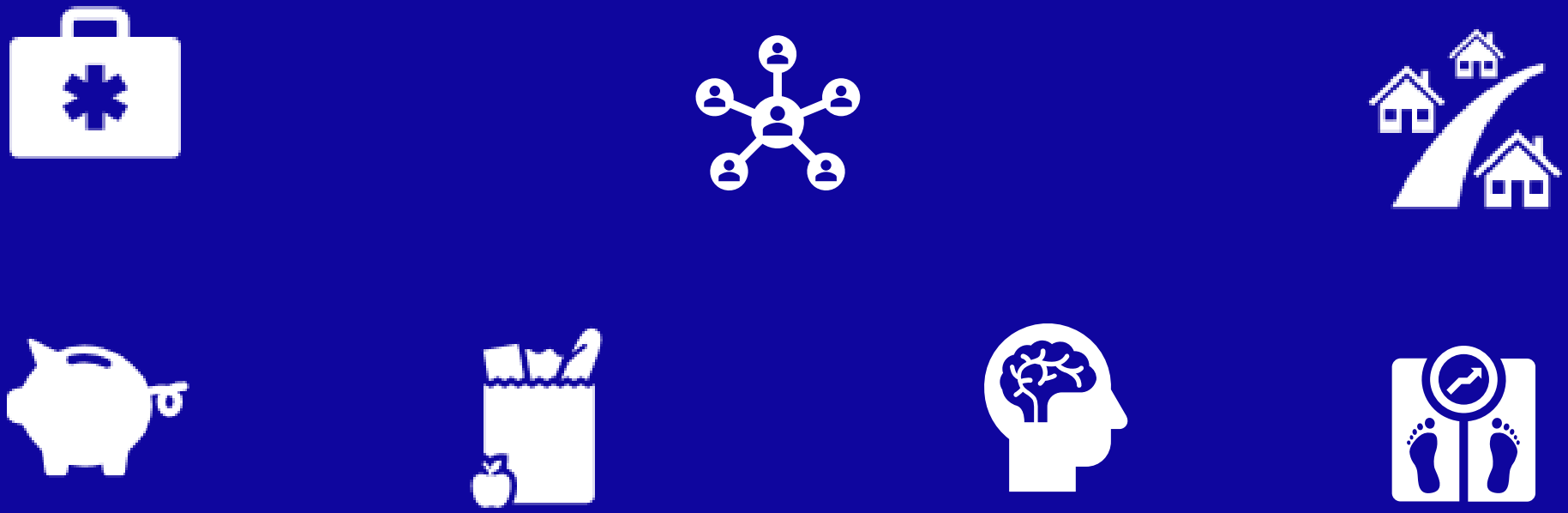
UMass Memorial Health

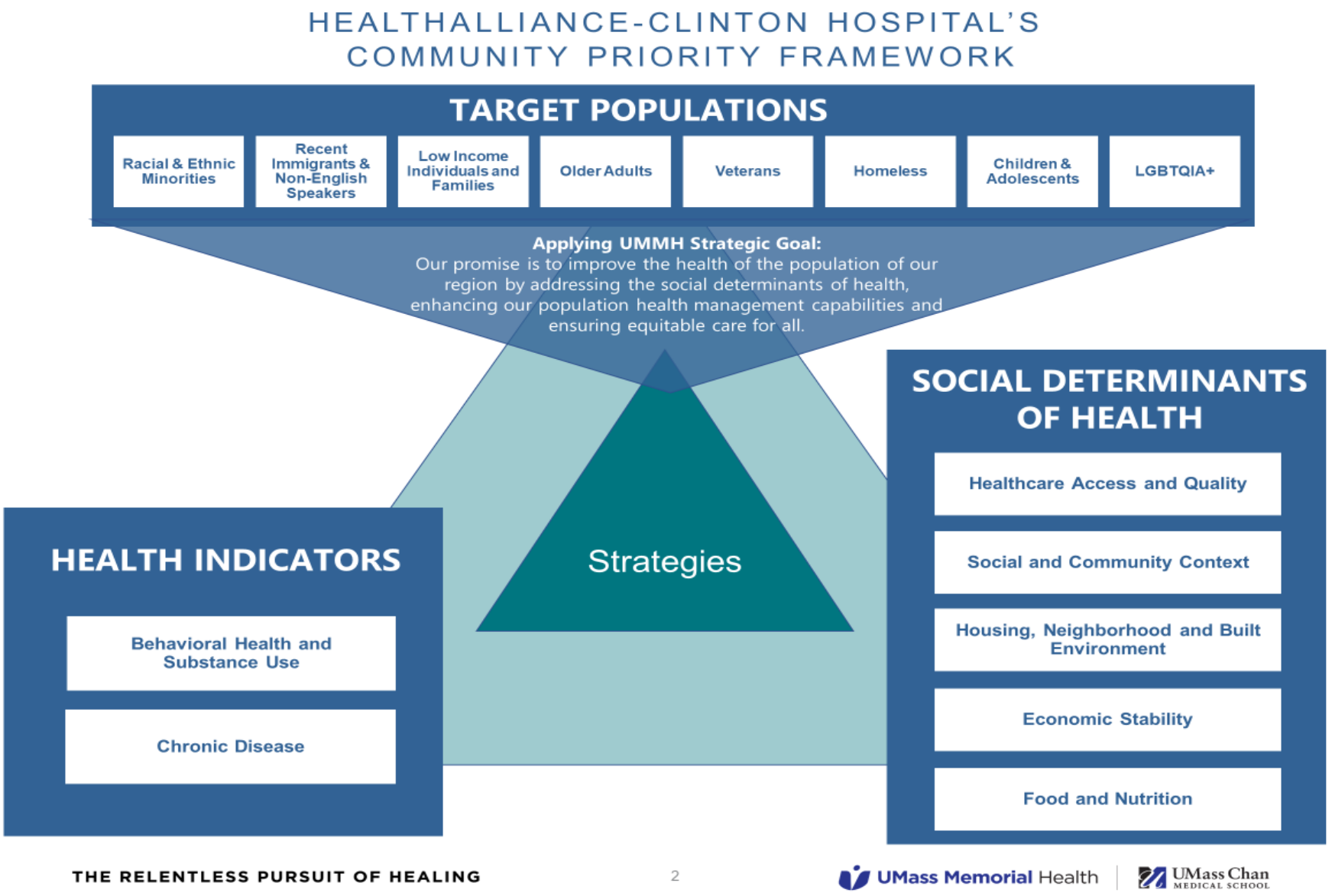
HEALTHALLIANCE-CLINTON HOSPITAL

Community Benefits

Strategic Implementation Plan

2022-2024





Approved and adopted by the UMass Memorial HealthAlliance-Clinton Hospital's Board of Trustees on December 3, 2021.

INTRODUCTION:

UMass Memorial Health - HealthAlliance-Clinton Hospital is a not-for-profit, full service, acute care hospital with a primary service area including Ashburnham, Ashby, Bolton, Clinton, Fitchburg, Gardner, Harvard, Lancaster, Leominster, Lunenburg, Princeton, Sterling, Townsend, and Westminster. As a member of UMass Memorial Health - HealthAlliance-Clinton Hospital offers direct access to the advanced medical technology and specialty services that are part of the region's academic medical center. The HealthAlliance-Clinton system includes: • 163-bed community hospital with services on three campuses in Clinton, Fitchburg (Burbank) and Leominster • Simonds-Sinon Regional Cancer Center • Simonds-Hurd Complementary Care Center • Outpatient physical therapy centers • Home health and hospice agency in total, HealthAlliance-Clinton Hospital has more than 1,600 employees and 400 physicians, providing 40 health care specialties.

HealthAlliance-Clinton Hospital'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." Our programs mirror the five core principles outlined by the Public Health Institute in terms of the "emphasis on communities with disproportionate unmet health-related needs; emphasis on primary prevention; building a seamless continuum of care; building community capacity; and collaborative governance."

> 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 Mission incorporates the World Health Organization's broad definition of health defined as "a state of complete physical, mental and social well-being and not merely the absence of disease." The UMass Memorial Health Care (UMMHC) Community Benefits Mission was developed and recommended by the Community Benefits Advisory Committee and approved by the UMass Memorial Health Care Board of Trustees.

SUMMARY COMMUNITY BENEFITS STRATEGIC IMPLEMENTATION PLAN

The 2021 Community Health Needs Assessment (CHNA) of UMass Memorial Health – HealthAlliance-Clinton Hospital was recently published in October of 2021. It presents issues related to the health, wellbeing and related factors that impact the health of those living in UMass Memorial Health – HealthAlliance-Clinton Hospital's (referenced as HealthAlliance-Clinton Hospital for the remainder of this document) catchment area. The study was a collaborative effort conducted by HealthAlliance-Clinton Hospital, the Montachusett Regional Planning Commission, Heywood Healthcare, and the Health Equity Partnership (CHNA 9). Various other organizations and individuals also contributed to this effort, including community-based organizations and

health service partners, as well as advocacy efforts from hospitals, health centers, rehabilitation centers, primary care physician and specialty networks, public health networks and local schools.

The study was intended to provide a comprehensive overview of the health status, issues and concerns of residents, as well as assets that currently exist to provide services to locals in need. The study also explores relevant social issues affecting health and wellbeing that exist across the catchment area, and even cross over bordering communities. The writing of the report is intended to inform local residents, government officials, businesses, community organizations and other relevant stakeholders of the health status of their communities using the most up-to-date and comprehensive quantitative and qualitative data. Throughout the study, special attention was paid to "communities within communities", health disparities and health equity, as well as housing and homelessness. Study researchers were careful to ensure that information and insights from under-represented racial/ethnic, socioeconomic and geographic groups were collected from Surveys and Focus Groups. Study authors made sure to take all of this insight into full consideration when analyzing data and writing the final report. This report's intent is to provide a comprehensive review of HealthAlliance-Clinton Hospital's catchment area.

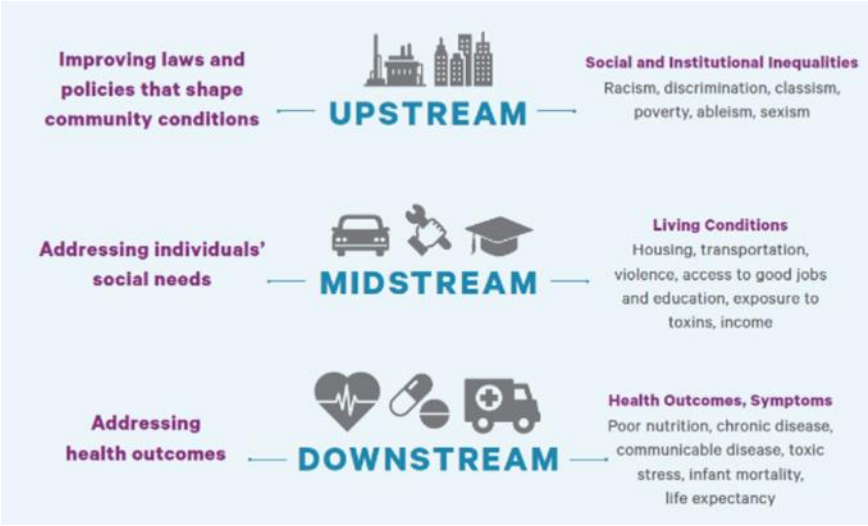


Figure 1: Streams of Public Health Impact

Broader Context of the CHIP (social determinants, health equity, and health in all policies)

As stated above, the purpose of the CHIP is to serve as a roadmap for the development of a comprehensive, accessible, equitable health care system capable of providing the highest quality services in a cost-effective manner to those who live and work in their service area. With this in mind, the CHNA and the CHIP provide vital information that will be used by HealthAlliance-Clinton Hospital and other stakeholders to help drive the region's community health improvement plan and identify community health strategies that will address community need and show public health value.

Despite HealthAlliance-Clinton Hospital's focus on clinical services and the overall health systems traditional emphasis on disease burden, physical health, and health services providers, it is important to note that the overall approach of this assessment and the Commonwealth's and the Federal governments expectations are much broader and more inclusive. For example, the Massachusetts Attorney General's Office, through the Community Benefits Guidelines, has established a set of priorities which are intended to be used to focus the community benefit work of hospitals. These priorities include:

1) Support of the Commonwealth's Health Care Reform Agenda,

2) Chronic Disease Management in Disadvantaged Populations,

3) Reducing Health Disparities,

4) Promoting Wellness of Vulnerable Populations.

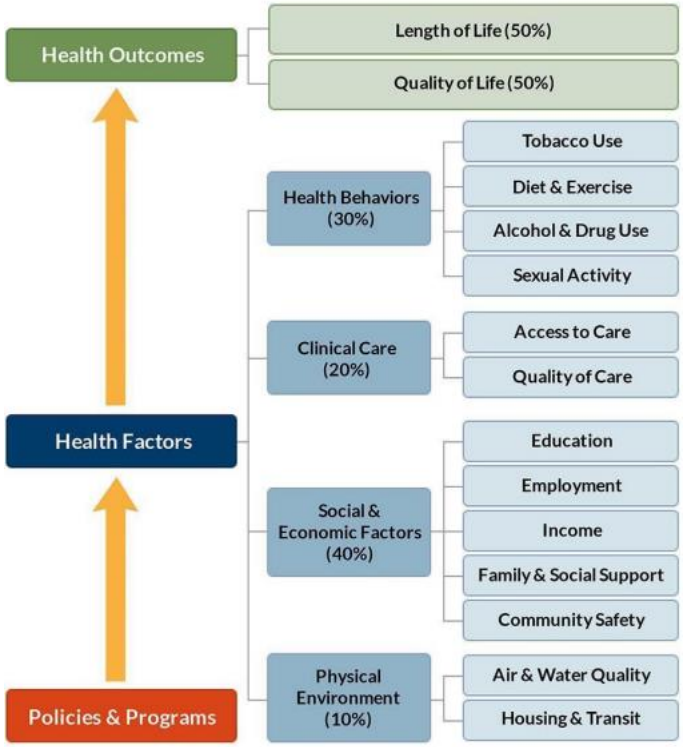


Figure 2: COMMUNITY HEALTH IMPROVEMENT FRAMEWORK

Moreover, there is a growing appreciation that health system improvements related to access and the capacity and quality of health care services have a relatively limited impact on overall health status, at least on their own; research shows that only 10-20% of one's overall health is attributable to clinical services; the remainder is linked to genetics, behavior, and social and physical environments. In order to have real and sustained impact on overall well-being and the health disparities that exist in HealthAlliance-Clinton Hospital's CBSA, the Hospital and its partners must also address the underlying social determinants, inequities, and injustices that are at the root of the health status issues that exist. In providing guidance related to the development of the CHIP, HealthAlliance-Clinton Hospital was clear that in addition to assessing health service gaps, capacity, utilization, and the distribution of health services that the assessment needed to consider a more extensive array of quantitative and qualitative data related to the underlying social determinants

of health. Furthermore, HealthAlliance-Clinton Hospital was clear that these issues needed to be considered when identifying community health priorities and developing the strategic action steps that would be at the heart of the CHIP. HealthAlliance-Clinton Hospital was also clear that in order for the CHNA and the implementation strategy to be aligned with the region's broader agenda, with respect to promoting health and wellbeing and addressing health disparities, the CHNA should be developed in the context health equity. Health equity is the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, underlying socioeconomic factors, and historical and contemporary injustices. Ultimately, the goal of health equity is the elimination of health and health care disparities.

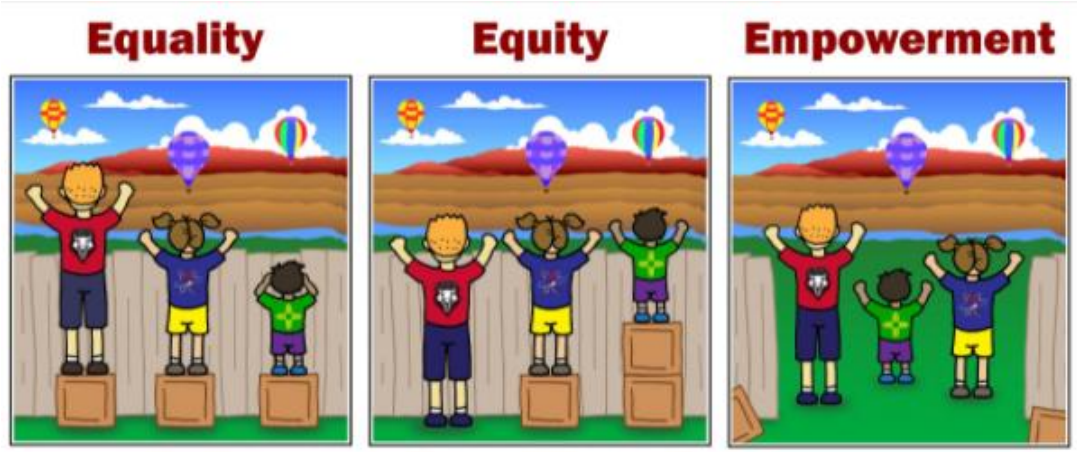


Figure 3: Health Equity

TARGET POPULATIONS

The Hospital's Community Benefit Strategic Implementation Plan includes activities that will support residents throughout its service area and from all segments of the population. However, based on the assessment's quantitative and qualitative findings, including discussions with a broad range of community participants, there was broad agreement that the Hospital's CB Strategic Implementation Plan should prioritize certain demographic and socio-economic segments of the population that have complex needs or face especially significant barriers to care, service gaps, or adverse social determinants of health that can put them at greater risk. More specifically, the assessment identified low-income populations, racial and ethnic minority and indigenous populations, recent immigrants, non-English speakers, low-income population, older adults, veterans, homeless, children and adolescents, and LGBTQIA as priority populations that deserve special attention.

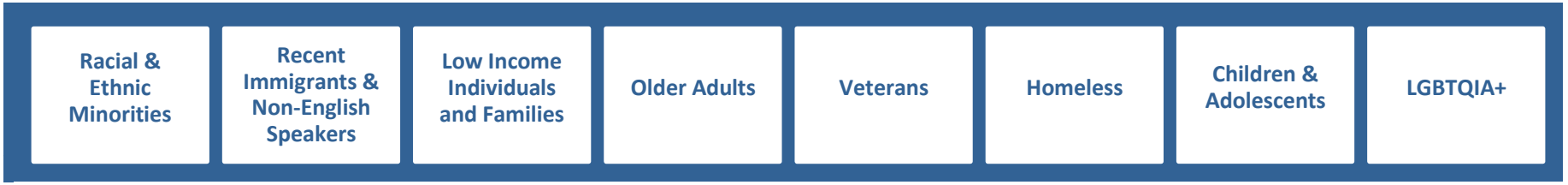


Figure 4: Target Populations

(1) Racial & Ethnic Minorities
- 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; ASL; West and East Africans
- Unique Issues around language and cultural competency, systemic racism, and access to wealth; mental health (stress and trauma)

(2) Recent Immigrants & Non-English Speakers
- Undocumented persons, migrants, immigrants, and refugees
- People whose primary language is not English, speaks another foreign language(s)

(3) **Low-Income Individuals and Families**
- People with low socio-economic status who struggle to afford basic household items (healthy food, utilities, weather appropriate clothing)

(4) Older Adults
- The aging population (62+) whose concerns center around transportation, isolation, mental health, and substance use

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

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

(7) Children and Adolescents
- People under 21 years of age, whose developing bodies and minds require special attention and care.

(8) LGBTQIA+
- Persons who express a spectrum of gender identities and sexual orientations that are counter to the mainstream.

PRIORITY AREAS AND GOALS:

Focusing on the social determinants of health and health indictors in the priority framework, UMass Memorial HealthAlliance-Clinton Hospital identified the following priority areas and overarching goals.

Priority Areas	Goal
Priority Area A1: **Health Care Access and Quality**	**Goal:** Increase access to comprehensive, high-quality, *equitable* health care services
Priority Area A2: **Social and Community Context**	**Goal:** Increase social and community support *for our target populations.*
Priority Area A3: **Housing, Neighborhood and Built Environment**	**Goal:** *Support efforts to improve housing stock,* neighborhoods and environments that promote *affordability*, health, and safety.
Priority Area A4: **Economic Stability**	**Goal:** Support efforts that lead to economic wellbeing for target populations.
Priority Area A5: **Healthy Food and Nutrition**	**Goal:** Reduce household food insecurity and hunger *through the promotion of equitable food access.*
Priority Area B1: **Behavioral Health and Substance Use**	**Goals:** *1) External*: Support social determinants of health (SDOH) efforts that lead to better mental health outcomes, including prevention of mental illness *2) Internal:* Expand and develop systems that support the continuum of mental health care to improve health outcomes.
Priority Area C1: **Chronic Disease**	**Goals:** 1) *External:* Support community-based prevention efforts for chronic diseases, particularly heart disease, diabetes, and cancer 2)*Internal*: Address access to diagnosis and self-management resources.

Note: This Plan 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 Massachusetts 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 greatest impact.

HEALTHALLIANCE-CLINTON HOSPITAL'S COMMUNITY BENEFITS PRIORITY FRAMEWORK

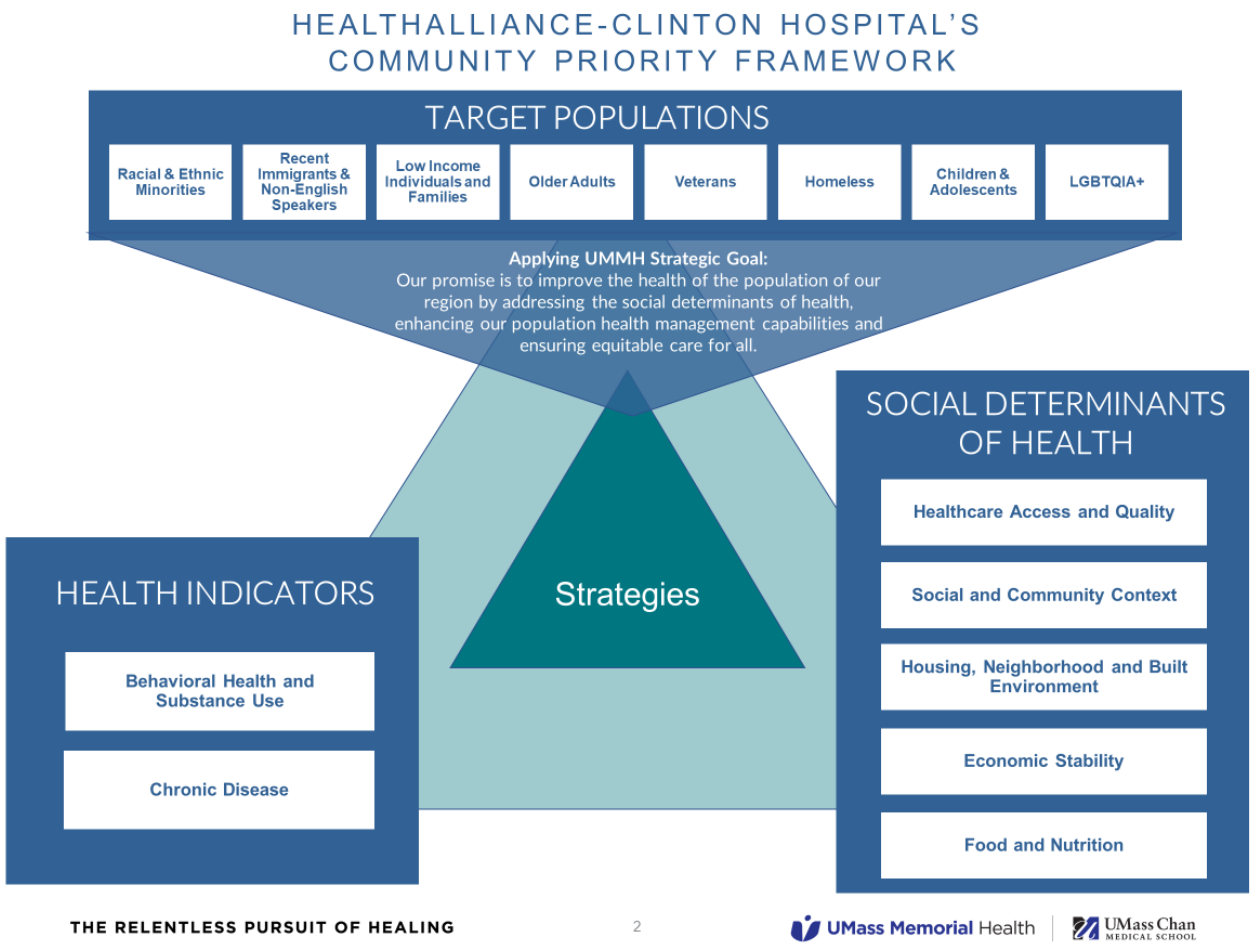


Figure 5: 2022-2024 HealthAlliance-Clinton Community Priority Framework

Building off the findings of the CHNA and the CHIP described above, the staff and leadership at HealthAlliance-Clinton Hospital, along with input from some community representatives developed a framework for prioritizing and selecting strategies and activities over the next three years that HealthAlliance-Clinton Hospital could put into action. The goal was to select a framework that would provide enough focus to be useful while leaving flexibility for updates and changes as the context and needs of the community shift over time.

The framework selected allows for the focus on strategies that have some intersectionality across a set of target populations and a set of health indicators and social determinants of health (which form our focus areas described below).

ENABLING STRUCTURES FOR ADDRESSING PRIORITY AREAS:

In alignment with the UMass Memorial Health system-wide goal to "improve the health of the population of our region by addressing the social determinants of health, enhancing our population health management capabilities and ensuring equitable care for all", HealthAlliance-Clinton Hospital is working to explore a wider network of enabling structures and leverage points throughout the entire organization to support our community priorities. This moves us toward a more efficient and integrated approach to community health engagement.

In particular, we've identified the following UMass Memorial Health and HealthAlliance-Clinton Hospital structures through which we will implement the strategies in our above identified priority areas:

Community Benefits Program:
Community Benefits are programs, activities, or services that improve the health of the community by providing treatment or promoting health as a response to an identified community need, and meet at least one of the following criteria:

- Improve access to health care to the medically underserved
- Enhance the public health of the community; or respond to the need of underserved populations
- Advance medical or health care knowledge through education or research
- Reduce or relieve the financial burden of government; or by supporting programs that would otherwise be discontinued because they operate at a financial loss
- Are done in collaboration with the community

The Determination of Need Process:
The Determination of Need (DoN) law and regulations governs how healthcare facilities implement Substantial Capital Expenditure, Substantial Change in Services and Original Licensure as well as many Transfers of Ownership and Changes. The purpose and objective of the DoN program is to encourage competition with a public health focus; to promote population health; to support the development of innovative health delivery methods and population health strategies within the health care delivery system; and to ensure that resources will be made reasonably and equitably available to every person within the Commonwealth at the lowest reasonable aggregate cost. In this way the Department hopes to advance the Commonwealth's goals for cost containment, improved public health outcomes, and delivery system transformation. (DPH definition)

Diversity, Equity, Inclusion, and Belonging: Working across the UMass Memorial Health system, the newly formed Office of Equity, Inclusion, and Belonging is focused on nurturing and empowering a diverse and engaged workforce at UMass Memorial Health. Some of the office's key focal activities include recruiting top diverse talent; building awareness understanding and respect, strengthening belonging to improve talent retention, connecting with community, and ensuring equity across our system's policies and initiatives.

Anchor Mission: In 2018, UMass Memorial Health enacted an Anchor Mission—a commitment to **consciously use** the **business and economic power** of UMass Memorial Health, in combination with our **human and intellectual resources,** to better the long-term welfare, equity, and resiliency of central Massachusetts communities. The work of the Anchor Mission traditionally falls into four pillars—investment (moving 1% of UMass Memorial's long term investments out of the stock market and into local investments that address the social determinants of health), purchasing (increasing the amount of business we do with local and/or minority and women owned businesses), hiring (creating quality employment and growth opportunities from the most vulnerable neighborhoods in Central Massachusetts), and volunteering (leveraging our workforce to get engaged in local efforts to address social determinants of health). UMass Memorial's Anchor Mission aligns with similar commitments with more than 60 other healthcare organizations across the country organized as the Healthcare Anchor Network.

Advocacy: As the largest employer in central Massachusetts, a major contributor to the local economy, and the safety healthcare provider for all of central MA, UMass Memorial Health wields a powerful voice in local, state, and national political decision making. In addition, many of HealthAlliance-Clinton Hospital and UMass Memorial Health leadership sit on national organizations who set policy and goals for healthcare organizations broadly. We see the immense value of focusing our advocacy attention on social determinants of health and the overall health and vitality of our community and local residents.

Clinical Integration: Historically, clinical integration efforts have focused on coordinating patient care across providers, settings, and time, making it easier for patients to get the care that they need in a safe, efficient, and timely way. We're moving beyond just thinking about clinical integration as a way to manage clinical care but to also address issues and environmental challenges that patients face—e.g. the social determinants of health. The UMass Memorial Population Health/Office of Clinical Integration was established to provide data and analytics, and health policy quality improvement, and coordination for clinical integration efforts across the system. Efforts in clinical integration don't have to be limited to efforts lead by this office—since the real opportunities for change can most often be identified and put into place by clinical teams themselves.

Goals and Strategies for Social Determinant of Health Priority Areas

Priority Area A1: Health Care Access and Quality Goal: Increase access to comprehensive, high-quality, *equitable* health care services		
Objective: Support priority populations gain access to resources such as affordable medical, dental, and mental health care services; insurance (Medicare or Medicaid enrollment); translation and transportation services; or housing, food, and education		
Programs/Strategies to Address Need	**New/Ongoing**	**Enabling Structure**
Provide health insurance outreach and support to assist individuals whose employers do not offer affordable coverage, who are self-employed, or who are unemployed	Ongoing	CB
Explore community health worker initiative to provide education, referral and follow-up, case management, home visiting, etc. for those at high risk for poor health outcomes	New	CB, Clinical Integration
Increase referral outcomes as a result of SDOH screening tools in inpatient/outpatient setting utilizing medical electronic record, CommunityHelp (an on-line resource inventory linking people to community resources) and warm handoffs to community partners	Ongoing	CB, Clinical Integration
Provide funding to address healthcare access/reduce barriers through HA-C's DoN grantmaking resources.	Ongoing	DON
Conduct health equity/diversity trainings with clinical and non-clinical partners to improve cultural competency and patient experience	New	DEIB, Anchor Mission
Support clinical and non-clinical partners in their efforts to improve health literacy and advance National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The National CLAS Standards aims to improve health care quality and advance health equity by establishing a framework for organizations to serve the nation's increasingly diverse communities)	Ongoing	DEIB, Anchor Mission
Advance the hospital's reputation among BIPOC populations	Ongoing	DEIB, Anchor Mission

In coordination with UMMH, execute an equity seed program to promote inclusion, expand innovation and collaboration to promote equitable care and support caregivers of color.	New	DEIB, Anchor Mission
Provide training regarding MassHealth's transportation benefits for hospital staff and other community providers (Use of PT1 form)	New	CB, Clinical Integration
Monitoring/Evaluation Approach: Track number of educational sessions Track number of ethnic/linguistic testimonials Track number of referrals outcomes Monitor grant strategies, outcomes to meet expectations		

Priority Area A2: Social and Community Context Goal: Increase social and community support *for our target populations.*		
Objective: Reduce barriers to accessing education, employment, and health care opportunities by increasing access to technology (high-speed broadband internet, hardware) and transit resources.		
Objective: Reduce social isolation among target population		
Programs/Strategies to Address Need	**New/Ongoing**	**Enabling Structure**
Advocate for policy changes to address the digital divide as a SDOH in order to strengthen healthcare access and allow for more patient and community-centered approaches	New	Advocacy, Anchor mission, Clinical Integration, CB
Support public, private, and community training programs that promote digital literacy, including health access	New	CB, Anchor Mission
Leverage public, private, nonprofit, and community collaborations to provide funding and in-kind support for digital inclusion. Work collaboratively to identify barriers to Internet, broadband technology access locally and develop solutions to overcome them.	New	CB, Anchor Mission, Advocacy, DON
Collaborate with community partners to raise awareness about LGBTQ issues and reduce health disparities for LGBTQ populations	New	CB, Clinical Integration, DEIB, DON
Support youth programs and services that seek to empower youth, build resiliency and address social isolation.	New	CB, DON, Anchor-volunteer
Provide patient referrals to community-based resources that seek to address social isolation including support groups or counseling, telephone or web-based support, social skills training or activities for social interaction. Support these community resources.	New	CB, DON, Anchor, Clinical Integration
Link people to community resources using on-line and phone resource inventory utilizing CommunityHelp	Ongoing	CB, Clinical Integration, DON

Monitoring/Evaluation Approach:

- Monitor grant strategies, outcomes to meet expectations
- Secure funding to support digital inclusion
- Identify models to develop community LGBTQ programs
- Number of referrals to community linkages/partnerships

Priority Area A3: Housing, Neighborhood and Built Environment Goal: Support efforts to improve housing stock, neighborhoods and environments that promote affordability, health, and safety.		
Objective: Promote health and safety in the places where people live, work, learn, and play.		
Programs/Strategies to Address Need	**New/Ongoing**	**Enabling Structure**
Provide support, including funding, for local community development activities such as affordable housing, anti-poverty programs, and infrastructure development	Ongoing	CB, Anchor Mission, DON
Enhance local public-private engagement to improve community identity, stimulate an improved quality of life for local residents, and spur increased investment and economic activity in Fitchburg, MA	Ongoing	CB, Anchor Mission, DON
Engage in cross-sector collaboration and advocacy efforts with the MA North Regional Housing network aiming to reduce homelessness and increase housing affordability	New (FY 2022)	CB, Anchor Mission, DON
As a pilot project, provide vulnerable patients with transportation services to and from the Simonds-Sinon Cancer Center located on the Fitchburg campus.	New	CB, Clinical Integration
In coordination with Montachusett Regional Transit Authority and WRTA, analyze current bus route utilization for all three campuses and seek opportunities to improve access (location of stops, schedules, bus shelters, etc.)	New	Advocacy, CB
In coordination with UMMH, HA-C will support investments into local projects to improve the welfare of our community, including projects that address homelessness and affordable housing.	Ongoing	CB, Anchor Mission, DON

Promote the use of existing walking and bike routes that connect local community assets (including hospital campuses) and supporting efforts for better utilization.	Ongoing	CB, Anchor Mission, DON
Support Placemaking efforts that reflect the priorities of the community and foster a sense of belonging and improve residents' quality of life, with a focus on increasing access to recreational assets near HA-C Campuses (Flat Rock-Fitchburg; Twin Cities Rail Trail- Leominster and Clinton's Complete Street initiatives (designed and operated to enable safe use and support mobility for all users).	New	CB, DON, Anchor Mission, Advocacy
Monitoring/Evaluation Approach: • Track number of educational sessions • Track number of referrals outcomes • Monitor grant strategies, outcomes to meet expectations		

Priority Area A4: Economic Stability Goal: Support efforts that lead to economic wellbeing for target populations.		
Objective: Promote hiring, retention, and workforce development of local racially and ethnically diverse residents; workplace culture that values diversity and inclusion; mentorship and support opportunities to advance to higher skilled positions.		
Programs/Strategies to Address Need	**New/Ongoing (Date Started)**	**Enabling Structure**
Develop hiring policies and resources that support local hiring and workforce pipeline development	New	DEIB, Anchor Mission
Provide scholarships and internships to priority population youth and providing bridge to at-risk youth to improve wellness and learn about careers in health care	Ongoing	CB, Anchor Mission
Build capacity, design and implement regional workforce blueprints that address the healthcare workforce crisis and identify which areas of the workforce, training and education systems will need to be built out to address workforce crisis	New	CB, DEIB, Anchor Mission
Support community based financial empowerment assets that seek to “bank the unbanked” by strengthening low-income people's financial inclusion, knowledge and access.	New	CB, DEIB, Anchor Mission
Monitoring/Evaluation Approach: • Track number of educational sessions • Track number of scholarships and internships • Track number of referrals outcomes • Monitor grant strategies, outcomes to meet expectations		

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Priority Area A5: Healthy Food and Nutrition
Goal: Reduce household food insecurity and hunger through the promotion of equitable food access.
  </td></tr>
<tr><td colspan="3">Objective: Increase access to food assistance programs, such as the National School Lunch Program (NSLP), the Women, Infants, and Children (WIC) program, and the Supplemental Nutrition Assistance Program (SNAP), address barriers to accessing healthy food</td></tr>
<tr><th>Programs/Strategies to Address Need</th><th>New/Ongoing</th><th>Enabling Structure</th></tr>
<tr><td>Expand access to affordable and nutritious food (eg, community gardens, Farmers Market Nutrition Program; Veggie Rx, a fruit and vegetable prescription program to alleviate food insecurity among patients with diabetes)</td><td>Ongoing</td><td>CB, DON, Anchor Mission</td></tr>
<tr><td>Work with CHNA 9’s Healthy Eating and Active Living Workgroup to expand access to healthy foods and recreational opportunities in partnership with area food banks, farmers markets, community garden organizations, recreational facilities, and other community organizations</td><td>Ongoing</td><td>CB, DON, Anchor Mission</td></tr>
<tr><td>Support local food banks and other community-based organizations to promote access to healthy foods and addressing obesity (e.g., Local food banks, Farmers Markets, community gardens and faith-based organizations)</td><td>Ongoing</td><td>CB, DON, Anchor Mission</td></tr>
<tr><td colspan="3">Monitoring/Evaluation Approach:
• Track number of educational sessions
• Track number of referrals outcomes
• Monitor grant strategies, outcomes to meet expectations</td></tr>
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GOALS AND STRATEGIES FOR SOCIAL DETERMINANT OF HEALTH PRIORITY AREAS

Priority Area B1: Behavioral Health and Substance Use		
Goal 1 (*External*): Support social determinants of health (SDOH) efforts that lead to better mental health outcomes, including prevention of mental illness		
Objective: Address social determinants of mental health that can accelerate advances in the dissemination of social interventions and increase social and institutional supports for targeted populations		
Programs/Strategies to Address Need	**New/Ongoing**	**Enabling Structure**
Continue and expand HA-C's Opioid Task Force, made up of healthcare providers, community leaders, patient advocates and many others to tackle the problem of heroin and prescription drug abuse in the area by reducing opioid and heroin addiction, preventing overdose deaths, and improving the well-being of our community.	Ongoing	CB, Clinical Integration, DON
Work to ensure access of NARCAN in the community	Ongoing	CB, Clinical Integration, DON
Increase recovery support navigation in EDs in coordination with CHL, GAAMHA and other providers	Ongoing	CB, Clinical Integration, DON
Identify community resources for patients in need of BH services and seek to improve coordination	Ongoing	CB, Clinical Integration, DON
Organize support groups with mental health organizations in the community to support those suffering from behavioral issues and their families and caregivers	Ongoing	CB, Clinical Integration
Goal 2(Internal): Expand and develop systems that support the continuum of mental health care to improve health outcomes.		
Objective: Reduce the stigma associated with behavioral health and substance use disorders.		
Programs/Strategies to Address Need	**New/Ongoing**	**Enabling Structure**
Provide Behavioral Health First Aid Training to caregivers	New	CB, Clinical Integration

Work with Community based behavioral health stakeholders to increase the capacity of the Hospital's Community Hospital Acceleration Revitalization and Transformation (CHART) Program activities in the Emergency Department	Ongoing	CB, Clinical Integration
Monitoring/Evaluation Approach: • Establishment of committee to develop model • Secure funding to develop community based mental health programs • Number of providers trained in Behavioral Health First Aid Training		

Priority Area C1:
Goal 1 (*External*)*:* Support community-based chronic disease prevention efforts, particularly focused on heart disease, diabetes, and cancer.
Objective: Increase patients' health-related knowledge via efforts to simplify health education materials, improve patient-provider communication, and increase overall literacy

Programs/Strategies to Address Need	New/Ongoing	Enabling Structure
Continue to with the region's board of health offices on community outreach, education, testing and vaccination efforts to address COVID-19 with an emphasis on addressing disparities and reaching vulnerable groups and populations including ethnic and linguistic populations.	New	CB, Clinical Integration
Support Community Health Worker (Promotoras de Salud) and recovery coaches' models	Ongoing	CB, Clinical Integration, DON
Organize educational opportunities and events for internal collaboration and external engagement around equity	New	CB, Clinical Integration
Engage marginalized patients in the design and validation of health innovation solutions	New	CB, Clinical Integration
Goal 2 (*Internal)*: address access to diagnosis and self-management resources.		
Objective: Reduce disparities in screening rates and health outcomes for priority populations segment		
Programs/Strategies to Address Need	**New/Ongoing**	**Enabling Structure**
Continue to conduct SDOH Screening in hospital and community settings. Implement strategy to connect needs of patients identified in screening tool with community-based resources.	Ongoing	Clinical Integration, CB, Population Health
Organize breast and lung cancer education, screening, and referral programs for priority populations	Ongoing	Clinical Integration, CB,

Monitoring/Evaluation Approach:

- Monitor grant strategies, outcomes to meet expectations
- Identify models
- Evidence of community linkages/partnerships

Monitoring Evaluation Plan:

Please note: A robust evaluation process will be developed for HA-C's Community Benefits Strategic Implementation Plan as part of Lean Six Sigma design project in early 2022. Components of the evaluation plan will include:

1. Development of objectives for each goal area that align with both the existing and proposed strategies
2. Identification of level of community engagement based off the Spectrum of Community Engagement
3. Alignment with other SDOH's for impact
4. Alignment with Health Indicators
5. Development of measurement outcomes/impacts for each strategy with identified metrics.

Appendix

Community Benefits Steering Committee HealthAlliance- Clinton Hospital representation:

Mary	Lotze	Community Co-Chair
Maureen	Croteau	Executive Assistant to the Hospital President
Kathy	Boudreau	Special Events Coordinator
Michael	Paruta	Sr. Director of Human Resources
Lisa	Duffy	ACNO
Patricia	Pistone	Senior Director of Development and External Affairs
Paul	MacKinnon	Corporate Executive Vice President/COO/CNO
Pamela	MacDonald	HR
Renee	Anderson	Director of Pastoral Care
Pamela	Connor	Manager, Clinical Support Services
Jackie	Zhou	Director of Clinical Performance Improvement
Eduardo	Urbina	Director, Leominster & Clinton ED
Teresa	Russo	Director of Cancer Services
Melissa	Dilorenzo	Director, Rehab and Ambulatory Services
Rosa	Fernandez	Director of Community Health & Volunteer Services
Jodi	Knode	Physician Relations Manager
Wendy	Chartrand	Chief Compliance/Privacy Officer
Steve	Roach	Hospital President
Patricia	Vailliant	Director, Diagnostic Imaging/Urgent Care/ Take Charge
Tayyaba	Salman	MD
Kimberly	Ebb	MD
Mary	Mathieu	Director, Care Coordination/Utilization Review
Arthur	St. Germain	Exec. Director, HealthAlliance Home Health & Hospice
Janice	Kucewicz	AVP, Quality & Regulatory Affairs

Kimberly	Nolen-Mott	Director, Psychiatric Services (Clinton)
Dave	Bilotta	Sr. Dir. Campus Facilities & Public Safety
Vanessa	Dacunha	Supervisor Interpreter Services
Amy Beth	Wightman	EDUCATION AND RESEARCH, NURSING EDUCATION
Elizabeth	Houde	Infection Control Practitioner
Caryn	Cote	Manager, Care Coordination/Utilization Review
Amanda	Wilson	Social Worker, MSW
Steven	McCue	VP, Chief Financial Officer
Charles	Cavagnaro	VP, Chief Medical Officer, Community Hospitals
Stephanie	Doan	Administrative Fellow

Community Benefits Advisory Board:

Jody	Briedel	North County Regional Director	WHEAT	Clinton
Christine	Cordio	Adult Education Director	Adult Learning Center	Clinton
Stephen	Curry	Health Director	Board of Health	General
Katherine	Boudreau	Community Outreach Specialist	Hospital	Hospital
Phil	Duffy	Community and Economic Development Director	City of Clinton	Clinton
Glenn	Eaton	Executive Director	MRPC	General
Rosa	Fernandez	Director, Community Health & Volunteer Services	Hospital	Hospital
Patricia	Pistone	Senior Director, External Affairs	Hospital	Hospital
Irene	Hernandez	Member	PFAC/Active Adults etc.	General
Neddy	Latimer	Executive Director	Spanish American Center	Leominster
Brandy	Litt	Director of Community Engagement and Support Services	LUK	Fitchburg
Sue	Lowe	Director of Patient Services & Community Outreach	Community Health Connections	Fitchburg
Chelsey	Patriss	Executive Director	CHNA9	General
McDonald	Peter	Executive Director	Sunrise Assisted Living	General
Francisco	Ramos	Community Organizer	NewVue Communities	General

Eladia	Romero	District Representative	Representative McGovern's Office	General
Melissa	Taska	Small Business Coordinator	City of Leominster	Leominster
Leona	Whetzel	VP, Community Benefits	Montachusett Opportunity Council	Fitchburg
Ayn	Yeagle	Executive Director	Growing Places	Leominster

Community Partners:

HA-C Patient Family Advisory Council
HA-C Diversity, Equity, Inclusion, and Belonging (DEIB)Advisory Council
Health Equity Partnership Members (CHNA9)
Montachusett Regional Planning Commission
Heywood Healthcare (Heywood & Athol Hospital)