COMMUNITY BENEFITS STRATEGIC IMPLEMENTATION PLAN
2022 – 2024
FOR UMASS MEMORIAL HARRINGTON HOSPITAL
AN AFFILIATE OF
UMASS MEMORIAL HEALTH

A COMMUNITY HEALTH IMPROVEMENT APPROACH TO ADDRESSING HEALTH INEQUITIES

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I. Introduction

UMass Memorial Health's Community Benefits 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." UMMH's Community Benefits Mission was developed and recommended by the Community Benefits Advisory Committee and approved by the UMass Memorial Health Board of Trustees.

Community Benefits Mission Statement
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 Health recognizes that health care delivery represents only a portion of an individual's and a community's health and in order 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 Benefit Plan targets the social/health factors that are important in the delivery of care. Our work with public health, schools, health centers, youth-at-risk and community partners leverages unique opportunities to address social factors and improve the health of the Greater Worcester community.

Our Community Health Improvement Approach and Guiding Principles:

The following principles are the foundation of our community health improvement approach:

- Health Equity is at the core of all of our work
- Address Social Determinants of Health/Root Cause Issues
- Partner with Public Health and community-based organizations
- Cross/multi-sectoral Partnerships
- The community knows best. Everyone can contribute to developing and implementing efforts to address root causes of health inequities
- The UMass Memorial Health Anchor Mission builds upon our Community Health Improvement work
- The use of accurate data
- Identify Community Health Needs through a robust assessment process
- Develop a Community Health Improvement Plan with targeted strategies and outcome measures

II. UMass Memorial Anchor Institution Mission

In 2018, to build upon and maximize the impact of our Community Benefits programming, UMass Memorial Health elevated and enhanced its community benefits work with the formal adoption of the Anchor Institution mission and strategy, which includes a $4.0 million investment fund that targets Social Determinants of Health (SDOH). The system wide Anchor Mission addresses SDOH in the local community by leveraging the full breadth and depth of the system's assets. The concept is developed by the Democracy Collaborative, a national research institute. The Anchor Mission encourages and challenges large institutions, with strong roots in a specific locale, to expand their traditional business practices and strength to more broadly improve and develop the economy of the areas they serve with a targeted focus on distressed neighborhoods. This means moving from a more clinically focused approach to a wider perspective including nonclinical, social, and environmental factors that affect a person's health such as housing, education, poverty, nutrition, economic stability and physical environment.

The Anchor Mission is comprised of four pillars: investing – devoting 1% of our investment portfolio to initiate local projects that bring neighborhood revitalization and economic vitality to the community; hiring – identifying opportunities to ensure employee diversity is reflective of our community; purchasing – supporting local businesses by buying locally whenever we can; and volunteering – offering opportunities where employees can get involved and contribute to the mission of our organization outside of their traditional roles. The Anchor Mission focuses on four primary pillars of: Investing, Hiring, Purchasing and Employee Volunteerism.

With the Anchor Mission, UMass Memorial, along with community stakeholders and a commitment to local investment, will create new opportunities to improve the economic outlook of vulnerable, low-income populations in our region. Active investment guided by the Anchor Mission, has included strategic investment in housing for vulnerable populations in Worcester and for the redevelopment of the former Ionic Avenue Boys Club into a creative arts community. In addition, the hospital system is working closely with community-based workforce organizations in developing employment strategies for vulnerable populations, including creating a hiring pipeline to positions within our organization. Additionally, the hospital system is incorporating efforts to buy locally, improve access to employment and investments into neighborhoods that are economically challenged.

Community Benefits staff are highly engaged in each of the four Anchor Mission pillar areas as well as a targeted effort identifying and establishing an Anchor District in the City of Worcester in one of the city's most economically distressed areas with high Social Vulnerability Index (SVI), a census tract level composite measure, used for determining communities that will likely need support before, during, and after emergency events. SVI calculations are based on measures associated with socioeconomic status, household composition, minority and language status, housing, and transportation.

UMass Memorial Health Harrington Hospital Community Benefits Strategic Implementation Plan utilizes the findings from the hospital's 2022 Community Health Needs Assessment and aligns with identified Priority Areas to maximize collective impact. This document provides an overview of our Priority Areas, partnerships, and community-based work. Questions or inquiries regarding UMass Memorial Harrington Hospital's Community Benefits strategies and efforts can be directed to: Sue Fafard-Desrosiers Outreach Director: Sue.Fafard-Desrosiers@umassmemorial.org.

Notation: This Plan is intended to be a fluid document that will be updated annually according to new opportunities, programming and partnerships. UMass Memorial Health Harrington Hospital recognizes that through the CHA 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.

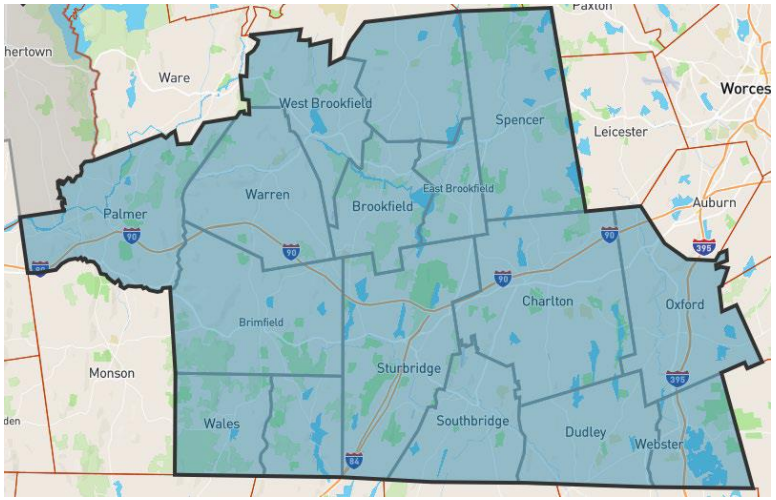
III. Targeted Geography and Vulnerable Populations

UMass Memorial Health aims to adhere to both the letter and the spirit of the IRS Community Health Needs Assessment (CHA) regulation in that it will be addressing the health needs and concerns of the region's most underserved populations. The IRS mandate gives hospitals flexibility in how they define the community discussed in the CHA. The community could be defined by a specific geographic area or target populations (e.g., children, seniors), if the definition still captures the interests of the most vulnerable groups such as the underserved, low income, or minority populations.

A. Geography:

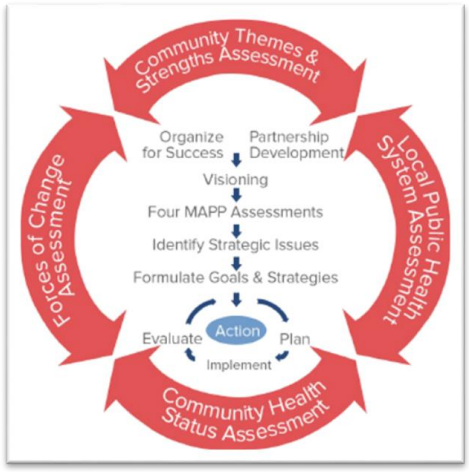
The CHA's Community Benefits Service Area (CBSA) includes the municipalities of Brimfield, Brookfield, Charlton, Dudley, East Brookfield, Holland, North Brookfield, Oxford, Palmer, Southbridge, Spencer, Sturbridge, Wales, Warren, Webster, and West Brookfield. Data tables in this report include data for Hampden County, Worcester County, and the Commonwealth of Massachusetts when possible. As a population-based assessment, the CHA considers the needs of the entire population - regardless of demographics, socioeconomics, health status, and if/where people receive health care services. Special attention is given to addressing the needs of populations that face disparities in health-related outcomes, have been disenfranchised, and those who are more likely to experience barriers to care.

CHA Service Area Map



The CHA and CHIP processes serve multiple purposes, including: 1) as the community health needs assessment for the hospital's Schedule H/Form 990 IRS requirements and Massachusetts Attorney General guidelines; and 2) engage the community in a collaborative health planning process to identify shared priorities, goals, objectives, and strategies for moving forward in a coordinated way.

The Mobilizing for Action through Planning and Partnerships (MAPP) framework was used to guide the CHA assessment. The MAPP Framework was developed by the National Association of County and City Health Officials (NACCHO) with support from the Centers for Disease Control and Prevention (CDC) and represents a best practice model for health improvement planning.



B. Focus on Health Equity and Social Determinants of Health

UMass Memorial Harrington Hospital also recognizes the need for the CHA to be aligned with the region's broader agenda of promoting health and well-being, addressing health disparities and conducting their efforts in the context of 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, ongoing societal efforts to address avoidable inequalities, underlying socioeconomic factors and injustices, whether historical or contemporary.

Source: Robert Wood Johnson Foundation

C. Vulnerable Populations/Target Populations

Target populations for UMass Memorial's Community Benefits initiatives are identified through a community input and planning process, collaborative efforts, and a Community Health Needs Assessment (CHA), which is conducted every three years. Our target populations focus on medically underserved and vulnerable groups of all ages in Worcester. Our most vulnerable populations include children, elders, ethnic and linguistic minorities and those living in poverty. These populations often become isolated and disenfranchised due to negligence, misperceptions and even fear. Targeted subpopulations have been defined as follows:

Older Adult Population: Older adults are among the fastest growing age groups. Seniors experience barriers to accessing medical and dental care, including a lack of transportation, mobility problems, insurance status and enrollment. Older individuals typically have more physical and mental health vulnerabilities and are more likely to rely on immediate community resources for support compared to young people. The first "baby boomers" (adults born between 1946 and 1964) turned 65 in 2011. Over the next 20 years, these baby boomers are now entering the older adult cohort. Chronic/complex conditions are by far the leading cause of death among older adults 73 and older are much more likely to develop chronic illnesses such as hypertension, diabetes, COPD, congestive heart failure, depression, anxiety, Alzheimer's disease, Parkinson's disease and dementia than younger adult cohorts. By 2030, the CDC and the Healthy People 2020 Initiative estimate that 37 million people nationwide (60% of the older adult population ages 65 and over) will need to manage more than one chronic medical condition. Major proportions of this group experience hospitalizations are admitted to nursing homes and receive home health services and other social support in home and community settings. The ability to live independently and to "age in-place"—or at least to find the least restrictive housing option—is a leading concern among older adults and their caregivers.

Ethnic and Linguistic Minorities: An extensive body of research illustrates the health disparities and differences in health care access and utilization by race and ethnicity. As stated by the Center for American Progress, "these disparities are not a result of individual or group behavior but decades of systematic inequality in American economic, housing, and health care systems." These disparities illustrate the disproportionate and often avoidable inequities that exist within communities and reinforce the importance of understanding demographics to identify populations more likely to experience adverse health outcomes. In all CBSA communities, most community residents identified as non-Hispanic white. However, it should be noted that the percentage of Hispanic/Latino residents in Hampden County (26%), and many of the CBSA communities, was significantly high compared to the Commonwealth overall.
Looking across all CBSA communities, percentages were particularly high in Southbridge (36%), Webster (14%), and Dudley (12%). In these communities, the most common nation of origin was Puerto Rico. Interviewees expressed concern about issues of discrimination, language and cultural barriers to care, and racial equity in the community.

Populations that are Food Insecure, Hungry, Obese/Overweight: Lack of physical fitness and poor nutrition are among the leading risk factors associated with obesity and chronic health issues. Both factors help to prevent disease and are essential for the healthy growth and development of children and adolescents, while overall fitness and the extent to which people are physically active reduce the risk for many chronic conditions and are linked to good emotional health. Over the past two decades, obesity rates in the United States have doubled for adults and tripled for children. Overall, these trends have affected all segments of the population, regardless of age, sex, race, ethnicity, education, income, or geographic region. People who are overweight are more likely to have type 2 diabetes, heart disease, stroke, gall bladder disease, cancer and musculoskeletal disorders (MDPH). Children who are obese at age 8 are 90% more likely to be overweight or obese as adults (MDPH).

Populations Living in Poverty: Level of income and poverty influences all aspects of an individual's life, including the ability to secure housing, needed goods (e.g., food, clothing), and services (e.g., transportation, health care, childcare). It also affects one's ability to maintain good physical and mental health. Lack of gainful and reliable employment is linked to several barriers to care, including lack of health insurance, inability to pay for health care services and copays, and inability to pay for transportation to enable individuals to receive services. Certain populations struggle to find and retain employment for a variety of reasons – from mental and physical health issues, to lack of childcare, to transportation issues and other factors. Poverty is highly correlated to poor health outcomes. The percentage of the total population living below the federal poverty level in Southbridge (19.6%) was nearly double than the Commonwealth overall (9.8%). Over a fourth of children in Southbridge live below the federal poverty level (26.6%) compared to 12.2% for the Commonwealth overall.

Underinsured/Uninsured: Access to affordable health care is vital to the health of individuals and the community. Massachusetts has made great strides in making health insurance attainable for nearly all residents. In 2016, only 2.5% of Massachusetts residents were uninsured, the lowest rate in the nation. Despite these factors, there are still substantial numbers of low-income, Mass Health insured, uninsured and otherwise vulnerable individuals who face health disparities and are not engaged in appropriate preventive, acute and chronic disease management services in the areas of medical, behavioral, and oral health services. Efforts must be made to support the safety net across the health, social service and public health continuum, expand access to services and reduce the barriers to care for vulnerable populations. The most significant barrier in this regard is related to a shortage of providers and practice sites that serve Mass Health insured and uninsured residents. This is particularly true in the areas of behavioral health and oral health services.

Youth at Risk: Over 35% of children under the age of 18 live in households for whom poverty status is determined and 39.7% live in households receiving Supplemental Security Income (SSI), cash public assistance income, or Food Stamp/SNAP benefits, according to the US Census Bureau, American Community Survey 2013-2017. Poverty, low educational attainment, and limited job opportunities are among the top social determinants leading to lower utilization of health care services and poor

health outcomes. Concerns around the health and wellness of young people, including young children, teens, and young adults, were at the forefront of discussions over the course of the Community Health Assessment. Most of the discussion centered on mental health concerns, especially in the wake of COVID-19, where young people may witness and bear the effects of stress in their homes and communities. Families, caregivers, and students have had routines interrupted, resulting in uncertainty, economic concerns, and anxiety. CHA interviewees identified the access to mental health services was difficult, due to cost and insurance barriers, lack of providers/services (especially for youth), and general access issues (e.g., transportation barriers, inability of parents to get children to appointments.)

IV. Community Health Needs Assessment (CHA) Planning

UMMH's Community Benefits Programs meet the Schedule H/Form 990 Internal Revenue Service and Massachusetts Attorney General reporting requirements for not-for-profit hospitals. 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." We embraced the Affordable Care Act requirements to conduct community health needs assessments and best practice creation of a community health improvement plan.

The UMass Memorial's Community Benefits Program works closely with medically underserved populations; neighborhood groups; local and state government officials; local and state Health Department staff and other municipal departments; faith-based organizations; advocacy groups and neighborhood; schools and other community-based organizations. In 2019 - 2022, the Community Benefits Program supported initiatives in such areas as: youth physical activity; healthy eating; youth employment; positive youth development; safe driving for teen's; community-based oral health; culturally sensitive health care for underserved and disconnected populations; residential substance use treatment for adult and youth mental health services and healthy behaviors; insurance enrollment, a medical legal partnership and community/clinical linkages for pediatric asthma. Beginning in March 2020, ADD specific notes community-based approaches were implemented to combat COVID-19 within neighborhoods targeting populations most at-risk.

Commented [RK1]: Update for Harrington

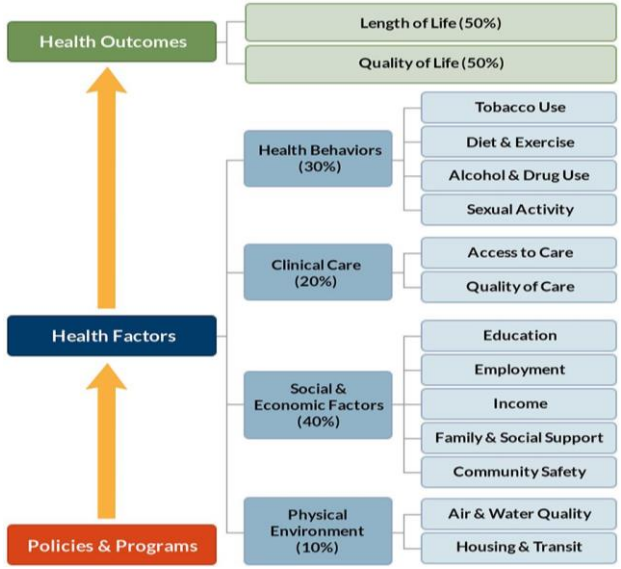
V. Methods

Over the past decade, there has been an increased understanding—among policymakers, public officials and service providers—of the importance of developing broad system-wide plans to guide public and private agencies, service providers and other stakeholders as they work collectively to address barriers to care, improve health status and strengthen regional health systems. To be effective, these plans and their assessments and recommendations must be:

- Comprehensive involving the full range of health care, social service and public health providers
- Data-driven—applying quantitative and qualitative data from primary and secondary sources in ways that allow for sound decision making
- Collaborative—engaging all relevant stakeholders including, public agencies, service providers and the at-large community in a transparent, inclusive process
- Action-oriented, measurable and justifiable—providing a clear path or roadmap that guides action in clear, specific, measurable ways and allows for the implementation of short-term and long-term strategies

• Evidence-based—implementing projects and strategies that are proven, rooted in clinical or service provider experience and that take into consideration the interests and needs of the target population. The CHA utilized a mixed-methods assessment approach that integrates quantitative and qualitative data. The 2022 effort focused on compiling information through an extensive community engagement effort that involved stakeholder interviews, focus groups, and a community health survey, as described below. Data and findings from recent local assessment and planning efforts have also been integrated.

Historically, health care systems have focused more on clinical services, physical health and treatment of chronic conditions, such as heart disease, cancer, asthma and diabetes. Over the past decade, there has been a clear shift to focus on preventing and addressing the underlying social, economic, behavioral and physical determinants of health. There is increasing awareness that these issues are at the root of poor individual health status, community well-being and overall population health. As shown in the Figure on the right, there is growing body of research shows that only a small portion of one's overall health can be attributed directly to access to and quality of clinical care. The remainder is linked to genetics and health behaviors. The 2022 Harrington Hospital Community Health Needs Assessment, along with the expectations of the Commonwealth, the federal government, and PHAB are framed with these ideas in mind.



The Community Health Improvement Planning process for the Harrington Hospital service area includes two major components:

1. A Community Health Assessment (CHA) to identify the social-economic factors and health-related needs and strengths of the hospital's service, and
2. A community-based Community Health Improvement Plan (CHIP) to determine major health priorities, overarching goals, and specific objectives and strategies that can be implemented in a coordinated way for this region.

Given the synergy in geography and processes, findings of the recent CHA inform both the CHIP and this UMass Memorial Harrington Hospital Community Benefits Strategic Implementation Plan. The CHA-CHIP processes utilized a participatory, evidence-based community-driven approach guided by the Mobilization for Action

through Planning and Partnerships (MAPP) process.[1, 2] To develop a shared vision and plan for improved community health, and help sustain implementation efforts, the Greater Worcester assessment and planning process engaged multi-sector community organizations, community members, and partners through different avenues:

Completion of the CHA included input from hundreds of individuals who participated in interviews, focus groups, community forums and strategic retreats (held virtually due to COVID). (See Appendix C for a full listing). Participants included representatives of health and social service organizations, public health departments, academic institutions, community-based organizations and advocacy groups, residents as well as businesses leaders and individuals who live and work in the community. In addition, 1,892 people completed electronic community health surveys. We also offered the same survey on paper for the people who didn't have access to computers and also for people who needed assistance filling them out, for example; the Hispanic population. We also sent it out to this same population, Spanish/Latino, non-speaking by electronic survey again and between the paper and electronic results, we received roughly 228 more survey results. The information gathered through these efforts enabled the CHA Facilitators to engage the community and gain a better understanding of the region's capacity, strengths, and weaknesses, as well as health status, barriers to care, service gaps and underlying determinants of health. While it was not possible for this assessment to involve all community stakeholders, it engaged a comprehensive and inclusive sample of the population; those involved showed commitment to strengthening the region's health system, particularly for people most at-risk.

Commented [RK2]: Add note about translation and distribution over survey in Spanish

Secondary and primary data from multiple sources was utilized in the completion of the CHA and special attention was given to social and economic indicators. The results of these efforts were synthesized in the CHA report and posted to the hospital's website.

The UMass Memorial Harrington Hospital Community Benefits Strategic Implementation Plan is developed taking into consideration needs and priorities identified in the 2019-2022 CHA. Based on this foundation, priority areas were identified, goals were defined, and objectives created for each goal and to operationalize these objectives and ensure alignment with the CHIP. Outcome indicators and a timeline were established for each priority area. The Community Benefits Plan is approved by the Community Benefits Committee of the UMass Memorial Health Board of Trustees.

VI. Summary of Community Needs

The following issues were identified in the 2019-2022 CHA. These needs informed the priorities, goals, objectives, and strategies of the UMass Memorial Harrington Hospital Community Benefit Strategic Implementation Plan.

The CHA identified six **Priority Populations**. Priorities were set in order to concentrate efforts, drive collective impact, and focus discussions in developing the Greater Worcester Community Health Improvement Plan. In alphabetical order they are as follows:

1. Individuals and families with limited economic means
2. Youth and adolescents

[1] www.uwgmc.org/CHA)

[2] MAPP, a comprehensive, planning process for improving health, is a strategic framework that local public health departments across the country have utilized to help direct their strategic planning efforts. MAPP is comprised of four distinct assessments that are the foundation of the planning process and includes the identification of strategic issues and goal/strategy formulation as prerequisites for action. Since health needs are constantly changing as a community and its context evolve, the cyclical nature of the MAPP planning/implementation/ evaluation/correction process allows for the periodic identification of new priorities and the realignment of activities and resources to address them. Advanced by the National Association of County and City Health Officials (NACCHO), MAPP's vision is for communities to achieve improved health and quality of life by mobilizing partnerships and taking strategic action. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. More information on MAPP can be found at: http://www.naccho.org/topics/infrastructure/mapp/

3. Individuals with chronic and complex conditions
4. Non-English speakers
5. Older adults

Priority Areas and Cross Cutting Issues
The CHA aims to identify the full range of community health issues affecting the region, across all its demographic and socioeconomic segments. The assessment is framed broadly to ensure that the breadth of unmet needs and community health issues are recognized. However, it is critical that the CHA identify leading community health issues based on the full range of data collected throughout the CHA process.

With this in mind, the leading community health issues were grouped into five priority areas:

- **Social determinants of health**, including economic insecurity, transportation, housing, food insecurity, cultural and linguistic barriers
- **Behavioral health (mental health and substance use)** including depression, stress, anxiety, trauma, social isolation, serious mental illness, interpersonal violence; opioids, alcohol, tobacco, and marijuana use
- **Access to care**, including affordability, access to primary care and behavioral health care, culturally and linguistically appropriate care
- **Chronic/complex conditions and their risk factors**, including heart disease and stroke, obesity, cancer, diabetes, and neurological conditions (e.g., Alzheimer's, dementia)
- **Health equity:** a cross-cutting priority that affects barriers to care, health outcomes, and health disparities in each of the other priority areas

The following crosscutting issues that underlie the leading health priorities were also identified as necessary to address to improve overall health status and reduce existing disparities:

- Racism, discrimination, and health equity
- Health system issues (e.g., workforce issues, health literacy, care coordination, health information technology, and health information exchange)

VII. UMass Memorial Harrington Hospital Community Benefits Strategic Implementation Plan

Priority: Social determinants of health, including economic insecurity, transportation, housing, food insecurity, cultural and linguistic barriers. The social determinants of health are the conditions in which people live, work, learn and play. These conditions influence and define quality of life for many segments of the population in the CHA service area. A dominant theme from key informant interviews and community forums was the tremendous impact that the underlying social determinants, particularly economic insecurity, housing, food insecurity, and transportation have on health status. Socioeconomic status, as measured by educational attainment, income, employment status, occupation, and the extent to which one lives in areas of economic disadvantage, is closely linked to morbidity, mortality, and overall well-being. Lower-than-average life expectancy is highly correlated with low-income status.

Food insecurity is linked to poverty, insufficient and unstable income. Food insecurity and related concerns including obesity and behaviors associated with obesity, such as access to healthy nutrition and physical activity. The data supports that these issues are considered critical given that heart disease and diabetes are among the leading causes of morbidity and mortality. Of particular concern is limited access to healthy foods and environments supporting active living for vulnerable populations and immigrant communities. The pandemic has increased food insecurity among families with children and communities of color, who were already faced hunger at much higher rates before the pandemic. The Worcester County Food Bank (WCFB) reports that there are over 75,000 food insecure households in Worcester County in 2021—approximately 1 in 12 people and 1 in 9 children. Among children, the rate is 1 in 8. Across the region, patrons visit food pantries in the short term to sustain them through periods of disability or job loss. Increasingly, food pantries are being used as long-term strategies to supplement monthly shortfalls in food.

Priority: Behavioral health (mental health and substance use: Mental health—including depression, anxiety, stress, trauma, and other conditions—was cited as the leading health issue for residents in the CHA service area. Individuals and organizations noted the following as particular concerns:

- The significant burden of stress and anxiety, especially as it relates to socioeconomic status (e.g., poverty, income, cost of living)
- The long-term mental health impacts and fatigue associated with marginalization and disenfranchisement in nearly all facets of life (for people of color, non-English speakers, individuals with disabilities, low income, individuals with mental health and SUD)
- The prevalence of mild to moderate depression across all nearly all segments of the population, from children to older adults
- The impact of adverse childhood experiences (e.g., abuse, witness to domestic violence, parents/caregivers with mental health issues or substance use disorder)

While these issues have been prevalent for many years, they were exacerbated by COVID-19. A critical concern is the lack of mental health treatment and support services across the spectrum of behavioral health services, including inpatient treatment, psychiatrists, age-specific specialists, providers that speak languages other than English, social workers, and counselors. In the CHA survey, mental illness or depression was identified as the leading health concern for the population overall, and better access to mental health services was the most common response to the question about what was most needed to improve the health of respondents' families and neighbors. Findings of the CHA showed that the percentage of adults with poor mental health in Harrington Hospital's service area was higher than the Commonwealth overall (14.0%) in most communities, with the exceptions of Charlton (13.3%), East Brookfield (13.4%), Sturbridge (12.4%), and West Brookfield (13.3%). In addition to mental health, substance use was identified as an issue of concern. Interviewees reinforced the co-morbidity that often occurs between mental health and substance use issues and identified a need for more services that treat both conditions simultaneously.

Priority: Increase Access to Care: Whether an individual has health insurance—and the extent to which it helps to pay for needed acute services and access to a full continuum of high-quality, timely and accessible preventive and disease management or follow-up services—has been shown to be critical to overall health and well-being. Access to a usual source of primary care is particularly important, since it greatly affects the individual's ability to receive regular preventive, routine and urgent care—and to manage chronic diseases. However, social determinants of health and the impact they have on health are very important and as such, are part of our Community Benefits Strategic Implementation Plan. Lack of gainful and reliable employment is linked to several barriers to care, including lack of health insurance, inability to pay for health care services and copays, and inability to pay for transportation to enable individuals to receive services. While Massachusetts has one of the highest health insurance coverage rates in the U.S., there are still pockets of individuals without coverage, including young people, immigrants, and refugees, as well as those with low incomes. These populations often struggle with access to care and face disparities with respect to social determents, chronic conditions, and other health-related outcomes.

Priority: Chronic/complex conditions and their risk factors
Priority: Health Equity/Health Disparities (Cross Cutting All Priorities)

Disparities in health status are large and pervasive nationally. For example, for most of the 15 leading causes of death—including heart disease, cancer, stroke, diabetes, kidney disease, hypertension, liver cirrhosis and homicide—Hispanics and African Americans have higher rates of chronic disease and deaths due to chronic illness than whites. Other data indicate that nationally, each year, nearly 100,000 Black people who die prematurely would live if there were no racial disparities in health. Additionally, while societal acceptance of the LGBTQ+ community has increased greatly over the past several decades, this population continues to face issues of disproportionate violence and discrimination, socioeconomic inequality, and health disparities. Though there is a tendency to view LGBTQ+ as a monolithic identity, some segments of the population experience greater disparities than others.

The Community Benefits Strategic Implementation Plan

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 UMass Memorial Harrington Hospital Community Benefits Priority Areas and Goals are listed below, followed by the detailed Community Benefit Strategic Implementation Plan. As mentioned previously, UMass Memorial's Plan aligns with findings of the CHA and the Greater Worcester Community Health Improvement Plan. The Community Benefits Strategic Implementation Plan will be tracked and updated annually.

VII. a. Priority Areas and Goals:

- **Social determinants of health**, including economic insecurity, transportation, housing, food insecurity, cultural and linguistic barriers
- **Behavioral health (mental health and substance use,** including depression, stress, anxiety, trauma, social isolation, serious mental illness, interpersonal violence; opioids, alcohol, tobacco, and marijuana use
- **Access to care**, including affordability, access to primary care and behavioral health care, culturally and linguistically appropriate care
- **Chronic/complex conditions and their risk factors**, including heart disease and stroke, obesity, cancer, diabetes, and neurological conditions (e.g., Alzheimer's, dementia)
- **Health equity:** a cross-cutting priority that affects barriers to care, health outcomes, and health disparities in each of the other priority areas.

Priority Areas and Goals

Priority Areas	Goal
Priority Area 1: **Social Determinants of Health**	**Goal:** Address social determinants of health needs including economic insecurity, transportation, housing, food insecurity, cultural and linguistic barriers among vulnerable populations as a means of improving access to needed resources and improving health outcomes.
Priority Area 2: **Behavioral health (Mental health and Substance use)**	**Goal:** Address behavioral and mental health needs and substance use, including: depression, stress, anxiety, trauma, social isolation, serious mental illness, interpersonal violence; opioids, alcohol, tobacco, and Marijuana is used among at-risk populations including youth and adults.
Priority Area 3: **Access to Care**	**Goal:** Support programs and develop collaboration efforts that will improve access to care for the medically underserved/uninsured in the hospital's service area.

Priority Area 4: **Chronic/complex conditions and their risk factors: (including: heart disease and stroke, obesity, cancer, diabetes, and neurological conditions (e.g., Alzheimer's, dementia)**	**Goal:**	Continue existing, and develop new, efforts with community stakeholders to address high rates of chronic conditions among vulnerable populations including screenings/education and other prevention efforts.
Priority Area 5: **Health equity:** a cross-cutting priority that affects barriers to care, health outcomes, and health disparities in each of the other priority areas	**Goal:**	Support programs and policies that promote health equity and reduce health disparities (e.g., workforce issues, health literacy, care coordination, health information technology, and health information exchange). Support the institution's Anchor Mission Strategy.

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. Programs, activities and outcomes listed below may be affected by or subject to potential restrictions related to the COVID pandemic.

Priority 1 - Social Determinants of Health

*(See also **Priority 5- Goal: Health Equity (Cross-Cutting Goal)***

Objective 1.1:	**Address social determinants of health needs including: economic insecurity, transportation, housing, food insecurity, cultural and linguistic barriers among vulnerable populations as a means of improving access to needed resources and improving health outcomes.**	
Outcome Indicators:	**Intended Annual Impact**	**Actual Outcomes**
Access to Healthy Eating/Nutrition:		

Objective 1.1: Address social determinants of health needs including: economic insecurity, transportation, housing, food insecurity, cultural and linguistic barriers among vulnerable populations as a means of improving access to needed resources and improving health outcomes.		
• Number of Community members receiving nutrition information including sugar, salt and fat contents of popular foods and drinks at Harrington on Wheels community outreach sites held at various Outreach places.	Conduct a minimum of 10 community outreaches in collaboration with the Harrington on Wheels program; Reach a minimum of 240 people.	Year 1: Year 2: Year 3:
• Number of people receiving complimentary body composition analysis screening done by Umass-HH Community Outreach in collaboration with the Harrington on Wheels program at community sites.	Conduct a minimum of 10 community outreaches at Harrington on Wheels program sites; Reach a minimum of 75 people.	Year 1: Year 2: Year 3:
• Number of people/households connected with WIC education and enrollment assistance when the WIC program joins the Harrington on Wheels program at their community outreach sites.	Conduct a minimum of 10 community outreach events with WIC joining the Harrington on Wheels at their outreach program sites; Reach a minimum of 200 people.	Year 1: Year 2: Year 3:
• Evidence of researching/exploring potential collaboration with the Regional Environmental Council mobile markets which is expanding services to South County.	Harrington On Wheels Community Outreach will join as many of these mobile markets in our target areas. We hope to have 6 or more events reaching 100+ people.	Year 1: Year 2: Year 3:
• CMHA Committee; RMG (Anchor investments for food insecurity).	Our Outreach program will try to collaborate with RMG and work with them as needed on Outreach sites and invite them to also join us on our sites. We hope to get together at least 5 times, reaching 100 people or so.	Year 1: Year 2: Year 3:

Objective 1.1: Address social determinants of health needs including: economic insecurity, transportation, housing, food insecurity, cultural and linguistic barriers among vulnerable populations as a means of improving access to needed resources and improving health outcomes.		
• Conduct a minimum of 45 community outreaches in collaboration with the Harrington on Wheels program;	Reach a minimum of 2,500 people	Year 1: Year 2: Year 3:
Access to Social Determinants of Health Resources:		
• Community Benefits staff to serve on the Community HELP governance committee structure for ongoing integration, and innovation utilizing Community HELP; increase awareness and usage of Community HELP among Community stakeholders.	Regular participation in the UMass Memorial Community HELP Steering Committee	Year 1: Year 2: Year 3:
• Collaborate with Healthy Families, a community-based organization providing information and linkage to diapers, food, housing, fuel assistance needs for parents/first time mothers with children five years old and under to be present onsite with the Harrington on Wheels program to provide information and connectivity to accessing resources.	Conduct a minimum of 10 community outreaches in collaboration with the Harrington on Wheels program; Reach a minimum of 200 people	Year 1: Year 2: Year 3:
• Reduce barriers to accessing Social Determinations of Health through a range of means including sustaining existing, and developing new, interventions and partnerships with community-based organizations as well as through local and state policy efforts.	• Number of programs addressing Social Determinations of Health sustained/ added 4-5 new agencies to help address as the SDOH.	Year 1: Year 2: Year 3:
Anchor Mission:		
• Address social determinants of health through Harrington Hospital staff participation in the UMass Memorial Anchor Mission efforts and pillar areas; Investment, Hiring, Purchasing and Employee Volunteerism.	Ensure Harrington Hospital staff inclusion in UMass Memorial Health Anchor Mission Committees and efforts.	Year 1: Year 2: Year 3:
STRATEGIES		**Timeline: Year 1,2,3**
Nutrition/Healthy Eating:		

Objective 1.1:	Address social determinants of health needs including: economic insecurity, transportation, housing, food insecurity, cultural and linguistic barriers among vulnerable populations as a means of improving access to needed resources and improving health outcomes.	
1.1.1	Address poor nutrition and access to healthy eating education as a means of improving health outcomes and preventing chronic conditions among vulnerable populations. Provide nutrition information including sugar, salt and fat contents of popular foods and drinks.	1,2,3
1.1.2	Offer complimentary body composition analysis screening in Umass-HH Community Outreach in collaboration with the Harrington on Wheels program at community sites.	1,2,3
1.1.3	Research means of ensuring access to healthy nutrition and education on SNAP and Massachusetts Healthy Incentives Program (HIP) for food insecure populations e.g., exploring potential collaboration with the Regional Environmental Council mobile markets which is expanding services to the South County.	TBD
1.1.4	Ensure Access to adequate nutrition for nursing mothers and infants among vulnerable, food insecure populations by continuing collaboration with WIC to be present onsite with the Harrington on Wheels program to provide infant nutrition education and WIC enrollment Assistance.	1,2,3
Social Determinants of Health/Anchor Mission:		
1.1.5	Foster Community and provide connectivity to social determinants of Health resources utilizing the Community HELP platform.	1,2,3
1.1.6	Address social determinants of health through participation in the UMass Memorial Anchor Mission efforts and pillar areas; Investment, Hiring, Purchasing and Employee Volunteerism.	TBD
1.1.7	Explore potential for expansion of UMass Memorial Medical/Legal Partnership expansion of services to Harrington. (Grant still in progress, waiting to hear).	TBD
Monitoring/Evaluation Approach: Tracking number of outreaches conducted and people served		

Priority 2- Goal: Behavioral health (mental health and substance use)

Objective 2.1:	Address behavioral and mental health needs and substance use, including: depression, stress, anxiety, trauma, social isolation, serious mental illness interpersonal violence; opioids, alcohol, tobacco, and marijuana use among at-risk populations including youth and adults.	
Outcome Indicators:	**Intended Annual Impact**	**Actual Outcomes**
Opioid Epidemic/ Opioid Awareness Education:		

Objective 2.1:	**Address behavioral and mental health needs and substance use, including: depression, stress, anxiety, trauma, social isolation, serious mental illness interpersonal violence; opioids, alcohol, tobacco, and marijuana use among at-risk populations including youth and adults.**	
• Number of people reached regarding opioid awareness information and education in the community.	A minimum of 250 people provided opioid information.	Year 1: Year 2: Year 3:
• Number of people participating in opioid awareness and education informational forums and presentations.	Hold a minimum of 2-3 forums daily and presentations; reach a minimum of 500 people.	Year 1: Year 2: Year 3:
Mental Health:		
• Number of people provided with Information on Harrington's AIC Unit in Webster and Southbridge connectivity to mental Health resources.	Provide a minimum of 500 people with Information on available mental Health services and how to access care.	Year 1: Year 2: Year 3:
STRATEGIES		**Timeline: Year 1,2,3**
Opioid Epidemic/ Opioid Awareness Education:		
2.1.1 Address the opioid crisis by continuing to provide opioid awareness information and education throughout Harrington's service area including providing focused education to the community and referring agencies, law enforcement and municipal leaders.		1,2,3
Mental Health: Foster awareness and access to mental health resources among vulnerable, at-risk populations in collaboration with Harrington Hospital's AIC Unit in Webster, the hospital's Partial Hospitalization Program (PHP)		1,2,3
Monitoring/Evaluation Approach: Tracking of people served/ end of year report		

Priority 3- Goal: Access to Care

Objective: Support programs and develop collaborative efforts that will improve access to care for the medically underserved/uninsured in the hospital's service area		
Outcome Indicators:	**Intended Annual Impact**	**Actual Outcomes**
• Number of people provided information connectivity to health insurance enrollment services, provided by Harrinton on Wheels verbally in the community.	A minimum of a total of 250 community members reached and provided with information at Harrington on Wheels neighborhood/community sites.	Year 1: Year 2: Year 3:
• Number of people provided with health insurance education and enrollment services by Umass-HMH services actually enrolled.	2,000 people	

Objective: Support programs and develop collaborative efforts that will improve access to care for the medically underserved/uninsured in the hospital's service area	
STRATEGIES	**Timeline: Year 1,2,3**
• Address barriers to accessing care and health insurance enrollment by providing information and connectivity to vulnerable populations on accessing health insurance enrollment services and connectivity with primary care/medical home and specialty care Harrington on Wheels -provides info on connecting to primary and/or specialty care/medical home	1,2,3
• Financial Benefit Advisors assist with health insurance enrollment, education and advocacy	
See also strategies improving access to: Behavioral/Mental Health services above	
Monitoring/Evaluation Approach: • Tracking of people served/ end of year outcomes	

Priority 4- Goal: Chronic Complex Conditions and their risk factors

Objective 4: Continue existing, and develop new, efforts with community stakeholders to address high rates of chronic conditions among vulnerable populations including screenings/education and other prevention efforts.		
Outcome Indicators:	**Intended Annual Impact**	**Actual Outcomes**
• Number of people participating in stroke and cardiovascular health education:	Through Community Outreach, we plan to impact roughly 1,400 people. Due to COVID-19, we are only offering the CPR-Stroke ED to employees only which is done by signing up, as employees need to renew. We hope to open our services to the community and teach a certified class in the near future.	Year 1: Year 2: Year 3:
• Number of people participating in Stop the Bleed-tourniquet training	As mentioned above, this is being offered through Community Outreach program only**.** Again, we hope to offer it to the Community as a signed-up training at our hospital, but due to COVID-19, we will continue to do it at community events when asked. We hope to do 50+.	Year 1: Year 2: Year 3:
• Number of people receiving free skin cancer screenings	This is a Community Outreach event used at special times of the year. We hope to reach 100 people.	Year 1: Year 2: Year 3:
• Evidence of exploring potential for collaboration with UMass Memorial Cancer Committee.	• To engage in a broader knowledge of cancer prevention to the community.	
STRATEGIES		**Timeline: Year 1,2,3**
4.1.1 **Cancer:** Provide ongoing cancer support to patients and caregivers as well as family members in the South-Central MA area including virtual and in person support groups for community members and patients.		1-3
4.1.2 **Stroke Education and Cardiovascular Health Education:** Harrington Hospital's Community Outreach team to continue to provide community education on symptoms of stroke and lifestyle modifications to increase cardiovascular health.		1-3

Objective 4: Continue existing, and develop new, efforts with community stakeholders to address high rates of chronic conditions among vulnerable populations including screenings/education and other prevention efforts.	
4.1.3 Provide Stop the Bleed: -tourniquet training in collaboration with the Harrington on Wheels program.	1-3
4.1.4 Explore providing Hands Only CPR at community sites (currently provided by Harrington for patients and families).	1
4.1.5 Health Screenings: Continue to provide free community skin analysis and sun damage screening utilizing a UV machine light box incorporating education on sunscreen lotions and skin cancer.	1-3
4.16 Address poor nutrition and access to healthy eating education as a means of improving health outcomes and preventing conditions among vulnerable populations. Provide nutrition information including sugar, salt and fat contents of popular foods and drinks (see Social Determinants of Health above).	1-3
4.1.7 Explore connectivity to UMass Memorial Cancer Committee for potential to bring cancer prevention related education and connectivity to screenings and care among minority populations facing disparities in health outcomes and accessing care.	2,3
Monitoring/Evaluation Approach:	

Priority 5- Goal: Health Equity (Cross-Cutting Goal)

UMass Memorial Anchor Mission

Objective 5	**Community Benefits and Harrington Hospital staff to remain engaged in the UMass Memorial Anchor Institution Mission and related Leadership, Steering, and Pillar Area Committees as a means of addressing Social Determinants of Health and addressing health inequities. These include: Steering, Investment, Hiring, Purchasing and Employee Volunteerism Committees and efforts.**	
Outcome Indicators:	**Intended Annual Impact**	**Actual Outcomes**
• **Steering and Implementation Committees** o Support ongoing development and activities guidance through participation on leadership committees including the Anchor Mission Steering and Implementation Committees	Regular participation in Committee meetings, planning efforts and activities	Year 1: Year 2: Year 3:
• **Investment Committee:** o Explore and identify potential funding opportunities and partners by linking with key stakeholders o Participate in the identification and selection process of projects for investment	Identification of Project for Investment	Year 1: Year 2: Year 3:
• **Hiring:** o Work with committee on further Development and implementation of "Outside-In and Inside-Up" approaches and pathways to employment and career opportunities within the UMass Memorial Harrington system for vulnerable populations facing barriers. o Identify potential training avenues/programs for existing and incoming employees o 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 o Data analytics of internal workforce and highest poverty census tracts	Identification of high turnover, employment needs within hospital system Identification of Community partners Alignment of Community partner needs and hospital opportunities Further development of pipeline for access to applying for identified hospital employment opportunities Development of training program to promote upward career path opportunities	Year 1: Year 2: Year 3:

Objective 5	**Community Benefits and Harrington Hospital staff to remain engaged in the UMass Memorial Anchor Institution Mission and related Leadership, Steering, and Pillar Area Committees as a means of addressing Social Determinants of Health and addressing health inequities. These include: Steering, Investment, Hiring, Purchasing and Employee Volunteerism Committees and efforts.**	
• **Employee Volunteerism** o Serve in guiding role as it relates to Community organization and Employee volunteerism opportunity identification and development in alignment with needs identified through the Community Health Needs Assessment and other Community-engaged processes. o Community Health Worker in Community Relations Office to work closely with Employee Volunteerism leaders for the planning and implementation of special volunteerism annual events such as the United Way Day of Caring, National Night Out and others.	Evidence of volunteer opportunity connectivity and planning to community opportunities in the City of Southbridge	Year 1: Year 2: Year 3:
STRATEGIES		**Timeline: Year 1,2,3**
5.1.1 Incorporate lessons learned and methods adopted during the COVID pandemic to reach vulnerable populations, ethnic and linguist minorities experiencing health disparities and barriers to resources, health and SDOH related education, resources and care. (e.g. transportation, language, technology divide)		1,2,3
5.1.2 Incorporate knowledge/learnings in working with community partners in emergent situations specifically for working with and reaching vulnerable populations		1,2,3
Monitoring/Evaluation Approach: • Ongoing coordination of various associated committees and strategy outcomes		

APPENDICES

IX. Appendix A:

A listing of data sources is available in the: Community Health Needs Assessment report:

X. Appendix B

2022-2025 Harrington Hospital Community Health Needs Assessment Key Informant Interviews, Focus Groups, virtual Community Forums, CHIP Community Conversations and other Engagement Efforts

Key Informant Interviews: were conducted with community partners including service providers, advocates, and representatives from community stakeholder organizations. . Due to the pandemic, all interviews were completed virtually, via phone or zoom, using a standard interview guide:

Stakeholder Interviews

Staff from JSI worked with Harrington to conduct stakeholder interviews with hospital staff and representatives from some of the leading community-based organizations in the service area. Stakeholders were asked to share their perspectives on leading social determinants of health, access to care issues, vulnerable populations, and opportunities for the hospital to address issues in collaboration with other community organizations.

XI. Interviewee Role & Affiliation

Interviewee	Role & Affiliation
Christina Beesley	Director of Outpatient Behavioral Health Services, UMass Memorial Health – Harrington Hospital
Emily Billings	Program Director, Southbridge Family Resource Center
Camille Diaz	Program Director, Healthy Families of Southern Worcester County
Brittany Garceau	Program Navigator, Addiction Immediate Care
Jenny McDonnell	Community Coordinator, South Central WIC Program
Edward Moore	President, UMass Memorial Health – Harrington Hospital
Ashley Rebello	Program Director, Sturbridge Day Habilitation (Center of Hope Foundation)
Dolores Toribio	Family Partner Supervisor, YOU, Inc.
Jennifer Tretheway	Satellite Site Coordinator, Family Health Center of Worcester (Southbridge)

In June of 2022, Harrington administered a web-based community health, open to all individuals who live and work in the hospital's service area. Hospital staff worked to craft a survey that was accessible and easy to understand. It was distributed widely, from June 23rd-August 22nd, 2022. Methods of distribution included:

- Postings on Facebook pages and social media platforms
- Email distribution lists
- Promotion at various community events
- Discussions with community stakeholders at meetings and engagements

Most Community Health Survey respondents:

- Identified as female (55%, n=979)
- Were under 60 years of age (55%, n=974)
- Identified as White/Caucasian (89%, n=1,578)
- Had a college degree – including degrees from technical schools (51%, n=906)
- Had annual household incomes below $75,000 (69%, n=1,238)

Quantitative Data & Data Limitations of the 2022-2025 CHA

For this report, data was gathered from a broad range of sources to characterize the community, better understand health status in the region, and to inform a comprehensive understanding of the many factors associated with poor health status. Whenever possible, data was collected at the municipal or zip code level. The Massachusetts Department of Public Health (MDPH) created the Population Health Information Tool (PHIT), which is meant to present data stratified by demographic and socioeconomic variables (e.g., gender identity, age, race, ethnicity, disability status, and poverty level) for counties, states, and municipalities. At the time this report was produced, data available via the PHIT was extremely limited. The most significant issue this limitation caused was the availability of timely data related to morbidity, mortality, health behaviors, and service utilization. Additionally, not all quantitative data was available in ways that were stratified by demographic characteristics, which limited the ability to identify health disparities in an objective way. Qualitative activities allowed for exploration of these issues, but the lack of objective quantitative data constrained the effort.

XII. Appendix C:

UMass Memorial Harrington Hospital Community Partners:

Commented [RK3]: Sue please add this list

- **Outpatient Behavior Health Services, Umass Memorial Health-Harrington Hospital**
- **Southbridge Family Resource Center- Southbridge MA, 01550**
- **Healthy Families of Southern Worcester County**
- **Addiction Immediate Care- Webster MA, 01570**
- **South Central WIC Program**
- **Sturbridge Day Habilitation (Center of Hope Foundation)- Sturbridge MA, 01566**
- **Southbridge Community Partners/Connections- Southbridge MA, 01550**
- **YMCA- Southbridge MA, 01550**
- **Family Health Center of Worcester**
- **Jacob Edwards Library- Southbridge MA, 01550**