

**COMMUNITY BENEFITS PLAN  
FOR CLINTON HOSPITAL  
FY2012 – FY2014  
AN AFFILIATE OF  
UMASS MEMORIAL HEALTH CARE, INC.**



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## I. Executive Summary

Clinton Hospital 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, as well as nonmedical conditions that negatively impact the health and wellness of our community.

### **Community Benefits Program**

Clinton Hospital has been involved in the development of the Community Health Needs Assessment (CHA) and utilizes the information in the CHA to collaborate with other community based organizations, schools, diverse stakeholders, and members of the community to adopt implementation strategies that address the unmet health needs of the hospital's catchment area.

Target populations for Clinton Hospital's Community Benefits initiatives are identified through a community input and planning process, collaborative efforts with a broad array of stakeholders, and the development of a Community Health Needs Assessment (CHA) which is conducted every three years. Clinton Hospital collaborates with the Community Health Network Area 9 (CHNA 9); a local coalition of public, non-profit, and private sectors working together to build healthier communities in Massachusetts through community-based prevention planning and health promotion. Other partners include key stakeholders such as: residents, consumers, coalitions, communities of faith, businesses, schools, health and human service organizations and local and state governments.

Our target populations focus on medically-underserved and vulnerable groups of all ages, as follows:

- Elderly
- Youth/children
- Populations living in poverty
- Underserved/uninsured
- Ethnic and Linguistic Minorities

Clinton Hospital's Community Benefits Program strives to meet and exceed the Schedule H/Form 990 IRS mandate to "promote health for a class of persons sufficiently large so the community as a whole benefits." Our programs mirror the five core principles outlined by the Public Health Institute in terms of the "emphasis on communities with disproportionate unmet health-related needs; emphasis on primary prevention; building a seamless continuum of care; building community capacity; and collaborative governance." Target populations for Clinton Hospital's Community Benefits initiatives are identified through a community input and planning process, collaborative efforts, and a CHA which is conducted every three years.

## **The Community Benefit Strategic Implementation Plan**

The focus areas of this Community Benefit Strategic Implementation Plan aligns well with the priorities identified by the CHA processes, as noted below:

**CHA Priority 1: Access to Health Care-** Health Disparities and Social Determinants of Health are very real issues and concerns for the North Central Massachusetts region. While quantitative data is limited in its scope and ability to demonstrate the breadth of the concern, qualitative information obtained through focus groups and interviews highlights the extraordinary challenges faced by racial and ethnic minorities and other populations which contribute to a poorer health status and quality of life. Barriers to optimal health status include, among others: social and cultural isolation; lack of adequate transportation resources; difficulty navigating the complexities of the healthcare and health insurance systems; difficulty affording the out-of-pocket costs of healthcare, and language and cultural barriers.

**CHA Priority 2: Food Security/Hunger/ Healthy Weight-** Obesity as a whole is a growing national, statewide, and local issue. The percentage of obese adults in CHNA 9 for the period of 2001 through 2007 was 22.1%, compared to the statewide rate of 19.4% for the same period. The percentage of adults who were overweight or obese was 61.5% as compared to a statewide rate of 55.4%.

**CHA Priority 3: Mental Health-** The economy has exacerbated many issues associated with health and access to care – affecting everything from housing, food and healthcare to the stressors of job loss, reductions in hours and a sense of hopelessness that all contribute to poor mental and physical health and risk of substance abuse and domestic violence.

Community Benefit Priority Areas	Goal
<p><b>Priority Area 1:</b> Access to Health Care</p>	<p><b>Goal 1:</b></p> <ul style="list-style-type: none"> <li>• Support programs and develop collaborative efforts that will improve access to health care for the medically underserved/uninsured/ethnic and linguistic minorities in the Clinton catchment area</li> </ul>
<p><b>Priority Area 2:</b> Food Security/Hunger/ Healthy Weight</p>	<p><b>Goal 2:</b></p> <ul style="list-style-type: none"> <li>• To alleviate immediate hunger through increased consumption and support initiatives that promote healthy weight</li> </ul>
<p><b>Priority Area 3:</b> Mental Health</p>	<p><b>Goal 3:</b></p> <ul style="list-style-type: none"> <li>• Improve mental health through prevention and by providing support to appropriate, mental health services</li> </ul>

Detailed action plans will be developed annually and tracked throughout the course of the year to monitor and evaluate progress and determine priorities for the next year. This plan is meant to be reviewed annually and adjusted to accommodate revisions that merit attention.

## II. Community Benefits Mission

**Mission Statement**

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

The Mission incorporates the World Health Organization’s broad definition of health defined as “a state of complete physical, mental and social well being and not merely the absence of disease.” The Clinton Hospital Community Benefits Mission was developed and recommended by the Community Benefits Advisory Committee and approved by the UMass Memorial Health Care Board of Trustees.

### **III. Targeted Geography and Vulnerable Populations**

Clinton Hospital aims to address 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, elderly), as long as the definition still captures the interests of more vulnerable groups such as the underserved, low income, or minority populations.

#### **Geography:**

Clinton Hospital primarily serves the communities of Clinton, Berlin, Bolton, Lancaster and Sterling with populations of 13,606, 2,866, 4,897, 7,582 and 9,564 respectively. The population of the total service area is 36,759.

Clinton has a population of 13,606. The majority of Clinton residents are White Non-Hispanic (84%), followed by Hispanic (11.6%) and Black Non-Hispanic (1.80%). The Clinton Hospital Service Area is also primarily White Non-Hispanic (88%), followed by Hispanic (6.4%), and Black Non-Hispanic (2.8%). Clinton Hospital's Community Benefits Plan focuses on the needs of Clinton due to its large concentration of diverse, vulnerable populations.

Clinton Hospital's 2011 Community Health Assessment of North Central Massachusetts is a joint effort between the Massachusetts Department of Public Health's Community Health Network Area of North Central Massachusetts (CHNA 9) and the Joint Coalition on Health (JCOH). The assessment is designed to provide information and analyses relative to the health status, issues, concerns, and assets of the North Central Region of Massachusetts. The assessment includes the 27 cities and towns covered by CHNA 9, including the cities of Fitchburg, Leominster, Gardner, and the towns of Ashburnham, Ashby, Ayer, Barre, Berlin, Bolton, Clinton, Groton, Hardwick, Harvard, Hubbardston, Lancaster, Lunenburg, New Braintree, Oakham, Pepperell, Princeton, Rutland, Shirley, Sterling, Templeton, Townsend, Westminster, and Winchendon) are also within the service area of the JCOH.

#### **Vulnerable Populations:**

Target populations for Clinton Hospital's Community Benefits initiatives are identified through a community input and planning process, collaborate efforts, and a CHA which is conducted every three years. Our target populations focus on medically underserved and vulnerable groups of all ages in Clinton and surrounding towns. Our most vulnerable populations include youth, elders living in public housing sites, ethnic and linguistic minorities and those living in poverty. These populations often become isolated and disenfranchised due to negligence, misperceptions and even fear. Four targeted subpopulations have been defined as follows:

**Elderly:**

- With respect to households composed of elderly persons aged 65 and older living alone, the State average is 30%. among the Study Area cities and towns, the highest percentages in this category were found in Hardwick (37%), Clinton (34%), and Gardner and Winchendon (both at 33%). Lowest percentages were found in Harvard and Bolton (both at 17%).

**Youth/children:**

- The CHA showed Clinton having the 3rd highest percentage of low-income students in school 2008-2009, at 41.4%. Three Study Area school districts also reported a significant student body for which English is not their first language. Compared to the State percentage of 15.4%, Fitchburg reported that English was not the first language for 29.4% of its students, with 19.5% of Clinton's students' and 18.2% of Leominster's reported the same.

**Populations living in poverty:**

- Unemployment and the fear of potential job loss also prevented many participants from seeking medical attention. Several people cited the inability to take time off from work to attend to their personal health for fear that it would place their jobs in jeopardy. With respect to poverty, participants reported poor living conditions (i.e., substandard housing and poor neighborhoods) and concerns for safety, including the presence of drugs and violence.

**Underserved/uninsured:**

- Consistently, all groups pointed to the cost of healthcare as a barrier to seeking treatment. Participants frequently complained about "co-pays" and the total monthly cost for healthcare (i.e., co-pays, premiums, medications, childcare, and transportation). Some reported that these costs reached \$600 or more for one month. They also noted that insufficient/limited insurance coverage was a barrier to healthcare. For those without health insurance, out-of-pocket costs often prohibited access to care.

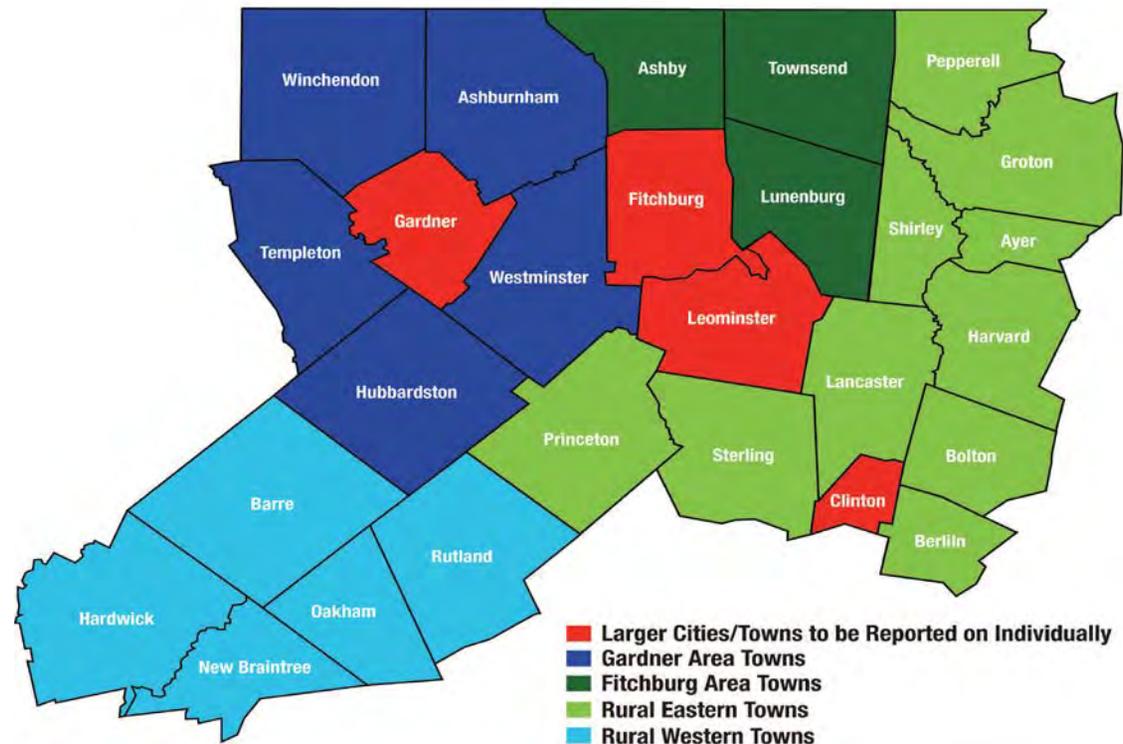
**Ethnic and Linguistic Minorities:**

- Among the African American, Latino and Asian groups, cultural norms were cited as barriers to health care. African Americans, while not confronting language barriers, nevertheless cited poor communication between patients and providers, and also referenced racism in the form of stereotyping and discrimination. A lack of cultural competence was mentioned across all three groups who felt that they could not explain their illness to providers who, in turn, did not have an understanding of their needs or beliefs. These experiences led to participants describing an atmosphere of fear and distrust in their interactions with healthcare providers and other public and private institutions. Hopelessness was also referenced among African Americans and Latinos.

## IV. Methods

Data in the CHA report are presented individually for the cities of Fitchburg, Gardner, Leominster, and the town of Clinton. The remaining smaller towns in CHNA 9 are combined into reporting regions to obtain meaningful data. These reporting regions are consistent with those reported in previous community health assessments to facilitate comparisons over time. The following map represents the Study Area and highlights the various reporting categories utilized in the assessment.

**CHNA 9 Service Area with Reporting Regions**



**Priority 1: Access to Health Care**

**Support programs and develop collaborative efforts that will improve access to health care for the medically underserved/uninsured/ethnic and linguistic minorities in the Clinton catchment area**

**Objective 1.1: Coordination of initiatives that address health disparities and support actions necessary to improve health outcomes of racial, ethnic, and underserved populations**

Outcome Indicators: Threshold	Target	Stretch
<ul style="list-style-type: none"> <li>Increase the number of persons with health insurance (Healthy People 2020)</li> </ul>	500	800
<ul style="list-style-type: none"> <li>Increase the proportion of people with a usual primary care provider (Healthy People 2020)</li> </ul>	500	800
<ul style="list-style-type: none"> <li>Sustain preventative screenings at community-based events (Healthy People 2020)</li> </ul>	2 community-based events	4 community-based events
<ul style="list-style-type: none"> <li>Reduce hospitalizations and emergency department visits for nonfatal injuries by reducing the fear of falling and increasing activity levels among elder population (Healthy People 2020)</li> </ul>	15	30
<ul style="list-style-type: none"> <li>Increase knowledge of chronic disease conditions</li> </ul>	150	300
<p><b>Potential Partners:</b></p> <ul style="list-style-type: none"> <li>Senior Centers</li> <li>Churches</li> <li>WHEAT Social Services</li> <li>Oriol Health</li> <li>Clinton Adult Learning Center</li> <li>Clinton Public Schools</li> <li>Clinton Community Partnerships for Children</li> <li>Minority Coalition including: the Health Disparities Committee, Heywood Hospital, Community Health Connections, Family Health Centers, Clinton Hospital, and Health Alliance Leominster Hospital</li> <li>UMass Memorial Health Care</li> <li>Community Health Network Area of North Central Massachusetts (CHNA 9)</li> <li>Town of Clinton Board of Health</li> </ul>		

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**Objective 1.1: Coordination of initiatives that address health disparities and support actions necessary to improve health outcomes of racial, ethnic, and underserved populations**

<b>Strategies:</b>	<b>Timeline: Year 1,2,3</b>
<p><b>1.1.1:</b> Outreach/Referral/Enrollment activities infrastructure that support health insurance enrollment resulting in positive outcomes for target populations</p> <ul style="list-style-type: none"><li>• Collaborate with community partners to facilitate health insurance enrollment</li><li>• Attend community events to provide health insurance enrollment information</li><li>• Identify opportunities to increase health insurance enrollment</li></ul>	1,2,3
<p><b>1.1.2:</b> Increase the number of individuals connected to primary care.</p> <ul style="list-style-type: none"><li>• Provide referral assistance to those receiving insurance enrollment assistance</li><li>• Provide information on available insurance enrollment and referral assistance at community events</li><li>• Identify opportunities to increase the capacity of primary care in the area</li></ul>	1,2,3
<p><b>1.1.3:</b> Increase access to health services to the target populations through outreach programs</p> <ul style="list-style-type: none"><li>• Provide blood pressure screenings for ethnic and linguistic minorities ( e.g., outpatient clinics, adult learning centers and others)</li><li>• Coordinate the delivery of “A Matter of Balance,” an evidence-based program that emphasizes falls prevention</li></ul>	1,2,3
<p><b>1.1.4:</b> Provide community-based education on cardiovascular disease, smoking, stroke, and nutrition</p> <ul style="list-style-type: none"><li>• Coordinate and participate in health fairs</li><li>• Provide community lectures at events that address health concerns and ensure the inclusion of information on chronic disease in the Highlander Community Newsletter published by Clinton Hospital</li></ul>	1,2,3

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**Monitoring/Evaluation Approach:**

- Track health insurance enrollments
- Program reporting
- Track number of events/ workshops

<b>Priority 2: Food Insecurity/Hunger/ Healthy Weight</b>		
<b>To support initiatives that address hunger and access to health food to promote healthy weight</b>		
<b>Objective 2.1: Increase access to healthy foods for vulnerable populations</b>		
<b>Outcome Indicators: Threshold</b>	<b>Target</b>	<b>Stretch</b>
• Support and coordinate a feeding program for populations living in poverty	80	160
• Support the coordination of the community garden located on Clinton Hospital grounds/ Number of residents participating in this program	25	50
• Number of residents who cultivate healthy foods in the community garden located on Clinton hospital grounds	30	60
• Identify opportunities to expand efforts that promote healthy weight	TBD	TBD
<b>Potential Partners:</b> <ul style="list-style-type: none"> <li>• Community residents</li> <li>• WHEAT Social Services</li> <li>• United Way Tri-County</li> <li>• Clinton High School</li> <li>• Growing Places</li> <li>• Clinton Parent Child Home Program</li> <li>• Fitness facility</li> <li>• Town's Parks and Recreational Department</li> </ul>		

**Priority 2: Food Insecurity/Hunger/ Healthy Weight**

**To support initiatives that address hunger and access to health food to promote healthy weight**

**Objective 2.1: Increase access to healthy foods for vulnerable populations**

<b>Strategies:</b>	<b>Timeline: Year 1,2,3</b>
<p><b>2.1.1:</b> Outreach/Referral/Enrollment activities infrastructure that support SNAP Nutrition Assistance enrollment resulting in positive outcomes for target populations</p> <ul style="list-style-type: none"><li>• Collaborate with community partners to facilitate SNAP Nutrition Assistance enrollment</li><li>• Attend community events to provide SNAP Nutrition Assistance enrollment information</li><li>• Identify opportunities to increase SNAP Nutrition Assistance enrollment</li></ul>	1,2,3
<p><b>2.1.2:</b> Increase access to healthy weight programs and resources</p> <ul style="list-style-type: none"><li>• Organize, coordinate and support an exercise program</li></ul>	1,2,3
<p><b>2.1.3:</b> Increase access to healthy nutrition</p> <ul style="list-style-type: none"><li>• Organize, coordinate and support Food Drives to help stock the WHEAT Social Services food pantry</li><li>• Support high school students “Youth Venture” healthy eating project</li><li>• Sustain a community garden on hospital premises</li></ul>	1,2,3
<p><b>Monitoring/Evaluation Approach:</b></p> <ul style="list-style-type: none"><li>• Track the number of people enrolled into SNAP Nutrition Assistance program</li><li>• Program reporting</li><li>• Track number of attendees at each program</li></ul>	

<b>Priority 3: Mental Health</b>		
<b>Improve access to mental health education, prevention, and support services</b>		
<b>Objective 3.1: Coordinate education, prevention and support services for community</b>		
<b>Outcome Indicators: Threshold</b>	<b>Target</b>	<b>Stretch</b>
<ul style="list-style-type: none"> <li>• Conduct preventative mental health screenings and referrals at community-based events</li> </ul>	2 community-based events	4 community-based events
<ul style="list-style-type: none"> <li>• Increase knowledge of mental health concerns through community lectures, support groups and through community events</li> </ul>	2 community-based lectures	4 community-based lectures
<ul style="list-style-type: none"> <li>• Number of community members participating in support groups</li> </ul>	A minimum of 20 support groups	28 support groups
<b>Potential Partners:</b> <ul style="list-style-type: none"> <li>• National Alliance for Mental Health (NAMI)</li> <li>• River Terrace Healthcare</li> <li>• Senior Centers</li> <li>• Montachusett Home Care senior agency</li> <li>• Department of Public of Health</li> <li>• Alzheimer Disease Association</li> <li>• Central MA agency on Aging</li> </ul>		

**Priority 3: Mental Health**

**Improve access to mental health education, prevention, and support services**

**Objective 3.1: Coordinate education, prevention and support services for community**

<b>Strategies:</b>	<b>Timeline: Year 1,2,3</b>
<p><b>3.1.1:</b> Increase access to mental health services</p> <ul style="list-style-type: none"><li>• Improve access to care for those in need of mental health services through community outreach and providing educational and informational materials through workshops and support groups</li><li>• Raise awareness of mental health resources through community lectures, support groups and the Highlander Community Newsletter published by Clinton Hospital</li></ul>	1,2,3
<p><b>3.1.2:</b> Raise awareness of mental health concerns</p> <ul style="list-style-type: none"><li>• Coordinate and participate in health fairs providing mental health resources</li><li>• Provide community-based education on mental health</li><li>• Improve awareness of mental health issues and resources through community lectures, support groups and the Highlander Community Newsletter published by Clinton Hospital</li></ul>	1,2,3
<p><b>3.1.3:</b> Coordinate support groups for those with concerns of mental illness</p> <ul style="list-style-type: none"><li>• Provide support groups for community members with a mental illness</li><li>• Provide support groups for families and friends of those with a mental illness</li></ul>	1,2,3
<p><b>Monitoring/Evaluation Approach:</b></p> <ul style="list-style-type: none"><li>• Track number of attendees at each program event</li><li>• Track number of mental health screenings and referrals provided</li><li>• Track number of attendees at each support group</li><li>• Track number of support groups</li></ul>	

## **APPENDIX A: Community Health Assessment Steering Committee**

Joyce Ryan, Montachusett Home Care  
Kathleen McDermott, Montachusett Opportunity Council  
Emily MacRae, MacRae Enterprises  
Catherine Apostoleris, Montachusett Opportunity Council  
Lorie Martiska, Heywood Hospital  
Mary Lourdes Burke, HealthAlliance Hospital  
Dolores Thibault-Muñoz, Cleghorn Neighborhood Center  
Erik Durmer, North Central Human Services  
Joanne L. Calista, Central MA Area Health Education Center, Inc. (CM AHEC)

### **Study Partners**

The Community Health Network Area of North Central Mass. (CHNA 9)  
The Joint Coalition on Health of North Central Massachusetts.  
The Minority Coalition of North Central Massachusetts.  
The qualitative work was completed with the combined efforts of the Minority Coalition of North Central Massachusetts, the Spanish American Center, Cleghorn Neighborhood Center, Heywood Hospital, HealthAlliance Hospital, Clinton Hospital, WHEAT, Three Pyramids, Beautiful Gate Church, New Hope Community Church, Twin Cities CDC, Gardner CDC, Memorial Congregational Church, Montachusett Opportunity Council and many other agencies and individuals.

### **Data Analysis**

#### **Quantitative Data**

Maureen DeFuria, William Van Faasen Sabbatical Fellow from Blue Cross Blue Shield of Massachusetts  
Joanne L. Calista, Central MA Area Health Education Center, Inc.

#### **Qualitative Data**

Emily MacRae, MacRae Enterprises  
Lynne Man  
Joanne L. Calista, Central MA Area Health Education Center, Inc.

## **APPENDIX B: Data Sources and Analyses**

Both quantitative and qualitative data were collected for the community health assessment. All data were gathered systematically utilizing the following standards or principles which guided the methodologies and source selections:

1. Availability of multiple years of data on study elements;
2. Specificity of data to the Study Area communities;
3. Appropriateness of data collection methodologies to the data source;
4. Broad participation among the stakeholder populations, and
5. Broad range of input from qualitative and quantitative sources.

The majority of the quantitative data collected for the CHA came from the Massachusetts Community Health Information Profile (Mass CHIP). Other sources include: the Massachusetts Department of Public Health; the United States Census Bureau; the Massachusetts Department of Workforce Development; the Massachusetts Department of Elementary and Secondary Education; and the Massachusetts Behavioral Health Partnership. Whenever possible, three years of data were used for each measure and, when feasible, data is provided for individual towns.

The quantitative data was analyzed and reported by Maureen DeFuria. Maureen worked with Heywood Hospital and the JCOH on a William Van Fassen Community Service Sabbatical from Blue Cross Blue Shield of Massachusetts for the period of September 2008 through February 2009. She also contracted with Heywood Hospital through an Essential Provider Trust Fund Grant for the period of March through June 2009, and then for an additional period through the funds provided by Heywood Hospital to the CHNA 9/JCOH Collaborative funding account. During that time, she gathered, analyzed and reported quantitative data for the report.

Qualitative data was elicited to enhance, clarify, and add “community voices” and real life experiences to the quantitative data included in the report. Qualitative data also provides a lens into current conditions – economic and cultural – which quantitative data cannot due to the lags between data collection, reporting, and retrieval. For example, the qualitative data presented here strongly reflects the economic crisis which occurred during the qualitative data collection process but after much of the quantitative data had already been collected and reported.

Qualitative data for this assessment was gathered via focus groups with community members and through interviews with community members and community leaders. Focus groups and interviews were conducted between the spring of 2009 and the spring of 2010. Those responsible for gathering qualitative data made every effort to ensure racial/ethnic, socioeconomic, and geographic diversity in the composition of focus groups and interview participants. Focus group notes and interviews were analyzed by Lynne Man and Emily MacRae Enterprises utilizing manual qualitative content analysis and were reviewed for consistency by Joanne Calista of the Central Massachusetts Area Health Education Center, Inc (CM AHEC). Participant feedback was only reported when expressed multiple times

in the data (i.e., descriptions and quotations are not recorded in the report if expressed solely by one participant). The findings of the focus groups are synthesized and are recorded within the body of the report.

Context:

### **a. Economic Crisis**

One environmental factor that has had an overriding impact on many aspects of health status and social determinants during the period the study was conducted is the collapse of the stock market in 2008 and the associated mortgage and housing crises, followed by a deep recession which lingers to this day. The impact of this economic crisis includes high unemployment rates, reduced state and federal funding for organizations and programs serving those in need, reduced funding for cities and towns resulting in job loss and service reductions, and a significant reduction in private and foundation philanthropy which is often relied upon to reduce the impact of other reductions in funding for nonprofit organizations. Some of the resulting effects of the economic crisis have been demonstrated in higher depression and suicide rates, increased reports of substance and alcohol abuse, domestic violence and child abuse, higher levels of crime (which create additional stress for victims and affected neighborhood residents), and greater stress caused by job loss and reductions in hours. For members of ethnic and racial minority populations, these stresses are compounded by cultural and social isolation, language barriers, and racism. In addition, while the Commonwealth of Massachusetts has taken the positive and noble step of attempting to insure everyone, the cost of providing that health insurance and the cost to individuals not qualifying for Mass Health are an unmanageable burden for many. Rising health insurance costs are also a deterring factor for small business growth which further delays our economic recovery. Efforts to address economic stability and job growth must occur at the same time as efforts to expand the safety net and services for the most vulnerable.

### **b. Health Disparities and Social Determinants of Health**

Addressing the issues of health disparities in North Central Massachusetts is a focal point of the assessment. Having the capacity to respond effectively to the critical public health needs of these communities begins with an accurate assessment of those needs. Quantitative data is presented with delineations by race and ethnicity wherever that information was available. Qualitative data from minority populations was gathered and analyzed under the direction of the minority community leaders of North Central Massachusetts. All focus groups and interviews were conducted in the primary language of the participants and facilitators of each group were cultural brokers and leaders from their respective communities. The groups were: Latino; African American; Asian (further delineated as Lao and Hmong), and Brazilian. The groups categorized as "General" were 95% non Hispanic Caucasian.