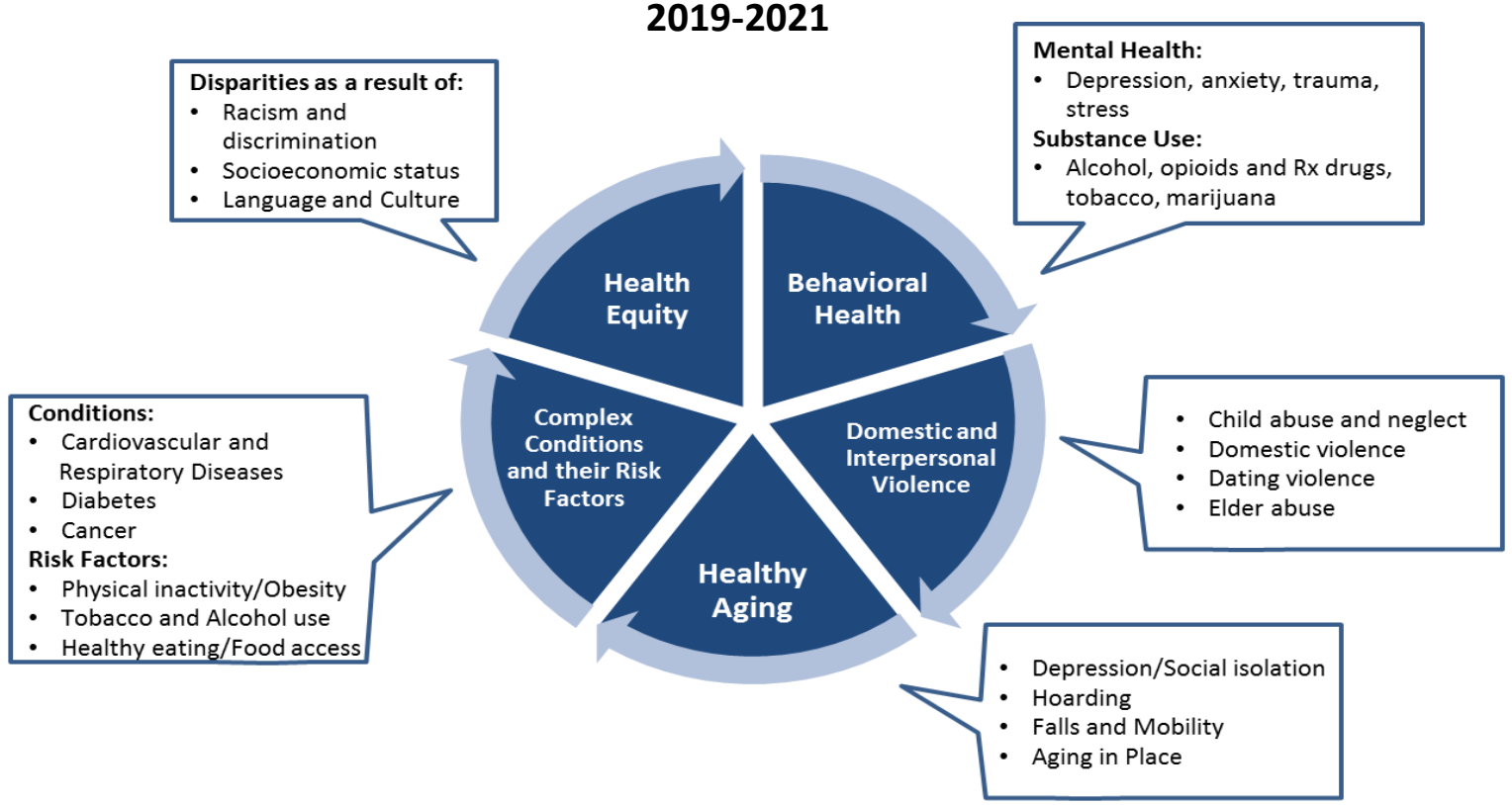
UMass Memorial HealthAlliance-Clinton Hospital
Community Benefits Strategic Implementation Plan
2019-2021



Social determinants of health: socioeconomic status, housing, transportation, social support, and access to care.

Systems issues: data and information sharing, workforce issues, care coordination, service integration, case management, health literacy/cultural competency, education/prevention.

Approved and adopted by the UMass Memorial HealthAlliance-Clinton Hospital's Board of Trustees on June 29, 2018

SUMMARY COMMUNITY BENEFITS STRATEGIC IMPLEMENTATION PLAN

Once all of the assessment's findings were compiled, The CHNA Steering Committee and the Advisory Committee participated in a strategic retreat that allowed them to review the full-breadth of quantitative and qualitative findings from Phases I and II, as well as to begin the Community Benefits (CB) Strategic Implementation Plan development process. More specifically, the Steering and Advisory Committees discussed the full range of findings by community health domain (e.g., chronic/complex conditions, behavioral health, elder health, domestic interpersonal violence, etc.) and then participated in a process that identified the population segments as well as the health-related issues that they believed should be prioritized with respect to the Hospital's CB Strategic Implementation Plan. Once the priorities were identified the Advisory Committee then discussed the range of community health/community benefit activities that were currently being implemented as well as the emerging strategic ideas that they believed should be included in UMass HealthAlliance-Clinton Hospital's updated CB Strategic Implementation Plan to respond to the prioritized community health issues.

Following is a summary discussion of the priority populations and community health issues that were prioritized by the Steering Committee with input from the Advisory Committee and other stakeholders at UMass HealthAlliance-Clinton Hospital and in the Community. Also included below are the goals, objectives, and core strategies that are included in the Hospital's CB Strategic Implementation Plan.

PRIORITY POPULATIONS

UMass HealthAlliance-Clinton Hospital, along with its other health, public health, social service, and community health partners, is committed to improving the health status and well-being of all residents living throughout its service area. Certainly, all geographic, demographic, and socioeconomic segments of the population face challenges of some kind that can hinder their access to care and regardless of age, race/ethnicity, income, family history, or health-related characteristics, no-one can completely avoid being impacted by health issues or risk factors, or perhaps more fundamentally escape the impacts of aging. The Hospital's CB 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/ethnic minority and indigenous populations, recent immigrants, non-English speakers, and older adults as priority populations that deserve /special attention.

COMMUNITY HEALTH PRIORITIES

UMass Memorial HealthAlliance-Clinton Hospital's CHNA approach and process provided ample opportunity to vet the quantitative and qualitative data compiled during the assessment. Based on this process, the Steering Committee with the support of the Hospital's staff, CHNA Advisory Committee, PFAC members, and other stakeholders has framed the community health needs into five priority strategic domains, which together encompass the broad range of health issues facing residents living in HA/CL Hospital's Service Area. These five broad strategic domains are: 1) Health Equity, 2) Behavioral Health (mental health and substance use), 3) Chronic/Complex Conditions and Risk Factors, 4) Healthy Relationships and Domestic/Interpersonal Violence, and 5) Healthy Aging.

In addition, the assessment and the Steering Committee identified two cross-cutting issues that underlie the leading health priorities and that they believe needed to be addressed to improve overall health status and reduce existing disparities. These two cross-cutting issues are: 1) the Leading Social Determinants of Health (e.g., housings, poverty, transportation, food access, etc.) and Health System Issues (e.g., health literacy, care coordination, information sharing, workforce issues, etc.).

At the Strategic Retreat, automated polling was conducted to identify at a broad level, which of the cross-cutting and topical areas should be prioritized. The following are the overall polling results. Overall, the Advisory Committee believed that among the strategic domains referenced above, behavioral health, including mental health and substance use, should be prioritized with 46% of participants selecting this issue as the number one priority. Healthy equity was identified as the second leading priority with 29% of participants selecting this issue. Chronic/complex conditions and their risk factors was selected as the third highest priorities with 25% of the vote. Elder health and Domestic/Interpersonal Violence, though recognized as priority issues, were not chosen as the leading issues by any members of the Advisory Committee.

The Hospital's CB Strategic Implementation Plan process took the prioritization process even further and identified a more detailed set of priorities within each strategic domain, which has further guided and will continue to guide HA/CL Hospital and its partners in the development and implementation of HA/CL Hospital's CB Strategic Implementation Plan.

Notation: 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.

I. Health Equity and Social Determinants of Health, and Health System Strengthening

Priority Area 1a: Promote Health Equity

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update
Promote Health Equity and Reduce Disparities for those Facing Racism and Discrimination	• Racial/Ethnic Minorities and Indigenous Populations • Recent Immigrants • LGBTQ • Other	• Increase awareness of health equity and impacts of social determinants • Reduce barriers to health care services and disparities in health outcomes • Promote cultural sensitivity at HA/CL Hospital and among other clinical and non-clinical partners	• Form a Diversity Inclusion Task Force with hospital and community representation • Conduct health equity/diversity trainings with clinical and non-clinical partners • Support CHNA 9 of North Central MA's work to address racism	• Diversity Inclusion Task Force created (Y/N) • # of Diversity Inclusion Task Force Meetings organized • # of Health Equity/Diversity trainings organized • # of people participating in Health Equity/Diversity training events • # of Community-based organizations participating in trainings by type of organization • Pre- and post-test assessment of those participating in Health Equity/Diversity trainings • Additional Measures pending. Developed by CHNA 9 as part of their activities targeted racial/ethnic minority and other vulnerable segments facing discrimination
Promote Equitable Care and Support for those with Limited English proficiency	• Children • Youth • Adults	• Increase access to interpreter services in community-settings to promote health education and access to services • Increase access to educational materials and resource inventories that promote prevention, address social determinants and link people to services	• Conduct health equity/diversity trainings with clinical and non-clinical partners • Work with Three Pyramids, WHEAT, Community Health Connections, the Salvation Army, and other community partners to enhance access to interpreter services and to materials that are linguistically appropriate • Support clinical and non-clinical partners in their efforts to improve health literacy and meet CLAS standards	• # of Health education and health literacy events organized • # of people participating in Health education and health literacy events • Pre- and post-test assessment of those participating in Health education and health literacy events • # of people provided interpreter services by priority population/language group • # of documents or flyers translated for community organizations

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update
			• Support the Adult Learning Center by increasing access to internships and workforce development	• # of documents or flyers distributed to residents in the service area • # of internships at Adult Learning Center supported by hospital
Promote Health Equity and Reduce Disparities in Access for LGBTQ Populations	• LGBT Population	• Increase awareness of health equity and impacts of social determinants • Reduce barriers to care and disparities in health outcomes • Promote health equity • Promote health literacy and cultural sensitivity at HA/CL Hospital and among HA/CL Hospital's clinical and non-clinical partners	• Conduct LGBTQ Sensitivity trainings with clinical and non-clinical partners • Explore how to best implement SOGI appropriate policies and procedures at the hospital • Collaborate with community partners to raise awareness about LGBTQ issues and reduce health disparities for LGBTQ populations	• # of LGBTQ Sensitivity trainings events organized • # of people participating in LGBTQ Sensitivity trainings events • Pre- and post-test assessment of those participating in LGBTQ Sensitivity trainings events • # of internal departments participating in efforts to implement revised SOGI guidelines • # of community partners participating in events to raise awareness about LGBTQ issues and health disparities

Priority Area 1b: Address Underlying Social Determinants and Health System Strengthening

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update
Increase Screening for Social Determinants of Health and Link Those in Need to Community Resources	• Low Income, marginalized populations	• Increase SDOH Screening • Develop robust resource inventory • Link those in need to community resources	• Conduct SDOH Screening in hospital and community settings • Link people to community resources using new on-line resource inventory	• # of SDOH screening events held at hospital and community settings • # of people screened for SDOH issues at screening events • # of people linked to community resources by type of resource • # of people who actually connected to services that were referred
Develop Partnerships with Low Income	• Low Income, marginalized populations	• Increase access to health education and screening service • Increase access to health and social services	• Work with low income housing managers, staff and residents to organize health education, screening, and self-management support services	• # of health education, awareness, screening, and referral events organized at hospital community settings

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update
Housing Facilities		• Reduce impacts of poverty • Promote engagement of appropriate primary care and self-management support	• Organize food security and food access projects targeted at public housing • Increase access to transportation for those in public housing in need • Work with CHNA 9 to develop programs geared to supporting those in public housing.	• # of people participating in health education, awareness, screening, and referral events • # of people who actually followed up on referrals and received support • # of food security and food access events organized at public housing facilities • # of people participating in food access and food security events • # of people provided transportation support at low income housing facilities
Support Workforce Development and Creation of Employment Opportunities	• Low Income, marginalized populations	• Increase mentorship opportunities for youth • Increase mentorship, training, and employment opportunities for adults • Support the advancement of HA/CL Hospital employees to higher-skilled positions with greater authority	• Organize and support mentorship programs for youth and adults to enhance skills/career advancement • Support Local Career Centers to conduct ESOL, GED, basic computer skills course, citizenship, and financial literacy classes • Provide job and career opportunities for targeted community residents	• # of mentorship programs for youth and older adults supported to enhance skills and career advancement • # of youth and adults supported by the programs by priority population • # of people from priority populations supported by job training programs • # of Workforce Development workshops organized (e.g., ESOL, GED, basic computer skills course, citizenship, and financial literacy classes) • # of people participating in workshops • # of people who participated in workshops that were able to get a job or move up the ladder to a higher skilled job by priority population
Promote Transportation Equity	• Low Income isolated, and marginalized populations	• Increase access to affordable, accessible transportation services	• Participate in regional transportation task force with CHNA 9 • Work with elder services providers to increase access to transportation for isolated older adults • Provide training regarding MassHealth's transportation benefits for hospital staff	• # of CHNA 9 Transportation Task Force Meeting participated in • # of MassHealth Transportation training events organized • # of people participating in MassHealth Transportation training events

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update
			and other community providers (Use of PT1 form)	• Pre- and post-test assessment of those participating in MassHealth Transportation training events • # of elder services providers worked with to increase access to transportation for isolated elders
Promote Healthy Eating and Active Living	• Children • Youth • Adults	• Increase access to healthy and affordable foods • Improve nutritional quality of the food supply • Decrease the number of individuals and families who suffer from food insecurity	• 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 • Support local food banks and other community-based organizations to promote access to healthy foods (e.g., Local food banks, Farmers Markets, and faith-based organizations)	• Additional Measures pending. Provided by CHNA 9 based on the specific healthy eating, active living activities organized • # of food drives, farmers markets, or recreational activity events organized • # of people participating in food drives, farmers markets, or recreational activity events • Amount of food compiled and distributed through events
Increase Access to Health Insurance and Other Public Assistance Programs	Low income & other marginalized population segment	• Provide assistance to priority populations to enroll them in health insurance and other public programs	• Support and/or organize enrollment and case management events at the hospital, at health fairs, and other community settings	• # of enrollment and case management events organized • # of community members enrolled in public assistance programs and provided case management / navigation support by priority population
Promote Resilience and Emergency Preparedness	• Local health depts. • Police and Fire Depts. • EMS	• Support cities/towns to promote resilience and EP	• Organize education and training events with first responders (EMS, Police, Fire), public health officers, and others in cities and towns	• # of education and resiliency training events with first responders organized • # of people participating in education and resiliency training events with first responders • Pre- and post-test assessment of those participating in education and resiliency training events with first responders

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update
Increase Access to Medical Services, Inc. Primary Care, OB/GYN, oral health, and Specialty Care Services	• Children • Youth • Adults	• Increase the number of patients receiving primary care medical services, including OB/GYN, oral health, behavioral health service • Increase the number of patients receiving medical specialty services	• Support and/or organize enrollment and case management events at targeted community venues • Support services and program at Community Health Connections	• # of enrollment and case management events organized • # of community members enrolled in public assistance programs who were provided case management / navigation support by priority population • # of Community Health Connection patients supported with respect to increasing their access to primary care, OB, oral health, and/or specialty care services

II. Community Health Priorities

Priority Area 2: Reduce Prevalence and Burden of Behavioral Health (Mental Health and Substance Use) (Prevention, Outreach/Identification, Treatment, and Recovery)

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update
Increase Access to Mental Health and Substance Use Education, Screening, Referral, Navigation Support, and Treatment Services	• Youth • Adults • First responder (EMS, Police, Fire) • School teachers/ educators Particularly Those Most Vulnerable	• Increase awareness of mental illness • Increase access to mental health services • Reduce disparities in screening rates and health outcomes for vulnerable segments • Increase access to alcohol and substance use support services • Reduce disparities in screening rates and health outcomes for vulnerable segments	• Form the Opioid Task Force with stakeholders throughout the community, including representatives from police, fire, first responders, public health departments, and other community organizations • Work with CHNA 9's Behavioral Health Workgroup to organize Mental Health First Aid workshops for priority pops. • Work with CHNA's Behavioral Health Workgroup to increase the capacity of the Hospital's Community Hospital Acceleration Revitalization and Transformation (CHART) Program activities in the Emergency Department setting to identify substance users and	• Opioid Task Force with key stakeholders in community created (Y/N) • # of Opioid Task Force Meetings organized • # of participants and individual organizations participating in Opioid Task Force meetings • # of Mental Health First Aid trainings organized • # of participants participating in Mental Health First Aid trainings • Pre- and post-test assessments of knowledge for those participating in Mental Health First Aid

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update
			work with partners to provide recovery support (e.g., through the use of Peer Recovery Coaches) • Organize support groups with mental health organizations in the community to support those suffering from behavioral issues and their families and caregivers • Promote behavioral health integration	• Additional Measures to be created. Pending details from Hospital CHART Team on programs continued in Hospital ED • # of Support Groups organized • # of participants participating support Groups • # of non-behavioral health practice sites supported to integrate behavioral health into their operations

Priority Area 3: Reduce Prevalence and Burden of Domestic and Interpersonal Violence

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update
Identify and Support Victims of Trauma, Domestic Violence, and Emotional Distress	• Victims of trauma & domestic Violence • People in emotional distress	• Increase awareness of risk factors, impacts, and appropriate responses to domestic and interpersonal violence • Increase outreach, education, and screening events • Increase access to trauma informed care • Increase access to temporary safe housing for victims of trauma and domestic violence	• Work with CHNA 9 to develop programs geared to supporting those impacted by domestic and interpersonal violence • Organize and facilitate peer support group for those in emotional distress or experiencing grief • Conduct domestic violence screening in the hospital inpatient and emergency department settings to identify people at risk of domestic or interpersonal violence and link them to community-based services • Work with community organizations to implement a “safe plan” that links victims of domestic violence to a safe environment	• Additional Measures to be created. Pending details from CHNA 9 on their domestic and interpersonal violence initiatives • # of Support Groups organized • # of participants participating in support Groups • # of domestic violence screening events organized • # of people screened at hospital practice sites, the Hospital ED, or other hospital and community-based settings • # of community organizations supported to implement the “Safe Plan” program that links victims of domestic violence

Priority Area 4: Reduce Prevalence and Burden of Chronic and Complex Conditions

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update
Improve Chronic Disease Management	• Low Income Adults	• Increase the # of adults who receive education and counseling regarding risk factors, healthy behaviors to increase chronic disease health literacy • Increase the number of adults screened for diabetes, hypertension, and asthma • Increase the number of adults with diabetes, hypertension, and persistent asthma who receive evidence-based counseling/ coaching and treatment • Increase the number of adults with diabetes, hypertension, and persistent asthma whose condition is controlled	• Implement evidence-based programs that identify those with chronic conditions and provide health education, and chronic disease management support • Support programs in clinical and non-clinical settings that educate and screen patients for diabetes, hypertension, and persistent asthma	• # of chronic disease management events organized for those with or at risk of Chronic Disease • # of people participating in chronic disease management events by setting and by priority population • Pre- and post-test assessment of knowledge at CD Management events • # of patients referred for care management support • % of patients referred who have remained in care and/or whose condition in well-managed
Reduce the prevalence of Tobacco Use	• Youth • Adults • Particularly those most vulnerable	• Increase the number of people screened for tobacco users • Increase the number of tobacco users referred to tobacco cessation efforts • Increase access to tobacco cessation	• Promote tobacco use screening, education and referral programs for tobacco use with clinical and non-clinical organizations • Organize and facilitate evidence-based smoking cessation services workshops	• # of practice sites where evidence-based screening, education, and referral programs were promoted to reduce prevalence of tobacco use • # of participants screened, educated and referred for cessation treatment at practice sites where programs were promoted • # of smoking cessation events organized • # of people participating in smoking cessation events
Increase Access Education, Screening and Referral Programs for those with C/C Conditions	•	• Increase the number of people in service area who are receiving health education, screening for chronic conditions, referral, and self-management support counseling	• Conduct Listen and Learn Events • Organize blood pressure, diabetes, and asthma screenings and referral programs for priority populations • Organize prostate cancer and breast cancer education, screening, and referral programs for priority populations	• # of listen and learn events • # of people participating in listen and learn events • Pre- and post-test assessment of knowledge for those participating in listen and learn events

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update
		• Increase the number of people in service area who receive cancer education, screening, and referral to counseling if deemed at risk or who have been screened positive.	• Organize support group for cancer survivors • Organize skin cancer screening programs for priority populations	• # of Chronic disease screening, counseling and referral events organized • # of people participating in chronic disease screening, counseling, and referral events • # of participants referred who engaged in care • # of those who engaged in care who were able to control their chronic condition
Reduce cancer disparities (access to screening and treatment)	• Low Income and Racial/ Ethnic Diverse Adults	• Increase the number of low income and racial/ethnic diverse adults educated and screened for cancer • Increase the number of adults who screen positive for cancer who are referred for education, counseling and treatment • Increase the number of adults who screen positive for cancer who are linked to a cancer navigator	• Administer grant program for community-based organizations to support evidence-based programs that promote cancer screening, prevention, and care navigation programs • Support access to cancer screening and treatment for low income, uninsured adults, including access to mammograms, colorectal screening, CT Scans, etc. • Link patients screened positive for cancer to Cancer Patient Navigators • Organize and facilitate peer support group for those being treated for cancer	• Additional Measures pending. Developed by the grantees per the grant guidance • # of cancer screening events organized targeting priority populations at-risk • # of people participating in cancer screening events organized • # of people who were screened positive who engaged in navigation services • # of people were who were screened positive who engaged in care • # of peer support groups organized • # of people participating in peer support groups

Priority Area 5: Promote Healthy Aging and Ability of Older adults (65+) to Live Independently

Goal	Priority Populations	Programmatic Objectives	Community Activities / Strategies	Metrics and Status Update
Promote Healthy Aging and Independent Living	• Older adults, particularly most vulnerable segments	• Increase awareness of healthy lifestyle changes • Reduce preventable Emergency Department and inpatient visits • Reduce barriers to aging in one's own home • Reduce elder health isolation	• Host community events that provide free cancer (e.g. skin cancer) screenings for populations over the age of 50 • Support Senior Centers and the Cancer Resource Center in their efforts to provide patients and community members with free services and educational information regarding chronic disease/cancer prevention, treatment, and support • Work with Montachusett Public Health Network to organize Hoarding Workshops for community residents	• # of community events organized for Older Adults related to cancer, other chronic/complex conditions • # of people participating in community events • Pre- and post-test assessment of those participating in community events • # of senior centers supported to provide education, screening, & referral services • # of Hoarding Workshops organized • # of people participating in Hoarding Workshops
Reduce Falls and Improve Mobility	• Older adults, particularly most vulnerable segments	• Reduce fear of falling • Increase activity levels • Reduce preventable Emergency Department and inpatient visits due to falls • Support efforts to increase access to transportation	• Organize Matter of Balance workshops for priority populations • Support initiatives that provide transportation for older adults to/from medical appointments, senior centers, social events, etc.	• # of Matter of Balance events organized • # of people participating in Matter of Balance events • Pre- and post-test assessment of those participating in Matter of Balance events • # of older adults supported with transportation assistance by priority population