Values:

UMMH 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.

UMMH 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 Health will provide leadership and innovation in seamless healthcare delivery, education and research, all of which are designed to provide exceptional value to our patients.

UMMH 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

SUMMARY COMMUNITY BENEFITS STRATEGIC IMPLEMENTATION PLAN

This Community Benefits Strategic Implementation Plan (SIP) is based on the findings of the 2024-2026 Community Health Needs Assessment (CHNA) published by UMass Memorial Health – HealthAlliance-Clinton Hospital in October of 2024. The CHNA's aim was to gain a greater understanding of the unmet health and social services needs of residents of North Central MA 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 between HA-C, Heywood Healthcare, Health Equity Partnership of North Central MA (CHNA 9), and Three Pyramids/The Minority Coalition. Various other organizations and individuals also contributed to this effort, including community-based organizations, hospital stakeholders, and residents of the service area.

The CHNA process synthesized statistics from secondary sources like the U.S. Census Bureau, the Massachusetts Department of Public Health, and the participating hospital systems with qualitative information gathered through pre-existing surveys of local 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 Areas" for the hospitals to address through their Community Benefits work. Throughout the CHNA process, special attention was paid to Social Determinants of Health, Social Drivers of Health, and Health-Related Social Needs and their impact on health disparities and health equity.

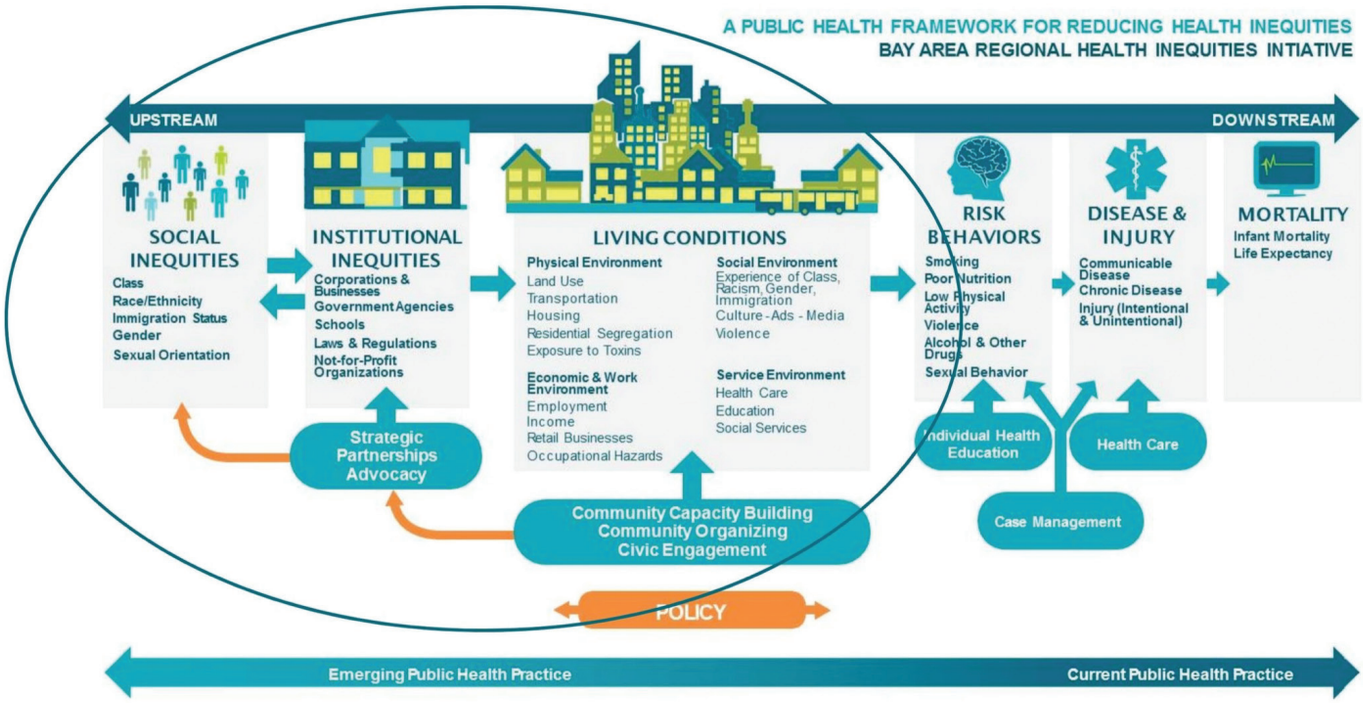
Note: *Social Determinants of Health, Social Drivers of Health, and Health-Related Social Needs all refer to the non-medical factors that influence an individual's health outcomes, but while "Social Determinants of Health" broadly encompasses the conditions in which people live, work, and age, "Social Drivers of Health" focuses on the structural factors that influence health outcomes and the degree of control individuals and communities have over their circumstances. "Health-Related Social Needs" address the specific, immediate challenges individuals face that can directly impact their health. Together, these concepts highlight the interconnected roles of societal factors in shaping overall well-being. This Strategic Implementation Plan uses the term Social Determinants of Health, however, we recognize the role of all three in advancing movement toward health equity and have incorporated strategies that address all three.*

SUMMARY COMMUNITY BENEFITS STRATEGIC IMPLEMENTATION PLAN – CONTINUED

Social Determinants of Health 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) new guidelines mandating that hospitals screen for SDOH, HealthAlliance-Clinton Hospital is increasingly recognizing the critical role of addressing Social Determinants of Health 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] 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, HA-C 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, HA-C'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."

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Identifying Priority Populations and Priority Areas

Between July and September 2024, the Community Health Needs Assessment planning committee, along with hospital leaders and their Community Benefits and Patient & Family Advisory Committees, reviewed the findings of the CHNA. In addition, HA-C 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

HA-C's Community Benefit Strategic Implementation Plan includes strategies and activities that will support residents throughout its service area and from all segments of the population. However, based on the 2024-2026 Community Health Needs Assessment's (CHNA's) quantitative and qualitative findings, including discussions with a broad range of community participants, the hospital'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 determinants of health that can put them at greater risk.

Specifically, the assessment identified the following groups of community members as the *Priority Populations* for this Strategic Implementation Plan:

PRIORITY POPULATIONS OVERVIEW

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

Low-Income Individuals and Families

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

Older Adults (75+)

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

Veterans

Persons who served in the active military, naval, or air service, and who were discharged or released therefrom under conditions other than dishonorable.

Homeless

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

Infants, Children, and Adolescents

People under 21 years of age, whose developing bodies and minds require special attention and care.

LGBTQIA+

Persons who express a spectrum of gender identities and sexual orientations that are counter to the mainstream.

Birthing People

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

Recent Immigrants & Non-English Speakers

Undocumented persons, migrants, immigrants, and refugees

PRIORITY AREAS

HA-C's Community Benefit Strategic Implementation Plan includes strategies and activities that will have a broad impact on the health and wellbeing of residents of North Central MA. However, based on the 2024-2026 Community Health Needs Assessment's (CHNA's) quantitative and qualitative findings, including discussions with a broad range of community participants, the hospital's SIP will prioritize certain areas:

PRIORITY AREA OVERVIEW

Priority Area #1
EQUITABLE ACCESS TO CARE

Cancer
Diabetes
Cardiovascular Disease
Respiratory Illness

Priority Area #2
BEHAVIORAL HEALTH

Mental Health
Substance Use

Priority Area #3
SOCIAL DETERMINANTS OF HEALTH

Financial Stability
Housing
Food Security
Transportation

Recognizing the value of diverse voices in planning, and with the above Priority Populations and Priority Areas identified, HA-C 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 Benefits Mission, Anchor Mission, and Health Equity Mission, as well as the corresponding strategic plans to ensure the system's level alignment and allow for the leveraging of resources.

UMMH 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 people experiencing poverty and other medically underserved populations. In addition, nonmedical conditions that negatively impact the health and wellness of our community are addressed.

UMMH 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 MA communities.

UMMH 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.

COMMUNITY HEALTH EQUITY FRAMEWORK

Finally, proposed strategies and activities were overlaid on an emerging merging approach to addressing health challenges both at the system and community hospital levels. Though still under development, the key concepts included in the Framework are:

Foundation:

- A grounding in social justice;
- Ongoing communication and trusting relationships between provider institutions and community members; and
- An orientation toward community-focused care through authentic and culturally humble engagement.

Enabling Environment:

- System-wide shared vision and aligned goals;
- Leaders and an organizational culture that leverage processes and innovations across departments and initiatives; and
- Community engagement that prioritizes voice and agency.

Levers:

- Interconnected levers that enable the health system to address social determinants 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 work force development. Hospitals use patient data to inform decisions, address disparities, and optimize resource distribution. Recruiting, training, and retaining a skilled and diverse work force ensures responsive, equitable care while addressing critical staffing shortages. Infrastructure Development 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.

  Funding and Investing prioritizes directing resources toward impactful local initiatives. Hospitals strategically invest in programs aligned with their mission, such as housing or food security projects, and support the regional economy through local purchasing. These efforts maximize community impact and advance health equity while fostering stronger ties between hospitals and the communities they serve.

  Social and Clinical 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 Health'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.

Through the processes above, the following Strategic Implementation Plan was developed for 2025-2027. The SIP provides enough focus to be useful as a guide for planning and implementing Community Benefits work over the next three years while also leaving flexibility for updates and changes as community needs shift over time and as new opportunities, programming, and partnerships reveal themselves.

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Strategic Implementation Plan 2025 – 2027

EQUITABLE ACCESS TO CARE

HA-C will promote equitable access to care for chronic and complex conditions by: 1) collecting and analyzing patient data through a health equity lens, 2) building and supporting our work force through internal programs and policy development as well as external partnerships, 3) diversifying our healthcare delivery design, and 4) supporting community programs that align with our equitable access goals.

MENTAL HEALTH & SUBSTANCE USE

HA-C will address our patients' mental health and substance use-related needs by: 1) providing training and information to healthcare workers and key community partners, 2) expanding the spectrum of in-house integrated mental health and substance use services to reduce wait times, and 3) supporting community programs that align with our mental health and substance use goals.

SOCIAL DETERMINANTS OF HEALTH

HA-C will address our patients' Social Determinants of Health (SDOH) by: 1) supporting the North Central MA economy through local purchasing, investments and hiring. 2) advocating for greater access to expanded benefits programs, 3) providing wide-reaching SDOH screening services and referrals by trained healthcare workers, and 4) supporting community programs that align with our SDOH goals.

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.

SIP | 2025 – 2027 | GOAL #1

Equitable Access to Care

HA-C will promote equitable access to care for chronic and complex conditions, with a focus on cancer, diabetes, cardiovascular disease, and respiratory illness. To do this, HA-C will:

Collect and analyze patient data through a health equity lens:

- Utilize data systems and tools to improve care and outcomes
- Utilize dashboards, along with training, to promote health equity among frontline staff
- Review stratified data regularly

Build and support our work force through internal programs and policy development as well as external partnerships:

- Create pipelines and career pathways (e.g. Patient Care Associates (PCA) or Nursing Assistants; Surgical Technologists, Medical Assistants and Lab Technicians)
- Promote diversity through hiring practices and community outreach
- Provide scholarships to local high school students seeking careers in healthcare while providing internal scholarships to caregivers seeking career pathways
- Train healthcare professionals in cultural competency
- Address barriers to positions for those with limited digital access or education
- Improve access to language resources for caregivers

Diversify our delivery system design:

- Provide non-traditional health services in non-traditional settings, including: telehealth, remote patient monitoring, mobile healthcare
- Conduct SDOH screenings and referrals
- Provide self-management programming
- Evaluate expanding UMASS Memorial Health's MEDS-TO-BEDS program that allows bringing pharmacy to the bedside at time of discharge
- Culturally Responsive Healthcare, including ongoing efforts to address cultural and linguistic barriers
- Improve access to Interpreter Services
- Improve transportation resources for patients, including in the Nashoba region

Support community programs that align with our Equitable Access to Care goal by providing capacity building resources to and funding efforts aimed at:

- Transportation resources for healthcare access
- Prenatal, postnatal, and infant care
- Chronic disease screenings, management, and education programming
- Childcare initiatives, including multi-lingual childcare training programs
- Telehealth access
- Health insurance access programming
- Address food insecurity by supporting the creation of a just regional food system
- Mental health and substance use services
- Support community based free care clinics
- Targeted outreach to BIPOC, LGBTQIA+ and people with disabilities

SIP | 2025 – 2027 | GOAL #2

Mental Health & Substance Use

HA-C will address our patients' mental health and substance use-related needs. To do this, HA-C will:

Provide training and information to healthcare workers and key community partners:

- Train hospital and local healthcare staff to identify and address behavioral health-related issues, including: dementia, domestic violence, and human trafficking
- Provide mental health training and resources, such as mindfulness training, to hospital caregivers and community partners
- Provide community education and resources related to mental health and substance use issues, available services, and stigma reduction

Expand the spectrum of in-house, integrated mental health and substance use services to reduce wait times:

- Improve integration of physical and behavioral healthcare
- Provide dementia support
- Develop programming for older adults and caregivers providing supports to loved ones in their home to address isolation.
- Distribute Naloxone and prescriptions at the Emergency Department
- Implement medication take-back programs
- Ensure access to palliative care and survivorship services

Support community programs that align with our mental health and substance use goal by providing infrastructure development resources to and funding efforts aimed at:

- Veterans' services, multi-cultural services, community health workers (CHWs), and doulas
- School- and community-based behavioral health services, including: drop-in centers, peer mentoring, and peer recovery supports
- Targeted outreach to BIPOC, LGBTQIA+, youth, and people with disabilities

SIP | 2025 – 2027 | GOAL #3

Social Determinants of Health

HA-C will address our patients' Social Determinants of Health with a particular focus on financial stability, housing, food security, and transportation. To do this, HA-C will:

Supporting the North Central MA economy through local purchasing, investments and hiring:

- Use our purchasing power in the food sector to catalyze local agricultural purchasing
- Ensure equitable access to investments and resources made by the hospital that benefit the community
- Engage community partners to promote local hiring opportunities

Advocate for greater access to expanded benefits programs:

- Support enrollment of the Supplemental Nutrition Assistance Program (SNAP) and MA Healthy Incentives Program (HIP)
- Provide health insurance enrollment services

Provide wide-reaching SDOH screening services and referrals by trained healthcare workers:

- Train healthcare staff on SDOH and the integration of SDOH considerations into clinical practice
- Continuously improve CAREWELL, the hospital's SDOH screening and referral platform
- Provide training to hospital staff on CAREWELL as well as local referral resources
- Expand hospital-led programs for high priority patients
- Increase resources for case management and care navigation

Support community programs that align with our SDOH goals by providing capacity building resources to and funding efforts aimed at:

- Reliable transportation, quality, affordable housing and utilities, childcare, and financial security
- Prenatal, perinatal, and infant health
- Nutrition education and food security (e.g. Food As Medicine program and transportation access)
- Access to healthy living opportunities (e.g., trails, rail trails, etc.)
- Targeted outreach to BIPOC, LGBTQIA+, people with disabilities, and people with limited English proficiency
- Use our community benefits lever to strengthen and support coordinated, diversified community-based infrastructure for food access

Note: *This SIP is intended to be a fluid document that will be updated annually according to new opportunities, programming, and partnerships and to coincide with the latest version of the North Central MA Community Health Improvement Plan (CHIP). UMass Memorial - HealthAlliance-Clinton Hospital recognizes that through the CHNA process, many needs have been identified. However, due to limited resources, it is not possible to address all identified community health needs. As such, we focus on priorities identified through the community engagement process in which we can partner and leverage resources to achieve the most significant impact.*

REFERENCES:

[1] World Health Organization. Social Determinants of Health. Accessed September 2024 at: https:// www.who.int/health-topics/social-determinants-of-health#tab=tab_1

[2] Bay Area Regional Health Inequities Initiative. BARHII Framework. Accessed July 2024 at: https://barhii.org/framework

[3] https://www.phi.org/wp-content/uploads/migration/uploads/application/files/n7skf55zoaa6zp1k2dcyljbyvwcdl43cfbsamlrub8knrh0p83.pdf