Saint Anne's Hospital

A STEWARD FAMILY HOSPITAL

Steward®

Community Benefits Plan

FY 2014

Table of Contents

Contents

Mission and Values

Mission Statement

Steward Health Care is committed to providing the highest quality care with compassion and respect.

We dedicate ourselves to:

- *Delivering affordable health care to all in the communities we serve*
- *Being responsible partners in the communities we serve*
- *Serving as advocates for the poor and underserved in the communities we serve*

Values

Compassion:

Providing care with empathy in such a way that the person experiences acceptance, concern, hopefulness and sensitivity

Accountability:

Accepting responsibility for continuous performance improvement, embracing change and seeking new opportunities to serve

Respect:

Honoring the dignity of each person

Excellence:

Exceeding expectations through teamwork and innovation

Stewardship:

Managing our financial and human resources responsibly in caring for those entrusted to us.

About Us

Saint Anne's Hospital (SAH) is a member of Steward Health Care System, the largest fully integrated community care organization in New England. Saint Anne's is a general medical and surgical hospital in Fall River, MA, with 160 beds. It provides acute care with state-of-the-art medical technology and a highly skilled staff.

Saint Anne's Hospital has earned the Gold Seal of Approval from The Joint Commission and offers specialized services in oncology, surgery, pediatrics, diabetes, orthopedics, breast care, rehabilitation, behavioral health, and pain management.

Saint Anne's Hospital has been named a **Top Hospital** for patient safety, quality of care and efficient use of resources. Of the 1,324 hospitals in the U.S. to participate in Leapfrog's annual survey in 2013, Saint Anne's Hospital is one of just 90 hospitals nationwide, and 55 urban hospitals in the country, to earn this distinction. The Leapfrog Group is a national non-profit watch dog group focused on improving the safety, quality and affordability of health care for Americans.

Further information regarding Saint Anne's Hospital is available at www.steward.org.

.

Our Community Health Benefits Mission Statement

Saint Anne's Hospital (SAH) is dedicated to serving the health care needs of our community by:

- Providing accessible, quality health care services to all within our culturally diverse community, including the poor, vulnerable, and disadvantaged.
- Providing preventative health, education, and wellness services.
- Working in collaboration with our community partners to identify and respond to unmet needs.
- Recommending to the Board of Directors of Saint Anne's Hospital the adoption of needed programs and services to address identified, prioritized, and unmet health care needs in the community.

Community Health Benefits Statement of Purpose

Saint Anne's Hospital (SAH) acts in compliance with The Massachusetts Attorney General's Guidelines for Non-Profit Hospitals as promised to our community and government.

Our community health benefits purpose is to:

- Maintain Community Health Benefits Committee that represents the diverse Fall River community.
- Monitor and evaluate outcomes of community benefit programs in comparison to community health needs.
- Review the findings with other health care planning groups in the community to avoid duplication and promote collaboration.
- Obtain feedback from the community on Saint Anne's community health benefits services.
- Develop a prioritized outcome measure for each service to utilize in evaluating its effectiveness.
- Contribute to the well-being of our community through outreach efforts including, but not limited to, reducing barriers to accessing health care, preventative health education, screening, wellness programs, and community-building.
- Regularly evaluate our community health benefits program.

Needs Assessment

Attorney General's direction: Assess the needs of our service areas and get direct input from our community about which programs to include in our plan.

Saint Anne's Hospital maintains a Community Health Benefits Department that focuses on integrating care across the spectrum of hospital, primary, and community-based care. The Community Health Benefits Committee guides the planning and execution of the community health initiatives. The committee is composed of hospital leadership, representatives of local health and human service organizations, city health and public works departments, community centers, churches, and schools. The results and recommendations here are designed to be the basis for strategic actions for Saint Anne's Hospital and its community partners.

The goal of the needs assessment is to identify unmet community health needs, vulnerable populations, and gaps in existing community health services. Data collection included research derived from online sources such as the US census, MassCHIP, and the Federal Reserve Bank; community provider surveys administered at churches, schools, government agencies, and community centers; and focus groups were conducted to capture data on perceived community health issues.

From these sources, data on health behaviors, health conditions, access to utilization of health services, and health care costs were examined for opportunities where the hospital, in partnership with the local community service providers, could make a difference in lowering per capita health care costs, improving quality, and improving the health of populations.

For 2014, Saint Anne's Hospital will participate in a community-wide health needs assessment with Community Partners under the leadership/direction of Greater Fall River Partners for a Healthier Community, Inc. (Partners). This assessment will include the communities of Fall River, Somerset, Swansea and Westport. Final health needs assessment and action plan will be completed and published /provided to the community on June 30, 2014.

Targeted Underserved Populations

Saint Anne's Hospital will focus our community health benefits efforts toward individuals and families who are most vulnerable, at-risk due to unemployment, poverty, substance abuse, mental health illness, chronic disease, and issues related to accessing primary health care or health insurance for manageable conditions. Our data indicate that race and ethnicity play a role in disease susceptibility. Saint Anne's will apply resources to understanding and compensating for these social determinants of health.

Community Health Benefits Plan

Attorney General's direction: the hospital should include in its community health benefits plan the target populations it plans to support, specific programs or activities that attend to the needs identified in the community health needs assessment, and measureable short- and long-term goals for each program or activity. (Source: *AG Guidelines,* page 6).

_____

Priority 1
Address Social Determinants of Health

Target Populations: Low-income residents; persons with limited-English proficiency (LEP) will be a subset of the target population.
Partners: Standard Pharmacy, Fall River Food Pantry, Marie's Place, First Baptist Church, United Interfaith Action (UIA), Southeast Center for Independent Learning, Bristol Elder Services, Justice Center of Southeastern MA, LLC, Saint Anne's Neighborhood Association (SANA) and the Dominican Sisters of the Presentation.
Goals:

1. Reduce barriers to health care access caused by poverty, unemployment, and lack of transportation.
2. Support access to healthy environments that support positive health outcomes including housing, parks, and clean neighborhoods.

Strategies:

1. **Blessed Marie Poussepin Outreach Ministry:** Provide vouchers for prescriptions, supplements, non-durable medical supplies, taxi service, food, and clothing.
2. **Transport Service:** Provide free transportation for oncology and behavioral health geriatric patients who would otherwise be unable to access care.

3. **Reduce Food Insecurity:** Provide monthly cash allocation to Fall River Food Pantry and Marie's Place to provide food to low income residents.
4. **Medical Legal Partnership (MLP):** Provide income-eligible (low-income) and elderly residents with free legal advocacy to eliminate barriers leading to poor health outcomes, which may include unsafe and unstable housing, domestic violence, and denial of public benefits.
5. **SAH Healthy Food Initiative:** Provide SAH patients and Greater Fall River community access to healthy and locally grown produce at the weekly seasonal SAH hospital-based farmer's market.

Priority 2
Improve Access to Care

Lack of understanding of enrollment and navigation of health insurance system were consistently mentioned by community-based key informants. Saint Anne's Hospital will work with community-based organizations in outreaching to communities served by the hospital in order to increase access to health care resources and health insurance in support of health care reform.

Community Health Advocate (CHA)
A community health advocate (CHA) follows up on incomplete health insurance applications; sometimes, a single document is all that is missing. The CHA provides individual follow-up, often in the home, and often in the applicant's native language. CHAs, or individuals who are trained in health insurance advocacy, have good success in getting more people covered by health insurance. Covered individuals often participate more actively in preventive care and avoid costly emergency room visits.

Even with the Health Care Reform Act and Affordable Care Act, certain vulnerable populations, such as undocumented residents, remain uninsured or underinsured. With high unemployment rates,

many more people find themselves with no insurance for the first time in their lives. Saint Anne's staff offers assistance to any persons seeking health care services and/or health insurance.

Target Populations: Uninsured and underinsured residents; persons with limited-English proficiency (LEP) are a subset of the target population whose linguistic and cultural needs will be addressed.

Partners: Faith communities, Justice Center of Southeastern MA, LLC/Medical-Legal Partnership (MLP), HealthFirst and SSTAR (community health centers), Community Counseling of Bristol County (CCBC).

Goals:

1. Provide assistance in enrolling uninsured in the most appropriate state or federally funded health insurance plan in support of health care reform.
2. Assist underinsured in upgrading to plan that provides broader coverage.
3. Refer community members to internal/community resources that support positive health outcomes.
4. Seek to initiate transportation between health centers and hospital-affiliated sites in order to increase transportation resources.
5. Gather more information on the needs of the Portuguese- and Spanish-speaking communities.

Strategies:

Health Insurance Advocacy: Bilingual health insurance advocate will assist target populations in completing and filing application forms for enrollment, re-enrollment, and upgrades to available state and federal funded insurance plans, and the advocate will refer to community resources to support improved access to care and health care reform.

Priority 3
Expand Utilization of Medical Legal Partnership (MLP)

Some medical issues can be exacerbated by legal issues related to health insurance, housing, and domestic violence. Saint Anne's Hospital is in our fourth year of Medical Legal Partnership (MLP), which offers free legal assistance to patients and some community members. MLP provides free legal intervention to remedy social conditions, address housing and domestic issues, and improve life and health for indigent and elderly patients. Research shows that unsafe or unstable housing, domestic violence, the inability to access public benefits, and other legal problems can intensify poor health outcomes among the most vulnerable in our community. In collaboration with the Justice Center of Southeastern, MA, free, on-site legal assistance is available to help with issues that include defending evictions, advocating for better housing conditions, drafting advanced directives, giving counsel, and providing advocacy on right to benefits, including health insurance.

Target Populations: Low-income residents. Uninsured and underinsured residents. Persons with limited-English proficiency (LEP) are a subset of the target population whose linguistic and cultural needs will be addressed.

Partners: Faith communities, Justice Center of Southeastern MA, LLC/Medical-Legal Partnership (MLP), HealthFirst and SSTAR (community health centers), Community Counseling of Bristol County (CCBC), other community non-profits, school systems, and local businesses.

Goals:

1. Expand awareness for MLP among all internal hospital departments and key community partners.
2. Expand the utilization of the MLP
3. Gather more information on the needs of the Portuguese- and Spanish-speaking communities through feedback from the MLP.

Strategies:

1. Educate providers, community partners and target population about MLP by holding educational seminars and/or meetings about the free services available through the MLP.
2. Refer community members to internal/community resources that support positive health outcomes fostering a collaborative relationship with the MLP.
3. MLP to provide assistance and resources to educating the uninsured/under insured about the most appropriate state or federal funded health insurance plans and assist enrollment as appropriate to ensure access to care.

Priority 4

Health Promotion and Prevention

Target populations: Vulnerable, at-risk populations who need health education, physicians/ health care providers caring for vulnerable, at-risk populations. Persons with limited-English proficiency (LEP) are a subset of the target population whose linguistic and cultural needs will be addressed.

Partners: Steward/SAH Diabetes Education Program, Fernandes Center for Children & Families (FCCF), Partners for a Healthier Community, BOLD (Building Our Lives Drug Free), Fall River Public Schools, other community not-for-profits, and local businesses.

Goals:

1. Build on the recommendations of the National Prevention Strategy and Healthy People 2020 to address health improvement through prevention and education.
2. Provide target populations with screenings for and education about high-risk health issues.
3. Provide education to health providers about high-risk health issues impacting vulnerable populations.

Strategies:

1. **Steward/SAH Diabetes Education Program**: Collaborate with community partners to offer diabetes outreach and education in multiple venues and formats to encourage prevention and adoption of lifestyle strategies to improve self-management. A minimum of two diabetes prevention/education programs will be offered in the community.
2. **Health Screenings:** Provide free screenings for diabetes, vascular disease, hypertension, and skin cancer.
3. **Health Education and Wellness:** Provide free education and wellness programs to target populations where they live, work and worship. Focus program topics on high-risk health issues identified in community health needs assessment.
4. **Child & Family Obesity Initiative:** Provide nutritional and behavioral health change support to high-risk children and their families with issues of obesity.
5. **Steward Farmers Market Voucher Program:** Provide high-risk diabetic patients who have issues of obesity with produce vouchers to be used at local farmer's markets to increase healthy vegetables and fruit intake.
6. **Faith Community Nursing:** Work in partnership with individuals, faith communities and mission-based agencies to ensure management of care through health counseling, health education, and referrals to community resources and primary care.

7. **Continuing Medical Education Programs:** Provide education to community physicians, nurses, social workers and other providers on topics related to medical needs of vulnerable populations.
8. **Prescription Drug Abuse Prevention:** Work in partnership with community-based agencies and primary care physicians to empower and educate patients about the risks of prescription drug abuse.

Priority 5
Behavioral Health and Substance Abuse

Care Coordination
Focus group and community provider input revealed a concern for difficulty in accessing behavioral health resources, which can be addressed by initiating care coordination for management of behavioral health patients. This is a multicomponent intervention that uses case managers to link primary care providers, patients, and mental health specialists. Studies have shown that such collaborative efforts improve negative-psychiatric symptoms, adherence to treatment, and response to treatment.

Target Populations: Seniors with or at risk for behavioral health issues, youth victims of violence/abuse, populations at risk for substance abuse and mental/behavioral health issues. Persons with limited-English proficiency (LEP) are a subset of the target population whose linguistic and cultural needs will be addressed.

Partners: Bristol Elder Services, Coastline Elderly Services, Corrigan Mental Health Center, SSTAR, Children's Advocacy Center of Bristol County (CACBC),Steppingstone, Inc, Community Counseling of Bristol County (CCBC), SAH Youth Trauma Program.

Goals:

1. Screen and refer to mental health services seniors at risk for behavioral health issues.
2. Screen and refer to treatment/community services individuals at risk for substance abuse and mental/behavioral health illness.
3. Provide diagnostic evaluation and psychotherapy to children who have witnessed or have been victims of trauma and/or abuse.
4. Provide education and training to providers serving target populations and populations at risk for mental health issues, substance abuse, and trauma.

Strategies:

1. **Senior Behavioral Health Services**: Provide free in-home mental health evaluations for individuals ages 60 and older. Refer those who screen positive to mental health providers. Provide community education regarding the mental health needs of older residents for professionals and the general community at senior centers, extended care facilities, and human service agencies.
2. **Youth Trauma Program (YTP):** Provide specialized evidenced-based services for child victims, including extended forensic interviews (EFT) and sexual abuse/trauma evaluations. YTP in collaboration with the CAC will ensure all children are referred to appropriate mental health care and specialized medical care/consultations; ensure increased outreach, education, and awareness toward the goal of prevention for child sexual abuse.
3. **Project ASSERT:** Provide screening, intervention, advocacy, and referrals to treatment/services for emergency room patients and community members detected for substance, alcohol and tobacco abuse, and for mental illness.

Priority 6
Chronic Disease Management and Support

Target Populations: Vulnerable Populations at risk for or diagnosed with chronic disease. Persons of limited-English proficiency (LEP) are a subset of the target population whose linguistic and cultural needs will be addressed.

Partners: People Inc., Bristol Elder Services, Quitworks, Steppingstone Inc, Fernandes Center for Children & Families, SSTAR, HealthFirst, faith communities, Health Access Collaborative and other community non-profits.

Goals:

1. Screen and provide referrals for education, treatment and/or disease self-management.
2. Provide education for tobacco-related conditions, substance abuse, mental health, diabetes, and hypertension.

Strategies:

1. **Diabetes Education and Self Management:** Provide free bilingual community screenings, monthly educational sessions and support groups to those at-risk for or diagnosed with diabetes. Plan and deliver diabetes health fair. Offer Screen to Intervene and diabetes self-management programs.
2. **Availability of medical interpreters**
   Foster the recruitment, training and monitoring of highly-qualified interpreters to work in health care facilities and in the community.
3. **Cancer Support and Wellness Programs:** Deliver complimentary support and wellness programs for residents diagnosed with cancer. Promote breast cancer awareness.
4. **Behavioral Care Navigation & Management:** In partnership with SSTAR, refer patients who present in the SAH Emergency Department with behavioral and

or substance abuse issues to be enrolled in a care-management initiative to be led by SSTAR Health Center clinical team.

5. **New U Program:** A weight management program for children and their families. Support & education to be provided by a dietitian and licensed psychologist.

Priority 7
Cross Continuum Care

Primary data – focus groups and provider input – recognized chronic disease as a major community health issue in the Saint Anne's community. Data also suggest that people with chronic diseases are more likely to go to hospitals, emergency rooms, and long-term care facilities. Transitioning from one care setting to another increases an individual's susceptibility to inefficiencies of a fragmented care system. A care transition team that brings various care providers together would be a good starting point in addressing the existing miscommunications and inefficiencies.

Target populations: Vulnerable populations at risk for or diagnosed with chronic disease, behavioral health issues, substance abuse; residents impacted by social determinants of health. Persons of limited-English proficiency (*LEP) are a subset of the target population whose linguistic and cultural needs will be addressed.*

Partners: SSTAR, Community Counseling of Bristol County, Bristol Elder Services, Corrigan Mental Health, Steward Home Care, Steppingstone Inc, Sub- Acute and Long Term Care Providers, Medical Legal Partnership and other community-based non-profits.

Goals:

1. Provide community-based services to support successful transition of care for patients discharged from hospital and/or emergency room.
2. Provide support to assist target populations in accessing primary care and community-based services.
3. Improve transitions between care processes with a long-term goal of reducing emergency department admissions and hospital readmissions leading to reducing health care costs.
4. Continue community engagement and expand care plan development in order to reduce Emergency Department recidivism and over-use.

Strategies:

1. **Community Health Advocate: Faith Community Nursing:** Work in partnership with individuals, faith communities, and providers to ensure management of care across the care continuum through health counseling, health education, and referrals to community resources and primary care.
2. **Collaborative Care:** Provide frequent users of emergency services in addition to patients frequently admitted to the hospital with support of a dedicated patient/behavioral health navigator who provides care management through a highly individualized care plan developed by an interdisciplinary team composed of hospital and community providers of care.
3. **Policy Advocacy:** Support community advocacy and healthy lifestyle policy initiatives, such as the addition of bicycle lanes to serve area neighborhoods and smoking laws that ban smoking in public places.
4. **ED Recidivism Initiative:** Implementation of ED Recidivism Care Plans in Emergency Department to decrease frequent use of emergency services by community members. Care Plans will address psychosocial and/or medical concerns. In addition, care plans will attempt to empower patients to utilize community resources to increase their overall health.

Priority 8
Community Capacity Building and Support

Target Populations: Vulnerable, under-served populations with unmet health needs.

Partners: Community organizations serving target populations.

Goals:

1. To provide cash support, in-kind goods, and pro-bono clinical and administrative services, and volunteer support to organizations seeking to improve health and well-being of target populations.

Strategies:

1. **Charitable Giving:** Provide grants and in-kind goods and services to local organizations able to leverage support towards: improving health outcomes, addressing social determinants of health, improving access to health services, and building community capacity and collaboration.
2. **Service to Community:** Engage employees at all levels to share expertise with area organizations in an effort to contribute to the improved health and well-being of our community.

Community Health Benefits Committee

Saint Anne's Hospital uses our expertise and resources, and leverages the expertise of our community partners, to target the particular needs of underserved and at-risk populations

Autumn Levesque, RD, LDN; Clinical Dietitian, Saint Anne's Hospital
Barbara Wales, Health Promotion Manager, Bristol Elder Services
Brian O'Connor, Esq., Program Manager, Justice Center of Southeast, MA LLC
Brittany Lynch, MSW, Medical Social Worker/Health Promotion Advocate, Saint Anne's Hospital
Michael Aguiar, Coalition Staff Director, BOLD-Building Our Lives Drug Free
Craig Jesiolowski, FACHE, President, Saint Anne's Hospital
Denise Marques, Continuing Medical Education Coordinator, Saint Anne's Hospital
Denise Wright, Clinical Director, Family HealthCare Center at SSTAR
Fred Grose, Executive Director, Health Access Collaborative of Southeast MA
Jennifer Salem-Russo, LICSW, Clinical Coordinator, Youth Trauma Program, Saint Anne's Hospital
Maria Sullivan, Director of Programs for Southeast Center for Independent Living
Karen Wenger, RN, MSN, FCN, Faith Community Nurse, Saint Anne's Hospital
Lisa Blanchette, Director, Health Access, Saint Anne's Hospital
Lisa DeMello, MSN, RN, ACNS-BC, Clinical Educator/Stroke Coordinator, Saint Anne's Hospital
Marcia Picard, Partners for a Healthier Community, Fall River School Wellness Coordinator
Marin Woods, RD, LDN, Clinical Nutrition Manager, Saint Anne's Hospital
Tracy Ibbotson, MEd, Administrative Director of Community Health Benefits, Saint Anne's Hospital

Rose Marie Couto, RN, CDE, RN, CDE, Diabetes Educator, Saint Anne's Hospital
Thomas F. Lyons, Chair, Retired, Board Member, Saint Anne's Hospital
Jennifer Espinola, Health Insurance Advocate/Community Health Benefits Resource Liaison, Saint Anne's Hospital
Michelle Loranger, Executive Director, Children's Advocacy Center of Bristol County
Weayonnoh Nelson, Esq., Staff Attorney, Medical Legal Partnership, Justice Center of Southeast MA, LLC
Natalia Konarski, Director, Interpreter Services, Saint Anne's Hospital
Karyl Benoit, Outreach Coordinator, Oncology Services, Saint Anne's Hospital
Susan Mitchell, LICSW, Program Director, Center for Behavioral Medicine, Saint Anne's Hospital
Kathleen Murphy, Community Organizer, United Interfaith Action (UIA)
Erin McGough, MSN, RN, CCM, Director of Case Management, Saint Anne's Hospital

Saint Anne's Hospital Community Health Benefits Staff:

Tracy Ibbotson, MEd.
Administrative Director , Community Health Benefits
Saint Anne's Hospital
795 Middle Street
Fall River, MA 02721
Tracy.ibbotson@steward.org
508-235-5289

Jennifer Espinola
Community Health Benefits Resource Liaison
Saint Anne's Hospital
795 Middle Street
Fall River MA 02721
Jennifer.espinola@steward.org
508-674-5600 ext. 5029

Brittany Lynch M. S. W.
Medical Social Worker/Health Promotion Advocate
Saint Anne's Hospital
795 Middle Street
Fall River MA 02721
Brittany.lynch@steward.org
508-674-5600 ext. 5514

Ana D'Abruzzo
Administrative Assistant, Community Health Benefits
Saint Anne's Hospital
795 Middle Street
Fall River, MA 02721
Ana.Dabruzzo@steward.org
508-674-5600 ext 2080

795 Middle St. Fall River, MA 02721
508- 674-5600
www.steward.org/Saint-Annes-Hospital