HARVARD T.H. CHAN SCHOOL OF PUBLIC HEALTH

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Anchoring Health beyond Clinical Care: UMass Memorial Health Care's Anchor Mission Project

"What did I get myself into?" Douglas Brown wondered to himself as he walked out of the September 2018 board meeting. He had just received unanimous and enthusiastic approval to pursue his "Anchor Mission" project at UMass Memorial Health Care (UMMHC) in Worcester, Massachusetts. He was extremely excited by the board's support, but also quite apprehensive about how to make the Anchor Mission a reality.

As the Chief Administrative Officer of UMMHC and president of UMass Memorial (UMM) Community Hospitals, Doug had spearheaded the Anchor Mission from its earliest exploratory efforts. The goal of the health system's Anchor Mission—an idea developed by the Democracy Collaborative, an economic think tank—was to address the social determinants of health in its community beyond the traditional approach of providing excellent clinical care. He had argued that UMMHC had an obligation as the largest employer and economic force in Central Massachusetts to consider the broader development of the community and to address non-clinical factors, like homelessness and social inequality that made people unhealthy. To achieve this goal, UMMHC's Anchor Mission would undertake three types of interventions: local hiring, local sourcing/purchasing, and place-based community investment projects.

While the board's enthusiasm was palpable and inspiring, Doug knew that sustaining it would require concrete accomplishments and a positive return on any investments the health system made in the project. The approval was just the first step. Innovation and new ways of thinking would be necessary. The bureaucracy behind a multi-billion-dollar healthcare organization would need to change. Even the doctors and nurses would need to change! He knew that the project had enormous potential but would become even more daunting from here.

Background: UMMHC

UMMHC was a $2.5 billion non-profit integrated health care delivery system based in Worcester, Massachusetts. The multi-campus health system was comprised of a 779-bed academic medical center (UMass Memorial Medical Center), two community hospitals (163-bed UMass Memorial HealthAlliance/Clinton Hospital, and 79-bed UMass Memorial-Marlborough Hospital), a large physician multi-specialty group practice, and numerous other related entities.

The system had 1,700 physicians on its medical staff, 3,000 registered nurses, and 13,000 total employees. UMMHC was affiliated with the University of Massachusetts Medical School, the only public medical school in Massachusetts, and was, by far, the largest health system in central Massachusetts. UMMHC's overall payor mix was approximately 39% private pay, 37% Medicare, 22% Medicaid, and 2% other. According to the Massachusetts Center for Health Information and Analysis (CHIA), UMass Memorial Medical Center had the highest number of emergency room visits and the second-highest percentage of public payer mix of any academic medical center in eastern/central Massachusetts in 2016.

Worcester City and County

The city and county of Worcester, where UMMHC is located, lay in central Massachusetts, a little less than an hour drive west from Boston. Worcester, with a population of about 180,000, was the second-largest city in New England and, like many other New England cities, was once a thriving manufacturing center, distinguished in the first half of the 20th century for its role in the growing airplane industry. A quote at the time of the Second World War boasted that "every American plane had a component manufactured in Worcester."

However, after World War II, the manufacturing sector slowly collapsed, and by the 1960s and 70s, the city and downtown center had fallen on hard times. The economy of the region began to recover by the late part of the century, driven largely by the growth of biotechnology, healthcare, and education. The demographics also began to shift. By 2016, Worcester County overall was still 85% white, but the city was 57% white, 20% Latino, 13% Black, and 7% Asian, with one in five residents foreign-born. Unemployment continued to decline from a high of 10.3% in 2009, to 3.3% by the end of 2017, a rate that was lower than the state average unemployment rate at the time. However, the median household income in the city in 2017 was $45,000 (compared to about $67,000 for the state), and the overall poverty rate was about 21%. Compared with other cities nationally, Worcester experienced the 20th largest increase in its concentrated poverty rate during the 2010 to 2016 time period.[1]

The most recent Community Health Assessment conducted by UMMHC and partners identified the major health issues in the area as mental health, substance use disorders, access to care, and health equity, as well as the needs of the elderly, and a high prevalence of chronic conditions, such as diabetes and heart disease. Some of the social factors that most contributed to health problems were poverty and unemployment, food insecurity, housing, transportation, access to care, racism/cultural insensitivity, the need for health education, and safety and violence.[2] Furthermore, despite a 4% decline in deaths from opioid overdoses in 2017 in the state as a whole, these deaths increased in Worcester County.[3]

[1] https://www.telegram.com/news/20180502/umass-containing-costs-on-backs-of-most-vulnerable
[2] https://www.umassmemorialhealthcare.org/sites/umass-memorial-hospital/files/Documents/About/Community_benefits/Full%202018%20CHA%20in%20PDF%2012-5-with%20UMMMC%20Eval%20of%20Impact.pdf
[3] https://www.telegram.com/news/20180920/umass-memorial-launches-opioid-task-force

New Leadership at UMMHC

UMMHC hired their current President and CEO, Eric Dickson, MD, MHCM, FACEP, in 2013, during a period when the institution was facing serious financial challenges. "The only reason I became CEO is because nobody else wanted the job," he explained, only somewhat jokingly. "Shortly after I became CEO, we lost $55 million on operations, came close to defaulting on our bonds, narrowly avoided a nursing strike, and had to respond to one patient killing another in our locked psychiatric unit."

Before assuming the CEO role, Dr. Dickson was president of the UMass Memorial Medical Group and served as chair of Emergency Medicine/interim chief operating officer at University of Iowa Hospitals and Clinics. Dr. Dickson began his medical career as a physical therapist and an Army combat medic. He graduated from UMass Medical School and continued as a resident and emergency room physician at the Medical Center. He also was a graduate of the Master in Health Care Management Program at the Harvard T.H. Chan School of Public Health. Dr. Dickson continued to do one shift per month in the emergency room at UMMMC after he became CEO.

One of Dr. Dickson's most trusted leaders within the organization was Douglas Brown, who had joined UMMHC in 2003 after previously directing the Massachusetts Medicaid Agency and working in the state Attorney General's office. Dr. Dickson promoted Doug to be President, UMass Memorial Community Hospitals and Chief Administrative Officer (CAO) of the system from his previous position as Senior Vice President and General Counsel.

Dr. Dickson, Doug, Chief Financial Officer Sergio Melgar, Chief of Staff Cheryl Lapriore, and the rest of the senior leadership team quickly improved the situation at UMMHC. They made several hard decisions including selling off some of the organization's real estate holdings, consolidating services, and implementing staff layoffs. But by 2014, UMMHC had generated an operating profit of $50 million, and the team had successfully negotiated a three-year nursing contract and improved the organization's debt rating.

Dr. Dickson focused much of his early efforts on improving "operational excellence" in both clinical quality and the patient experience. He implemented a Lean Management approach throughout the organization that emphasized continual process improvement and standardized work practices. The approach used tools like idea boards as well as regular team huddles to encourage all employees to have a say in improving how things were done.[4] **Exhibit 1** provides a summary of UMMHC's volume statistics and financial performance from 2013 through 2018.

Not only did UMMHC become a national model for using Lean Management techniques in a healthcare organization, but the approach provided a blueprint for managing improvements over time. "In the past we had the same meeting over and over again. We didn't have a framework for execution," Dr. Dickson said. "Now, when we decide to do something, it goes on

[4] The idea board is a Lean Management tool used at UMass Memorial to stimulate employee thinking around process improvement.

the wall [top organizational priorities were visibly posted in the board room and CEO conference room, with the person responsible and green/yellow/red progress indicators] and it gets done."

Community Benefits Program at UMMHC

As a clinician, Dr. Dickson focused heavily on improving the quality of care and operations at the Medical Center. Doug Brown, with his background in public service and law, was concerned with ways that the Medical Center could impact the social and health needs of the community at large. UMMHC had a nationally recognized Community Benefits program[5] which, under the leadership of Monica Lowell, the Vice President of Community Benefits and a longtime Worcester resident, was ranked in the top four nationwide by the American Hospital Association (AHA).

In 2015, Doug had attended a talk at a Massachusetts Health & Hospital Association meeting about a "Blue Zones Project," a population health improvement approach that could be adapted to any specific geographic area. Based on the work of Dan Buettner, "Blue Zones" projects utilized a set of best practices for how communities could foster better health and happiness, such as building walkable urban areas and increasing the numbers of trees and green areas. Doug thought Worcester could be the right community for such a project. He organized a large community meeting, which included local government officials, community members, and other organizations, to discuss the idea. Their conclusion was that the upfront costs were too high and the long-term benefits questionable. While this project didn't work, Doug saw firsthand the enthusiasm and readiness in the community for a large civic improvement project of some type.

Two years later, in 2017, Monica and her supervisor, Cheryl, led efforts to apply for the Foster McGaw Prize, which was the American Hospital Association's highest recognition for community benefits programs at healthcare organizations in the country. UMMHC was picked as a finalist and held a site visit for the selection committee in October 2017. Cheryl said, "Dr. Dickson commented that it was one of the proudest times of his tenure here." Though UMMHC eventually finished as a runner-up for the prize, Cheryl added that the process "enriched the conversation about our community benefits program with our Trustees and our organization."

Earlier that year, in February 2017, Doug Brown and Rick Siegrist, the chair of UMMHC's Board of Trustees, attended a Governance Institute conference. While there, they went to a talk by Randy Oostra, President and CEO of ProMedica, a large healthcare provider in northwest Ohio. Randy spoke of the journey that ProMedica was taking as they expanded their vision beyond providing high quality clinical care into developing an Anchor Mission, "a very broad-based, multi-faceted program to address the social determinants of health in the communities we serve."[6]

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[5] In Massachusetts, Community Benefits programs are mandated for large non-profits.

[6] "Embracing an Anchor Mission: ProMedica's All-In Strategy." Randy Oostra, President and CEO, ProMedica. https://democracycollaborative.org/sites/clone.community-wealth.org/files/downloads/Promedica-web.pdf. Accessed 1/12/2019.

Doug and Rick were intrigued and thought this could be the right project for UMMHC in Worcester. But Doug was also concerned: "We have a robust and a nationally recognized community benefits program at UMass Memorial. It was imperative to me that the Anchor Mission not be thought of as another community benefits program or an appendix to it. It is something very different. An Anchor Mission is focused on leveraging the full power of the organization to develop and implement strategies to address systemic problems tied to poverty and inequality in the community."

The Idea of an Anchor Mission

What is an Anchor Mission? The idea, as UMMHC pursued it, came from the Democracy Collaborative, a Washington, DC, think tank that worked to create new economic models. The Democracy Collaborative defined an Anchor Mission as:

> A commitment to consciously apply the long-term, place-based economic power of the institution, in combination with its human and intellectual resources, to better the long-term welfare of the community in which the institution is anchored.[7]

In a 2015 publication, the Democracy Collaborative used this idea to challenge hospitals and healthcare systems to go "all in" to make their communities healthier. The rationale was that the so-called social determinants of health—basically where we live, work and play—were more important to someone's health status than the clinical care they receive. However, healthcare systems were designed to provide clinical care, with few interventions directed at these social factors. An Anchor Mission would allow organizations to address the social factors by using their economic assets, such as hiring and sourcing policies and their investment portfolios.

In practice, an Anchor Mission had three pillars: sourcing/purchasing, hiring, and investing. In purchasing, the idea was to buy and source materials from local companies in the communities they serve. For example, institutions could get their linen cleaned, their properties landscaped, and the food in the cafeteria from local companies. Supporting local businesses would improve the economic condition of the community, creating more jobs and money, allowing people to make healthier decisions. Moreover, purchasing policies could be utilized to support marginalized communities by emphasizing women- and minority-owned businesses in their contracting.

The hiring pillar improved health and community through similar means, by hiring locally. Anchor institutions could hire directly from communities where they were located to improve the economic condition of residents. People with jobs, especially jobs with health insurance, have better health. Again, inequality in the community could be addressed by concentrating on hiring people from certain areas or certain demographic groups.

[7] https://democracycollaborative.org/sites/clone.community-wealth.org/files/downloads/CanHospitalsHealAmericasCommunities.pdf

The final pillar was investment. Anchor institutions often had large investment portfolios which consisted of a range of financial securities, such as bonds, stocks, and real estate. The objective of investment portfolios was usually to maximize profits, often within a set of restrictions such as not investing in tobacco companies. However, the Anchor Mission recommended that institutions consider location, or "place," in their investment decisions so that the local community could also benefit. While place-based investing was still an investment, the rate of return might be less than in other options, but there were social benefits of investing in the community that should be considered.

But, how to operationalize this idea? The Democracy Collaborative provided practical guidance for organizations getting started. These included the Healthcare Anchor Network, which provided periodic calls, annual conferences, and collected best practices across over 40 institutions around the country. They also provided case studies, including detailed descriptions of Anchor Missions at Rush Medical Center in Chicago and ProMedica in Toledo, and "toolkits" for each pillar.

Is an Anchor Mission right for UMMHC?

To help assess the feasibility and applicability of the Anchor Mission idea to UMMHC, and make recommendations on whether to proceed, Doug and Rick brought in two doctoral students from the Harvard T.H. Chan School of Public Health to act as fellows during the winter of 2018. Ahmad Al Kasir and Eric Coles spent the month of January interviewing internal and external stakeholders. They also toured multiple neighborhoods in Worcester and witnessed first-hand the dichotomy of a city that was experiencing an economic uptick, but where simultaneously many residents were fighting perpetual poverty exacerbated by the raging opioid epidemic in the state.

One of their earliest conclusions was that while UMMHC had a history of local hiring, sourcing/purchasing, and investing, it had usually done so in an *ad hoc* manner. For example, the institution had data on where employees lived, but this information was not quantified or reported to the leaders of the organization. Their second conclusion was that programs to address community needs were generally based on the findings of the Community Health Needs Assessment (CHNA) reports that were done every three years. Community-based programs were usually addressed through grants administered by the Community Benefits Department. Although these programs were highly regarded, Ahmad and Eric found in their interviews with UMMHC staff that these community-facing programs were viewed as charity, and that the community benefits program was thought of as what UMMHC did *for* the community. One clear indication of this was that the community benefits programs did not claim a position "on the wall," a reference to the key performance measures that were tracked on a consistent basis and shared on posters on the walls of meeting rooms and conference halls throughout the organization. In contrast, an Anchor Mission would push the organization to adopt community initiatives as a business strategy in which UMMHC would work *with* the community.

As the VP for Community Benefits, Monica agreed:

> An Anchor Mission is another emerging strategy toward achieving health equity by leveraging the strength and assets of the organization to positively impact the social and economic factors that affect the health of the community. This complements existing Community Benefits' longstanding work in that the Anchor Mission incorporates non-traditional approaches, partnerships, and institutional assets. For example, it uses the three pillars approach of: Investment, Procurement, and Hiring.

Although Ahmad and Eric were advised in several interviews that it would be useful if they could find local businesses suitable for investments, they found that the problem did not lie in a lack of available opportunities, but rather in the need for a systematic approach to identifying community-facing initiatives in Worcester. For instance, the health system did not have the infrastructure to capture patient data that would help identify opportunities for targeted interventions to address the complex and overlapping social and economic factors responsible for most health inequities.[8] With an Anchor Mission strategy, UMMHC's efforts could focus on decreasing social inequality not solely as a community benefit but because social inequality hindered the organization's ability to improve the health of the community, and also impacted the system's financial margins.

Ahmad and Eric concluded that developing an Anchor Mission would require UMMHC to reallocate resources and realign institutional policy. Equally critical to the long-term viability of the Anchor Mission would be changes to the organization's culture. As they pointed out, when things are going well, community benefit programs were safe and continued to receive funding. However, the frequent changes in the healthcare environment posed a risk to the continuity of the Anchor Mission if it were viewed as another benefits program.

Their recommendation to Doug was clear: UMMHC was well-positioned to take on an Anchor Mission. They identified several key factors that set the stage for success. First, the community benefits program was award-winning and nationally recognized. Second, they had connections to the community through a program called Community Healthlink, which provided mental health services and support for homeless individuals. Finally, they had recently taken an inventory of social service programs through an effort called Community HELP (see **Exhibit 2**) that was established to build connections with their Accountable Care Organization population. Through an Anchor Mission, UMMHC would be able to build upon these connections and develop an intentional system that would allow it to magnify its social impact.

This was particularly important given the concerns from the community following recent decisions to reorganize inpatient psychiatric services including reducing inpatient beds, not participating in the Massachusetts Medicaid Accountable Care Organization, and closing some low-volume clinical services.

[8] Source: CDC: https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html

As shown in **Exhibit 3**, Doug submitted a proposal to Dr. Dickson in mid-February, recommending that UMMHC adopt an Anchor Mission, to be phased in gradually over three years. Dr. Dickson approved the next steps, and the project moved past its first checkpoint.

June 2018—Offsite Board Meeting

In June 2018, the UMMHC Board of Trustees convened for an offsite board meeting in conjunction with the annual Massachusetts Health and Hospital Association meeting on Cape Cod. A vote on whether UMMHC should or should not adopt an Anchor Mission was early on the day's agenda. Among those present was CEO Randy Oostra of ProMedica, the not-for-profit health system with 13 hospitals and 70,000 employees that had pioneered Anchor Mission efforts in their headquarters' city of Toledo, Ohio. ProMedica had adopted the "all-in" Anchor Mission strategy and received national recognition for its efforts to address social determinants of health. They had documented reductions in health care costs tied to their Food Clinic initiative. Doug had invited Randy to present ProMedica's Anchor Mission journey to the board and to describe the successes that they had achieved. **Exhibit 4** provides a summary of that journey.

Cheryl and Monica also presented the community benefits report and highlighted UMMHC's achievement of becoming a finalist in the prestigious 2017 Foster McGaw Prize for excellence in community service. Ahmad and Eric presented the findings from their research on the Anchor Mission initiative, after which Doug presented the proposal he had drafted for Dr. Dickson.

When Rick Siegrist, the board chair, opened the Q&A session before the vote, Doug and Cheryl were rather surprised to learn that several board members thought UMMHC should implement the Anchor Mission in less than the proposed three years. "It's one thing to get a unanimous vote from the board that we should adopt the Anchor Mission strategy," explained Doug, "but a quicker implementation was not the criticism that I expected."

Dr. Dickson explained why he wanted to move forward with the Anchor Mission for UMMHC:

> We were definitely primed to do this. Our community initiatives revolved around the CHNA, and focused on issues such as pediatric asthma, elderly falls, and obesity amongst others, and we were finalists in the Foster McGaw prize. We also focused on the partnership with United Way and had a goal of increasing UMass employee contributions. Yet we also had many things coming at us from service consolidations and the Massachusetts Nurses Association ballot initiative. I questioned if we could really put something else on our plate, but there was a convincing argument that the busy folks are not going to be overworked. For example, the investment and the supply chain teams had the capacity to carry the Anchor Mission operationally. Because we did not need to add resources but only shift them, we gave this the green light.

Forming the Anchor Mission Steering Committee

The next step was to form an internal Steering Committee to discuss and identify project ideas. When Doug and Cheryl met to decide who to bring on the Anchor Mission Steering Committee, one of their main goals was to bring on members from various departments across the

organization. They also wanted to form a team that could help define how the Anchor Mission effort differed from a community benefits program.

As Doug explained:

> The Anchor Mission is focused on developing and implementing strategies to address systemic problems tied to poverty and inequality in the community. Hence, in addition to people with experience in community benefits, it was also important to include people from outside the community benefits team with high levels of expertise, including from the investment committee, the strategy department, and the medical school. We also aimed to bring on folks with personal attributes that would be a good addition for the group; people who can think outside the box and are willing to challenge the status quo.

Cheryl added:

> Beyond the executive members of the committee, it was important to include core team members who are not seated in the executive suite. It was important to look beyond the usual suspects and it was critical to connect with people who have an innate passion around this work. Maybe they didn't describe it as an "Anchor Mission" in the past, but it is the kind of work that gives them the personal opportunity to make an impact.

At the first meeting of the committee, David Zuckerman from the Democracy Collaborative and its Healthcare Anchor Mission Network presented an overview of the Anchor Mission idea and the resources available. He explained the three pillars of an Anchor Mission—purchasing, sourcing/purchasing, and hiring—and described the formation of the Anchor Mission Network. This presentation was nearly every committee member's first exposure to the idea of an Anchor Mission. While they still had many questions, the committee members were clearly excited to be on the project and at the start of something new.

In July 2018, Ahmad and Eric returned to their work at UMMHC and were tasked with leading the "early learning" stage of the Anchor Mission. They reviewed the literature written by the Democracy Collaborative and interviewed staff from other organizations that had implemented an Anchor Mission. They presented summaries of their work to the Steering Committee, emphasizing the various strategies on hiring, purchasing, and place-based investing that were implemented by other health systems across the country. Their presentations were structured as "deep dives" on each of the three anchor strategy domains. Doug and Cheryl wanted these presentations to serve as a tool to educate and facilitate discussion among the members of the Steering Committee.

Furthermore, the leading internal experts in each of the areas—hiring, investing, or purchasing—helped to prepare for the meetings on each topic with the Steering Committee. For example, prior to the meeting on investments, Bob Feldman, Corporate Controller and member of the Steering Committee, was personally involved in reviewing the investment toolkit prepared by the Democracy Collaborative and was prepared to respond to any questions from the rest of the committee. "We were not initiating a project with a start and end date," explained Cheryl. "The anchor strategy is a paradigm shift in the way we do things and requires cultural

adaptations across the entire organization. It was critical that the committee members understood this fact and that the potential leaders were bought in."

The Steering Committee was expected to define how the Anchor Mission differed from other initiatives underway at UMMHC. This included not only the community benefits programs, but also UMMHC's Medicare Accountable Care Organization (ACO) program under which the organization was paid in a capitated format to meet the healthcare needs of the population. John Greenwood was the head of the Medicare ACO at UMMHC and was an acting member of the Steering Committee.

The Steering Committee was also supposed to identify which of the strategies (hiring, purchasing, or investing) to focus on as a first step for the Anchor Mission. However, as they became more familiar with the range of possibilities, they became interested in piloting initiatives across all three domains. Doug and Cheryl asked Ahmad and Eric to work with the Steering Committee to develop a list of potential projects that could would be presented for a vote during a retreat on August 3rd.

August 2018: Steering Committee Retreat

In addition to the Steering Committee members and the Harvard doctoral fellows, Doug and Cheryl invited a representative from the SHARE unions, which included over 3,000 employees from UMMHC and UMass Medical School. Furthermore, two representatives were flown in from the Democracy Collaborative to facilitate the retreat process.

Following a presentation from the Democracy Collaborative, the Steering Committee members were split into groups to review the list of potential pilot projects that UMMHC could implement in each Anchor Mission domain. After a discussion, each group voted on the top three projects in their domain in order to narrow down the list of potential projects. Each group then presented their possible projects and discussed their rationale for the choices based on the projects' potential impact and feasibility. The retreat ended with a final vote with everyone on the Steering Committee voting for one project per domain. The three projects approved by the Steering Committee were to:

1. Allocate 1% of their investment portfolio to targeted community investments with an expected return.
2. Provide targeted technical training for entry-level positions for current and prospective employees. The trainees would be from targeted neighborhoods.
3. Build a system for local purchasing and aid local organizations to increase their supply capacity.

After the Retreat

"I do not recall the last time we witnessed as much excitement and engagement from our executives as we did today," responded Doug when asked about his thoughts on the retreat. The facilitators from the Democracy Collaborative agreed. Toward the end of the retreat, they had opened the meeting up for members to share their comments on the voting process. Many of the

members of the Steering Committee had expressed pride and gratitude for being involved in the Anchor Mission initiative. Shortly after the retreat, Doug emailed Rick and Dr. Dickson to update them on the progress of the initiative (see **Exhibit 5**). In that email, he made sure to highlight the passionate engagement of the Anchor Mission committee. Some of the comments included "This is the coolest thing I have ever done at UMass Memorial," "I have been here for over 20 years and have seen and supported a number of projects. Nothing has been as important as this," and "I am proud of our organization."

"I am 180 degrees today from where I was early on," explained Dr. Dickson when asked about the progress made by the Anchor Mission team.

> At first, I thought, oh great, Doug and Rick get to go to a conference and now I have more work on yet another thing that will use up organizational energy. However, the ability to narrow it down to few things that we're going to do first and seeing the initial steps and the excitement it generated is what changed my view. This might be one of those things that we can take pride in and get our caregivers to be more engaged.

Subcommittees for each Anchor Mission domain were formed. Each was led by a chair and co-chair who were responsible for developing policies and criteria around each project, and were to form their own meeting schedule, make their own subcommittee membership decisions, and develop a plan for implementation. The subcommittees reported to Doug and Cheryl and were expected to present their updates at future meetings of the Anchor Mission Steering Committee as well as in the next Board meeting scheduled for September.

September Board Meeting

The September meeting was the first opportunity for the whole board to hear about the progress made over the summer. Doug prepared a brief overview of the key measures of inequities in the local area and the opportunities for intervention. Doug spoke about the success of the August retreat, especially in regard to engaging employees for a new mission.

In addition, the three subcommittee chairs described the progress made on each project. The investment committee was working to define the criteria to be used to evaluate place-based investment opportunities. The hiring committee was evaluating specific positions that could be leveraged for a hiring pipeline from specific communities. And the purchasing committee was reviewing policies and looking for specific opportunities to buy from local businesses.

The board was enthusiastic and unanimously approved the project. Within the next month, the project was included on the wall of top importance projects in the CEO Boardroom. Looking back on it, Dr. Dickson reported, "I've never seen anything get on the wall as fast." Doug left the meeting hopeful for the project but also knowing that there was much more to do. As he pondered what was next, he challenged himself with three questions:

1. How do we move forward from this "feel good" moment to implementing real change in the community?

2. What is the best way to convince our appropriately conservative Board Investment Committee to designate 1% of the health system's investment portfolio to targeted community investment, with a reasonable expected return on that investment?

3. How can we sustain the current momentum at a time when UMMHC has just experienced an operating loss after several years of profitability and has had to terminate several underutilized services despite community opposition?

Exhibit 1: Statistics and Financial Metrics

UMass Memorial Health Care
(dollars in thousands)

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Inpatient Discharges	49,979	47,639	49,930	49,816	49,703	48,924
ER Visits	215,014	215,479	222,846	222,108	222,561	223,121
Net Revenues	$2,186,135	$2,252,208	$2,241,710	$2,373,453	$2,447,062	$2,496,474
Operating Income	-$55,247	$53,827	$58,038	$40,695	$10,563	-$28,400
Investments	$740,262	$761,925	$722,122	$787,895	$832,291	$806,875

Exhibit 2: CommunityHELP

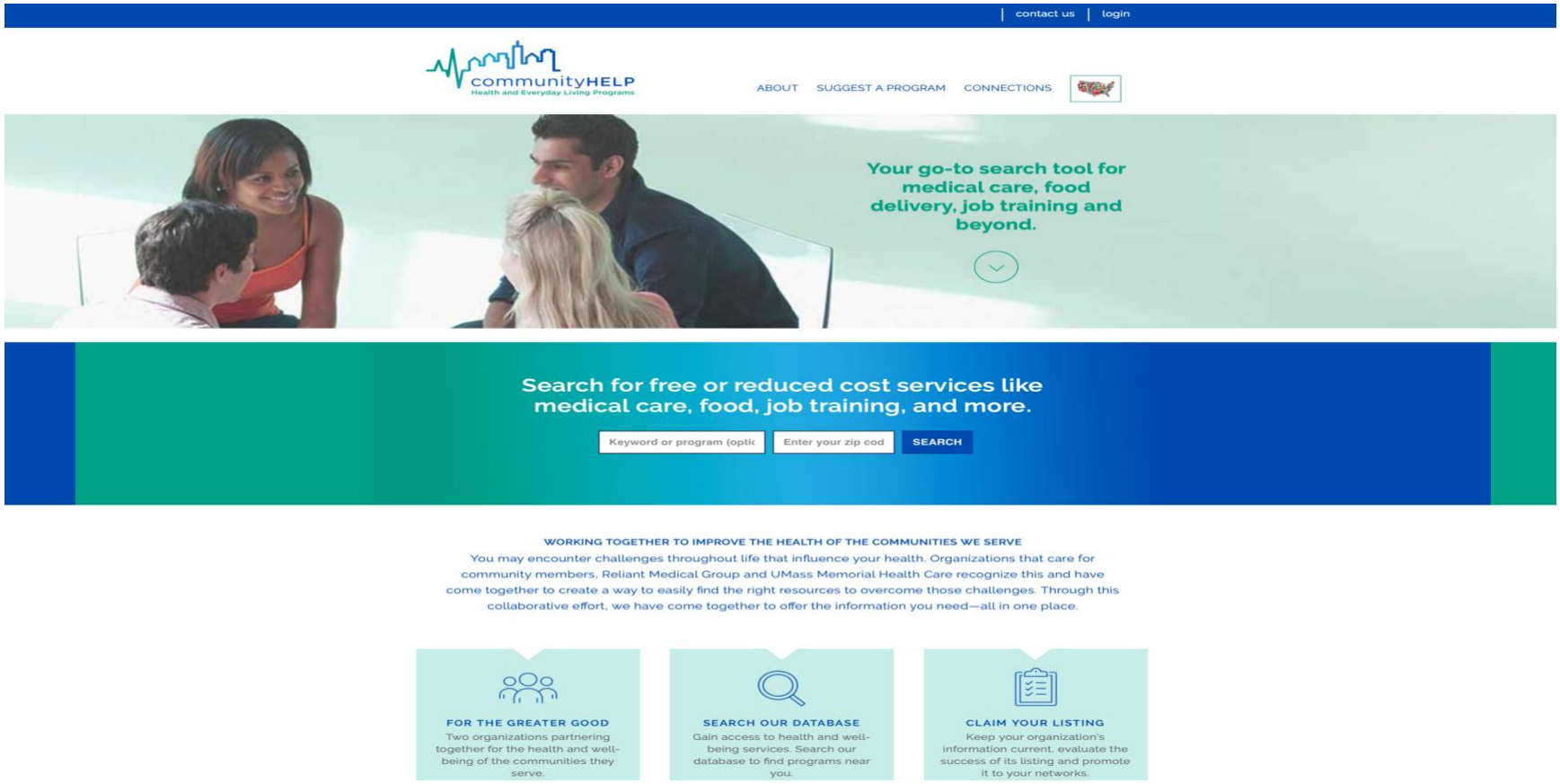

Exhibit 3: Anchor Mission Proposal from Doug Brown

Anchor Mission
Our Proposal
2-16-18

Recommendations:

1. Adopt an Anchor Mission as an aspiration for our organization.
2. Include in our strategy document and make it visual along with our other priorities.
3. Do so as a system.
4. Pursue this gradually, in phases, so that we calibrate our energy and investment with the readiness of the organization.
    a. Spend the necessary time up front to learn from others, educate our key internal stakeholders and set it up for success.
5. Three phases as follows:

- **Year 1**: Educates our boards and senior management on what it is, obtain approval from our board(s), add to our strategy and visual management system, develop a governance structure (I am thinking a system-wide committee, with appropriate competencies represented, reporting in to our Parent CB committee), tackle one initiative within the "hiring" purview, following the toolkit developed by the Democracy Collaborative, pursuing potential for obtaining better data through Epic.
- **Year 2**. Implement data changes in Epic, tackle one initiative in the "sourcing" purview, pursue version 2.0 on hiring, explore "investment" opportunities.
- **Year 3**. Review and use data obtained, make decisions on using portion of investment portfolio for community investment with ROI, next versions of hiring and sourcing.

Benefits:

- Aligned with our mission
- Right thing to do
- Will truly set us apart – huge communication and marketing and branding opportunity
- Will set us (and our community) up to take more risk
- Will help in regulatory sphere as non-profits increasingly under scrutiny to justify exempt status

Exhibit 4: ProMedica and Social Determinants of Health

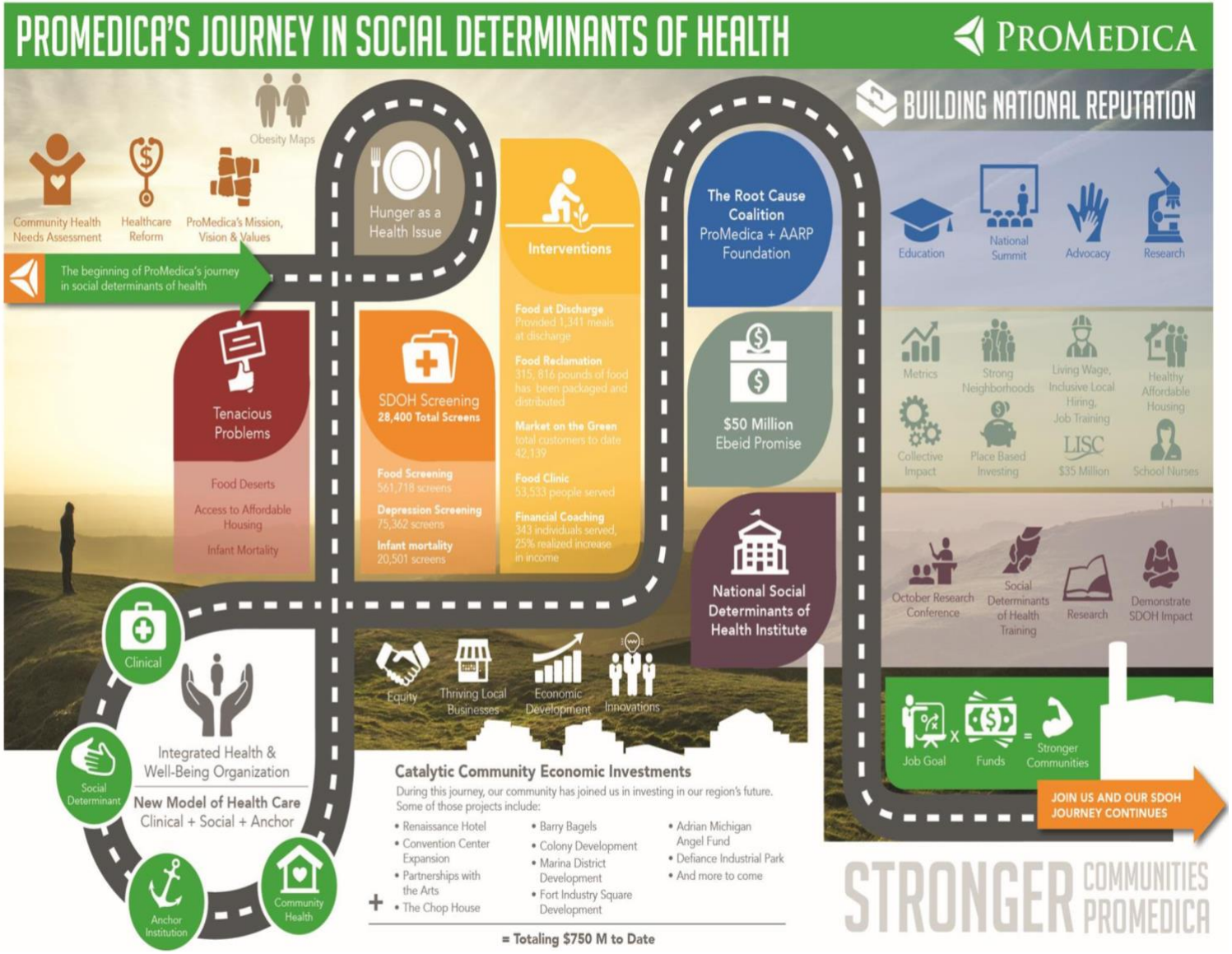

Exhibit 5: UMMHC Anchor Mission Update Memo from Doug Brown to Rick Siegrist and Dr. Eric Dickson, August 8, 2018

Rick and Eric: I wanted to let you both know that we had a retreat of our Anchor Mission Steering Committee last Friday and it was a huge success. Since we have not had an opportunity to brief both of you yet on this work, I wanted to do so by way of this e-mail. Cheryl and I look forward to following up for more discussion in person.

As background, we formed this Steering Committee after the June board retreat to help educate ourselves, plan next steps, and develop an action plan to recommend to the two of you and the board. Eric and Ahmad have been instrumental in this process and its success. The Steering Committee includes approximately 20 individuals who were carefully selected to represent a broad array of perspectives from within our health care system. It includes representation from several of our entities, two clinical chairs, and expertise from: finance and investment, purchasing, human resources, population health, legal, behavioral health (from CHL), and of course community benefit and engagement from Monica and others. We even had leaders of our SHARE union participate. It is a great and highly engaged group.

The group met several times over the summer to learn more about being an Anchor Institution and pursuing an Anchor Mission. We did several deep dives into the three areas of purchasing, hiring, and investment. This work culminated in a half-day retreat last Friday. The retreat was facilitated by David Zuckerman of the Democracy Collaborative and one of his colleagues who do this around the country. The retreat focused first on our values and why each member believes we should pursue this work. We then had a presentation on the demographics of our region and the geographic segregation of poverty that exists within our market—the differences are stark (one zip code in Worcester has a 50% unemployment rate). We did this exercise to start to get an idea of a particular geography we might try to focus on. We are scheduling a neighborhood tour for the group that Monica will lead.

We then broke into groups around the three major categories of purchasing, hiring, and investment. Each group considered a list of several potential projects that had been vetted in advance and prioritized each based on its impact and feasibility. The entire group then came together and voted on the top priorities. Everyone agreed that we should pursue at least one specific project in each category and chairs have been identified for each group. Details will follow, but in summary the recommendations fall along the following lines: (1) allocate 1% of our investment portfolio (approx. $4 million) to target toward carefully selected community investments with an expected return. We would develop criteria and work with and through another experienced organization (like a bank or CDC) on these investments. (2) targeted technical training for entry level positions that is accessible both internally to existing employees and externally to potential new employees. Target specific neighborhoods. (3) build a system for local purchasing, create tools to support that system, and train and educate internally and externally on such tools to increase capacity of local organizations with which we could work.

Most importantly, **I wanted to convey the intense passion that was generated at this retreat**. I have never experienced a meeting here where so many employees felt so good

and so engaged about the work they were doing. It was honestly quite moving to see how excited people are about this work. Here are just a few quotes from the debrief at the end of the retreat: “I am proud of our organization.” “Words cannot explain my appreciation for being included in this work.” “This is the coolest thing I have ever done at UMass Memorial.” “I will always remember this day.” “This gets me out of the daily grind to think about something bigger.” “This was fascinating and rewarding.” “Outstanding work.” “I am privileged to work with such awesome and passionate people.” “I have been here for 20 years and have seen and supported a lot of projects. Nothing has been as important as this.”

There is no doubt that this work will leave an indelible mark on our community. But what has become even more clear to me is the potential it has to engage and inspire our employees like nothing we have seen before. We look forward to your thoughts and feedback. Thanks for your support. *Doug*