Saint Anne's Hospital

A STEWARD FAMILY HOSPITAL

Steward

2022 Community Benefits

Implementation Strategy

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Might through Light – Saint Anne's Hospital aglow in orange in solidarity for Unity Day

In recognition of ***National Unity Day,*** Saint Anne's Hospital joined the City of Fall River and other community partners in lighting its outer façade in bright orange to stand in solidarity against bullying and other social injustices. (10/20/21)

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 Saint Anne's Hospital -

Founded by the Dominican Sisters of the Presentation in 1906, Saint Anne's Hospital in Fall River, Massachusetts, is a full-service, acute care Catholic hospital with 211 beds and satellite locations in Dartmouth, Attleboro, Swansea, New Bedford, and Stoughton, MA.

A member of Steward Health Care, Saint Anne's provides nationally recognized patient- and family-centered inpatient care and outpatient clinical services to patients from surrounding Massachusetts and Rhode Island communities. Saint Anne's key services include the Center for Orthopedic Excellence; bariatric surgery; multiple robotic-assisted surgical capabilities, including orthopedic surgery, spine surgery, bariatric surgery, and general surgery; Saint Anne's Hospital Regional Cancer Center; two ambulatory surgery centers; the Center for Pain Management; and inpatient geriatric psychiatry services. In addition to earning the Leapfrog Group's "Straight A's" for patient safety since 2012, Saint Anne's has earned national recognitions for cancer care, spine surgery, bariatric surgery, stroke care, patient experience and safety. Follow us on Facebook, Instagram, Twitter, and LinkedIn

More information about Saint Anne's Hospital is available at www.saintanneshospital.org.

Community Benefits Mission Statement

Saint Anne's Hospital 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, regardless of their ability to pay
- Providing preventive health, education, and wellness services
- Working in collaboration with our community to identify and respond to unmet needs
- Educating community members around prevention and disease management, particularly for chronic diseases such as diabetes, heart disease, cancer, and substance use disorder
- Addressing the social determinants or root causes of health disparities, including substance abuse, poverty, unemployment, housing, homelessness, domestic violence, sexual abuse, and behavioral/mental health issues
- Recommending to Senior Leadership and to the hospital Board of Directors the adoption of programs and services to address identified, prioritized, and unmet health care needs in the community

Community Benefits Statement of Purpose

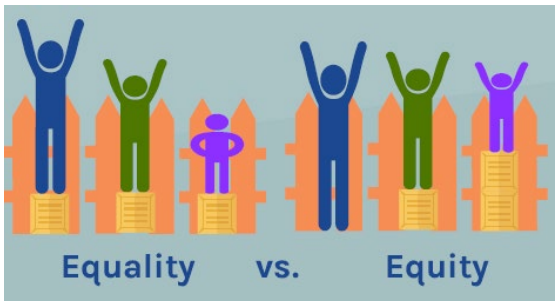
Saint Anne's Hospital, in voluntary compliance with the Massachusetts Office of the Attorney General's Guidelines for Non-profit Hospitals, is committed to serving our community and, as such, outlines the following aims for our community benefits for the 2022 calendar year:

- Improve the overall health status of people in our service area through the lens of health equity
- Provide accessible, high-quality care and services to all those in our community, regardless of their ability to pay
- Collaborate with staff, providers, and community representatives to deliver meaningful programs that address statewide health priorities and local health issues
- Identify and prioritize unmet needs and select those that can most effectively be addressed with available resources
- Contribute to the well-being of our community through outreach efforts including, but not limited to, reducing barriers to accessing health care, preventive health education, screening, managing chronic health conditions, wellness programs, and community-building
- Regularly evaluate our community benefits programs

Adopting a Health Equity Lens

Health equity can be defined in many ways but is essentially a condition in which all people have the opportunity to be as healthy as possible, and in which no one is "disadvantaged from achieving this potential because of their social position or other socially determined circumstance."[1] Importantly, equity is not the same as equality. To equalize opportunities, those with worse health and fewer resources need more efforts expended to improve their health (see Figure 4). That is, while understanding the impact of social determinants of health within a community, it is also crucial to understand how underserved populations are disproportionately affected by social determinants (*source: Saint Anne's Hospital (SAH) 2021 Community Needs Assessment (CHNA))*

Figure 4
Equality Versus Equity



[1]Braveman, P.A., *Monitoring equity in health and health care: a conceptual framework*. Journal of health, population, and nutrition, 2003. 21(3): p. 181.

Community Health Needs Assessment

This 2022 Community Health Benefits Implementation Strategy (IS) is based on the 2021 Community Health Needs Assessment (CHNA) in compliance with the Attorney General's Office (AGO) guidelines to conduct triennial assessments on community health status. The goal of the 2021 assessment was to identify still-unmet and emergent community health needs, vulnerable populations, and gaps in existing community health services with the added concern for the health-related effects of COVID-19.

The 2021 CHNA was completed by gathering and analyzing publicly available health indicators, conducting a review of the literature on population health, and assembling and reporting primary qualitative data. Community partner organizations such as Fall River Family Service Association, Steppingstone Incorporated, the United Way of Greater Fall River, and others participated in the collection of primary data through community focus groups and key informant surveys and interviews, with the goal of achieving a high level of community engagement in the assessment process.

As we continue to strive to be the premier regional choice for health care services in an evolving health care landscape, we must make significant investments on social determinants of health. It is well documented that race, ethnicity, and socio-economic factors are primary indicators of health status. SAH will collaborate with community partners to address social determinants of health, such as social and physical environments, housing, violence, and trauma, all of which place our community at greater risk for poor health outcomes. Together, with the leadership of our Community Benefits Advisory Committee (CBAC), we will work to improve the health and well-being of those in the targeted underserved population.

Targeted Underserved Populations

In 2022, Saint Anne's Hospital will focus our Community Benefits programs and initiatives on individuals and families who are most vulnerable due to:

- poverty
- homelessness
- trauma
- substance use disorder
- mental health disease
- chronic disease (i.e., diabetes, cancer, heart disease, substance use disorder)
- obesity/poor nutrition
- lack of access to health care
- lack of health insurance/under-insured/cost of health care
- Limited English Proficiency (LEP)/language barriers
- sexual orientation/gender identity/LGBTQ+
- at-risk elders
- at-risk veteran status

Individuals/families displaced and/or disproportionately adversely effected by the pandemic (2020) have been identified as a specific targeted population. Data indicate that race, ethnicity, cultural diversity, and limited-English proficiency underlie health disparities.

Building on our initiatives to embrace cultural diversity and inclusion, Saint Anne's Hospital will continue to promote person-centered, culturally competent care. This encompasses welcoming all and taking the extra time to engage patients while applying active listening skills. It may extend to learning more about a patient's culture to be able to connect. We will continue to ask our employees to increase their efforts, to "walk in our patients' shoes," to be able to support and care for them with even greater empathy and compassion. Saint Anne's Hospital/Steward Health Care is committed to learning new approaches in delivering care and to creating an environment of inclusion for all races, ages, religions, disabilities, ethnicities, sexual orientations, and gender identities.

Community Benefits Plan

Source: Saint Anne's Hospital Key Informant Survey, 2021

Saint Anne's Hospital will align its community benefits priorities and goals with guidance provided by the Massachusetts Attorney General's Office and the Department of Public Health. Our success in addressing community health issues present in the SAH service area will come from coordinated regional strategies with public health and population health management agencies, community partners, and community coalitions.

The priorities and the plan were approved by the Community Benefits Advisory Committee (CBAC).

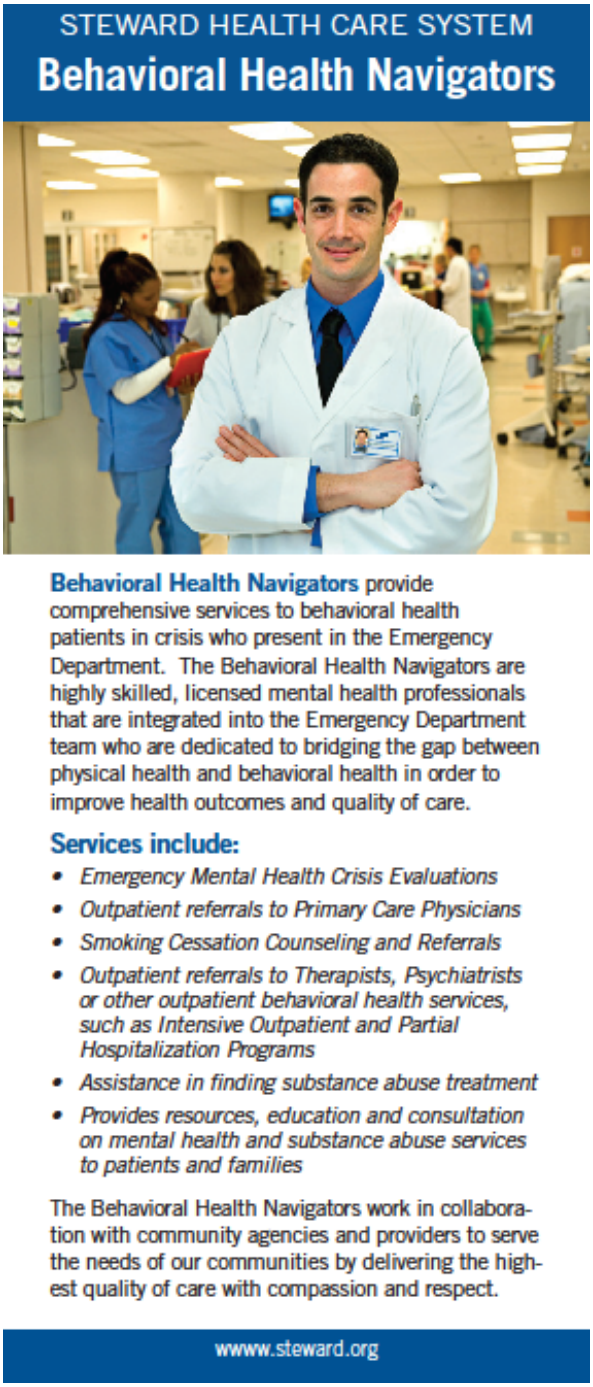
Priority Issue	Sub-Categories
Behavioral Health	Mental Health, Substance Use Disorder, Youth Trauma
Housing and Homelessness	Affordability and Stability, Barriers to Shelter/Housing
Wellness & Chronic Disease	Unhealthy behaviors, Health Outcomes, Prevention
Food Insecurity	Persons who are food insecure, SNAP Gap, Nutrition Literacy
Health Access and Equity	Underserved populations, Obstacles to Care, Health Literacy, Cultural Competency

The following Community Benefits Plan will be implemented and monitored for effectiveness.

Priority 1 - Behavioral Health-Mental Health, Substance Use Disorder & Trauma

Fall River has been hit harder by the opioid epidemic than almost any community in the state. The city saw 75 fatal opioid overdoses in 2020, 67 in 2019 and 55 in 2018, according to state data. This places Fall River, the 10th largest city in Massachusetts, fourth on the list of cities with the most opioid deaths in the state in recent years, after Boston, Springfield and Worcester. *The Herald News*, December 29,2021

Behavioral health/mental health issues were cited by key informants as the primary health challenge in the region, closely linked with many of the other health and community issues faced by residents. This is especially true of individuals with a substance use disorder, as evidenced by a growing population of patients with dual diagnosis, that is, individuals who experience a substance use issue along with a mental health issue. This patient population is also prone to chronic medical conditions due to and exacerbated by unhealthy behaviors and chronic neglect of self-care, such as COPD, lung cancer, hepatitis, malnutrition, Type 2 diabetes, obesity, and heart disease. Key informants and focus group members confirmed the link between substance abuse and mental health, noting that it is difficult to treat patients effectively if these issues are not addressed simultaneously.



Our community health needs assessment showed the leading cause of hospitalizations in Bristol County to be mental health and substance use disorder. For the SAH Primary Service Area (PSA), Fall River had significantly higher rates for alcohol and intravenous drug use. Focus group and community provider input revealed a concern for difficulty in accessing behavioral health resources, which often requires multi-disciplinary care coordination between primary care providers, patients, and mental health/substance use disorder specialists. Studies have shown that a coordinated approach to care management through specialized patient care navigators improves patient outcomes.

The opioid crisis of recent years has led to the creation of many task forces across Bristol County to address treatment, harm reduction, and overall services to adults with substance use disorders (SUD). This good work has seen a recent decrease in overdose deaths, but the incidence and negative impacts of substance use remain a significant concern. The negative impact of SUD on families and children is profound and multi-generational.

Program: Behavioral Health Navigation

Target Population: Patients with behavioral health disorders: mental illness, substance/alcohol use disorder or dual diagnosis
Responsible Party: Brittany M. Lynch, MSW, LICSW, Director of Patient Care Transitions/Social Work, Saint Anne's Hospital
Community Partners: Bay Cove Emergency Services, Community Counseling Services of Bristol County (CCBC), and other community agencies and providers to serve the complex needs of patients with behavioral health disorders
Budget: includes salaries and administrative support for Behavioral Health Navigator role
Description: Provide screening/assessment, intervention, advocacy, and referrals to treatment/services for SAH Emergency Department patients and inpatients assessed/screened for substance/alcohol use disorder, mental illness, or dual diagnosis. Provide resources, education, and consultation on mental health and substance abuse services for patients and families.

Short Term Goals- 1 Year

1. Provide dedicated behavioral health patient navigation and advocacy to all frequent utilizers of emergency department services who screen positive for behavioral health needs.

2. Offer access to the SAH Addictions Nurse Specialist, the Peer Recovery Coach Program, and the Steward Health Care Network intensive care management programs to patients who present in the ED with behavioral and/or SUD in support of recovery

3. Develop and maintain electronic care plans for frequent utilizers of the SAH Emergency Department (ED) to reduce recidivism to 10%, improve care coordination, and improve patient outcomes. Success of this goal depends upon providers accessing and updating the care plans.

4. Participate in at least 3 behavioral and mental health awareness meetings, events, or trainings in 2022

Long Term Goals – 2-5 Years

1. In partnership with Steward Health Care Network (SHCN), improve patient outcomes and reduce cost for patients enrolled in Steward Health Choice (Medicaid and Medicare Accountable Care Organizations) by addressing the gaps in services for high-risk members with chronic disease including, behavioral health and/or substance use disorders.

2. Participate in the MDPH-sponsored Emergency Department Information Exchange (EDIE) Program to improve care coordination for frequent utilizers of hospital-level EDs and to reduce ED recidivism caused by unmanaged chronic disease, including mental health or SUD by 5% over 5 years.

Program: Certified Addictions Nurse Specialist (CARN)

Target Population: Patients and community members with substance/opioid/alcohol use disorder
Responsible Party: Stephanie Perry, RN, CARN, Addictions Nurse Specialist, Saint Anne's Hospital
Community Partners: Seven Hills Behavioral Health, Steppingstone Inc., Peer2Peer Recovery Project, SSTAR, HealthFirst Family Care Center, THRIVE for Humanity, FIRST Step Inn, Catholic Social Services, Police and Fire Departments in Primary Service Area (PSA), Departments of Public Health in PSA, School Districts in PSA, and other community-based agencies serving individuals with SUD or dual diagnosis.
Budget: Includes salary and administrative support for Addictions Nurse Specialist role.
Description: Integrates strong medical/surgical and mental/behavioral health nursing skills/judgment with knowledge of addiction and treatments to optimize patient care and recovery outcomes. Uses person-centered approach to care, including shared decision-making to promote patient self-determination. Serves as a resource to the community in educating on prevention; intervention strategies, including direct street outreach, overdose reversal and harm reduction; treatment options; and management of substance use disorder.

Short Term Goals – 1 Year

1. Provide support, advocacy, and referrals to treatment for SAH ED patients and inpatients screened positive for SUD who consent to consultation.

2. Provide family and caregivers of those with SUD with recovery support educational materials.

3. Reduce the stigma associated with SUD by participating in a minimum of 4 provider-facing trainings/programs (i.e., ED Narcan Distribution Program, trainings for new orientees and student nurses) to provide health professionals with education on prevention, intervention, treatment, and management of patients with SUDs.

4. Educate community organizations, including school personnel and community members, on prevention; intervention, including educational materials on Section 35 involuntary mandate to treatment; treatment options; and management of individuals with SUD. Participate in a minimum of 2 community-facing trainings.

5. Continue direct "street outreach" in collaboration with community partners, SSTAR Integrated Mobile Health, Seven Hills Behavioral Health, Peer2Peer, Thrive, FIRST Step Inn, Fall River Police and Fire Departments, and the Fall River Department of Health and Human Services. Offer harm reduction and recovery resources to a minimum of 5 individuals per outreach week.

6. In collaboration with community partners, including faith-based organizations, expand the "Spiritual Pillar" beyond the opioid crisis to all those whose lives have been touched by the diseases of addiction and/or mental health. Sponsor at least one community-facing event/training in 2022. This goal was unmet in 2021 due to COVID.

Long Term Goals – 2-5 Years

1. In addition to maintaining collaborative outreach programs with the municipalities of Fall River and Somerset, establish similar programs with Swansea or Westport municipalities by offering at least 2 community-facing trainings in overdose reversal, intervention strategies, treatment options, and recovery supports and resources. Goal was delayed in 2021 due to COVID.

2. Establish a pilot program to assist primary care physicians in initiating office-based Medical-Assisted Treatment (MAT) for SUD with patients who screen positive. The goal is to assist at least 4 patients in the first year of the pilot program. This goal was delayed due to COVID.

3. Provide consultation to other Steward hospitals and outside entities on how to set up an Addiction Nurse Specialist program. By 2026, assist a minimum of 2 hospitals or other entities to establish a similar program.

Program: Peer Recovery Coach Program

Target Population: Individuals with substance/opioid use disorder
Responsible Party: Tracy Ibbotson, M Ed., Administrative Director, Community Health Benefits, Saint Anne's Hospital
Responsible Clinical Partner: Stephanie Perry, CARN, Addictions Nurse Specialist, Saint Anne's Hospital
Responsible Community Partner: Michael Bryant, LADC II, CARC, Project Director, Peer2Peer Recovery Project, Steppingstone Incorporated
Budget: $18,000 annually

Description: In collaboration with Peer2Peer (P2P) Recovery Project, provide peer recovery support and services to patients with substance use disorder. Peer Recovery Coaches promote recovery by removing barriers and serving as role models and mentors. Guidance from a peer with similarly lived experience brings hope and a sense of belongingness that are critical to substance use recovery.

Fall River continues to be devastated by the opioid overdose epidemic in Massachusetts and the pandemic served only to amplify this crisis. While this epidemic continues, persons seeking recovery in our community experience numerous barriers, including long wait lists for treatment, untreated symptoms of co-occurring health conditions, lack of financial resources to pay for treatment, and other challenges.

Saint Anne's Hospital is privileged to partner with P2P, not only by bringing Peer Recovery Coaching into the hospital, but also by supporting Peer Recovery Center to provide a safe space for individuals to work on their recovery goals, participate in one-on-one support, group support and education, as well as recovery, recreational and wellness groups and activities. Saint Anne's

Hospital Community Benefits was instrumental in helping P2P launch an on-site division of Al-Anon.

Short Term Goals – 1 Year

1. Offer Recovery Coaching Services to 100% of SAH Emergency Department patients and inpatients assessed/screened positive for SUD.

2. Provide at least one health promotion workshops/trainings to Peer Recovery Coaches at the Peer Recovery Center or in the community (i.e., wound care, diabetes education, stroke awareness). Goal unmet in 2021 due to COVID.

Long Term Goals – 2-5 Years

1. Through documented proven effectiveness, advocate for the role of the Peer Recovery Coach as a valued member of the multidisciplinary team caring for patients with SUD, both in the acute care and non-acute care settings.
2. Increase health literacy among those recovering from substance use disorder by providing a least 2 health promotion activities at the Peer Recovery Center annually over 5 years. Goal delayed in 2021 due to COVID.

Program: Youth Trauma Program (YTP)

Target Population: Children and adolescents from birth through 21 who have been victims of sexual abuse, physical abuse, and other trauma, including the loss of a loved one due to homicide, dating violence, or violence at home, among peers and in the community

Responsible Party: Stephanie Sayles, LICSW, Coordinator, Youth Trauma Program

Responsible Community Partner: Youth Trauma Program, a program of The Justice Resource Institute (JRI) and the Fernandes Center for Children and Families of Saint Anne's Hospital

Community Partners: Fall River School District, The Children's Advocacy Center of Bristol County, and other human services agencies serving the child and adolescent victims of crime/violence and trauma

Budget: YTP services are free, as it is funded by the Massachusetts Office for Victim Assistance (MOVA) through a 1984 Victims of Crime Act grant from the Office of Justice Programs and the U.S. Department of Justice. Saint Anne's Hospital provides the required matching dollars as a collaborative and founding organization. In 2019, grant funding for the YTP was increased to expand services based on program efficacy.

Description: Established in 1984, the Youth Trauma Program's mission is to assist children and families in dealing with the effects of trauma. The program reflects Saint Anne's Hospital's commitment to the diverse needs of the community and to the improvement of the physical and mental health of its population. The YTP provides specialized evidenced-based services/therapies for child victims of sexual abuse/trauma. Professional services include individual, family, and group counseling for parents/caregivers, children and adolescents, crisis

response in schools and community outreach and education. Provide education and training to providers serving target populations and populations at risk for mental health issues, addictions/substance use disorder, and trauma.

Short Term Goals – 1 Year

1. Increase the number of children being offered specialized evidenced-based services for trauma and/or abuse/neglect by 2% over 2021.

2. In partnership with the Southeastern Infant Mental Health Task Force, increase awareness about infant mental health and the impact of trauma on infants and young children and offer resources to address. Participate in a minimum of one provider-facing event.

3. Offer individual and group counseling sessions to children and adolescents who have been impacted by parental or caregiver substance use disorder. Provide services to 100% of children and adolescents meeting these criteria who are referred to the program.

Long Term Goals – 2- 5 Years

1. Expand program reach by 2-4% annually, based on increased demand for specialized evidenced-based assessments and therapies to children who have witnessed or have been victims of trauma and/or abuse. This goal has been delayed due to COVID and staffing shortages.

2. In partnership with the Southeastern Infant Mental Health Task Force, increase awareness of infant mental health and the impact of trauma on infants and young children and offer resources to address. The importance of this goal has been amplified by COVID.

Priority 2– Housing Stability/Affordability and Homelessness

"The interconnectedness between homelessness, mental health, and substance use disorder was a top issue among key informants. 36.3% of homeless adults have a serious mental illness and 30.8% have a substance use disorder. Providers noted that these issues need to be tackled simultaneously for maximum impact "

(Source: 2021 SAH CHNA)

While not directly a health issue, housing stability and quality can have a great effect on health outcomes. Housing issues identified by key informants focused primarily on quality, affordability, and availability. A report conducted by the Public Policy Center in 2017 concluded that Fall River's existing housing stock consists largely of units occupied by renters in multifamily buildings constructed prior to 1940[2]. Stakeholder interviews revealed that older multifamily units in low-income neighborhoods were perceived to be deficient, and that a lack of code enforcement and low property values provide little incentive for landlords to meet the Commonwealth's minimum housing standards, which creates substandard living conditions for tenants.

In addition, while rents and home prices in Fall River are relatively affordable compared to statewide median housing costs, many families in the city still struggle to find affordable housing. In order to secure housing, some have to rent or buy at costs that are above their means, increasing the cost-of-living burden on these low-income households. Some key informants and focus group members identified homelessness as a significant issue in the region, which is partly a result of a shortage of affordable housing. Mental health and substance abuse issues, which are highly prevalent among the homeless population, are also key factors in the homelessness equation[3].

Fall River has participated in the U.S. Department of Housing and Urban Development's Point in Time (PIT) Counts for more than 20 years. This is an annual count of sheltered and unsheltered homeless persons on a single night in January[4].

> "*There were 325 homeless individuals in Fall River counted during the 2021 point-in time count. Over thirty-eight percent of the homeless population were children under age 18 and about half were female*" (Source: 2021 SAH CHNA)

Expanding on existing collaborative strategies and goals to further address the region's housing and homelessness issues are key components of this implementation strategy.

Program: Outreach and Advocacy – Housing Stability and Homelessness

Target Population: Individuals and families experiencing or at risk for housing instability or homelessness

Responsible Party: Tracy Ibbotson, M.Ed., Administrative Director, Community Health Benefits

[2] Source: http://publicpolicycenter.org/wp/wp-content/uploads/2016/11/ Towards-an-Evidence-Based-Housing-Policy-in-Fall-River-Massachusetts.pdf.

[3] Source: https: //www.nationalhomeless.org/factsheets/addiction.pdf. Retrieved December 17, 2018.

[4] Source: https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf

Responsible Community Partner: Mary Camara, Coordinator of Homeless Programs, Fall River Community Development Agency, City of Fall River, Chair, Mayor's Task Force to End Homelessness

Community Partners: City of Fall River, Fall River Police Department, Fall River Fire Department and EMS, Medical-Legal Partnership Boston (MLPB), Social Justice Center of Southeastern MA, Fall River Housing Authority (FRHA), Steppingstone Incorporated First Step Inn, Catholic Social Services, United Way of Greater Fall River, MDPH, Eliot Homeless Services, Steward Health Care Network, City of Fall River Department of Veterans Services, and other community non-profit service organizations, including faith-based.

SAH will continue to partner with organizations that actively implement programs promoting safe and stable housing, fostering education, promoting a skilled labor force, addressing issues of food insecurity, and providing social services to underserved populations. Specific attention will be focused on those who are more likely to have limited access to stable housing, safe and supportive environments, and opportunities for higher learning.

Short Term Goals – 1 year

1. Remain an active member of the Mayor's City-Wide Task Force to End Homelessness to connect representatives from the City Task Force and Steward Health Care Network's Steward Choice Medicaid ACO Outreach Team, on a quarterly basis, to explore opportunities to share data, expand services, and prioritize resources to prevent homelessness.

2. Participate in the city-wide annual Point-In-Time (PIT) Study of Unsheltered Homelessness Population in Fall River, due to COVID scheduled for Feb. 23, 2022.

3. Continue Medical-Legal Partnership to provide SAH staff access to free legal assistance to mitigate social determinants of health impacting housing stability and income supports.

Long Term Goal -2-5 years

Leverage position as an anchor organization to engage the City of Fall River, other health care systems and community partner organizations, including the private sector through the Fall River Chamber of Commerce, to participate in large-scale community health improvement planning by developing and implementing a multi-year, multi-tiered Community Health Improvement Plan (CHIP) by 2027.

Program: Street Outreach "*Street Homeless Coalition*"

Target Population: Individuals who are homeless living unsheltered and/or in area encampments

Responsible Party: Stephanie Perry, RN, CARN, Addictions Nurse Specialist, Saint Anne's Hospital

Responsible Community Partners: Partners for a Healthier Community Substance Addiction Task Force, The Mayor's Office, Fall River EMS Mobile Integrated Health (MIH) Division and SSTAR's Mobile Health Treatment RV, the Fall River Police Department, Thrive for Humanity and other non-profit human service agencies.

Description: An active member of the Greater Fall River Substance Addiction Task Force (SATF), Stephanie Perry SAH addictions nurse in collaboration with the Mayor's Office convened a "*Street Homeless Coalition*," an ad-hoc committee of SATF to address barriers to treatment for

those suffering from SUD, often with acute medical conditions including mental illness, and living in area encampments.

Short Term Goals – 1 year

1. Facilitate access to primary care health services, wound care, harm reduction, same day Suboxone prescriptions, HIV testing, administering COVID vaccine for those who are homeless, at-risk, in need, and without access to services.

2. Facilitate access to more coordinated care and resources for those in the community who are living unsheltered in encampments across the City.

3. Work to reduce the barriers and policies that prohibit these highest-risk individuals from seeking treatment; fast-tracking pathways to obtaining birth certificates and ID cards from the DMV at no cost to the clients; access to laundry and shower vouchers and increased food distribution sites.

Long Term Goal – 2-5 years

Permanent, sustainable, long term plan for shelter during the cold weather months (Dec-April)

Priority 3 -Chronic Disease–Cancer, Heart Disease and Diabetes and Wellness/Health Promotion

Primary data, as well as focus groups and provider input gathered during the 2021 Community Needs Assessment, recognized chronic disease as a major community health issue with a focus on addiction and mental health. Addiction or substance use disorder is a chronic, incurable but treatable brain disease. Patients with addiction or substance use disorders usually present with co-morbidities such as diabetes, hypertension, hepatitis, pancreatic disease, heart failure, HIV, mental illness, and poly-substance use. Given their early age of onset and poor rates of recognition and treatment, behavioral health conditions are arguably among the most chronic illnesses[5].

As noted in the Community Health Needs Assessment, health and wellness often compete with more immediate day-to-day priorities for many Greater Fall River residents. Consequently, chronic disease prevalence is much higher in comparison to state and national averages. This includes higher rates of cancer, diabetes, coronary heart disease, stroke, chronic obstructive pulmonary disease (COPD), and asthma. Data also suggest that people with chronic diseases are more likely to go to hospitals and emergency rooms. Transitioning from one care setting to another increases an individual's susceptibility to receive fragmented care. The SAH 2022 Implementation Strategy will address these chronic conditions through screenings, specialized care coordination and referrals to community-based health education, and disease management support services.

[5]Source: https://www.saintanneshospital.org/about-us/community-health-outreach

Cancer:

Saint Anne's Hospital Regional Cancer Center Psychosocial Services bring together expert clinicians and services to support all aspects of care – from health-related social needs like stable housing and income supports, to assistance with care navigation and access to treatment.

Program: Specialized Oncology Nurse Navigator

Target Population: Individuals with a cancer diagnosis, including family members and significant others

Responsible Party: Nancy Sullivan, RN, MS, CCM, Oncology Nurse Navigator, Saint Anne's Hospital Regional Cancer Center

Budget: includes salary and administrative support for Oncology Nurse Navigator role

Description: As the patient's main contact for information and guidance, the oncology nurse navigator provides assistance through care coordination, referrals for financial assistance, treatment planning, and other support as needed.

Short Term Goals- 1 –Year

1. Offer comprehensive cancer care navigation to 100% of cancer patients.
2. Increase number of patients referred to the oncology social work team to be assessed for additional supports, including health insurance navigation, enrollment assistance, free legal assistance, and transportation for care by 2% over 2021.

Long Term Goals – 2-5 Years

Through the development and implementation of strengths-based screening tool for health-related social needs, intervene upstream on the social determinants of health, reducing the number of cancer patients who self-report episodes of housing or income instability or other barriers to care.

Program: Psychosocial Oncology Social Work Services

Target Population: Individuals with a cancer diagnosis and their caregivers

Responsible Party: Carrie Mathers-Kurland, LICSW, Manager, Psychosocial Oncology Services, Saint Anne's Hospital Regional Cancer Center

Budget: includes salary and administrative support for the Oncology Social Work roles

Description: Specialized social workers assist patients and families with psychosocial support and resources, including referrals to Medical-Legal Partnership Program for increased assistance with health-related social needs, ranging from consults to intakes for legal representation; Financial Counseling Services to assist in health insurance enrollment and/or expanded coverage; and Transport Services to reduce barriers to health care.

Short Term Goal – 1-year

Address social determinants of health and barriers to care for 100% of cancer patients screened positive by providing assistance with legal, financial and transportation concerns.

Long Term Goal – 2-5 years
Through the development and implementation of strengths-based screening tool for health-related social needs, reduce the number of oncology patients who self-report episodes of housing or income instability or other barriers to care.

Program: Cancer Support and Wellness Programs

Target Population: Individuals with a cancer diagnosis, including caregivers
Responsible Party: Carrie Mathers Kurland, LICSW, Manager, Psychosocial Oncology Services, Saint Anne's Regional Cancer Center
Responsible Community Partner: American Cancer Society (ACS)
Budget: includes salary and administrative support for programs
Description: Program offerings include cancer support groups (e.g., Life Part II, Facing Cancer Together); Gratitude Journaling; Mindfulness/Meditation Training; Fundamentals of Watercolor Painting and other creative arts; access at SAH to an American Cancer Society-supported wig boutique; a patient/community member resource room; and access to complimentary transportation for eligible oncology patients who would otherwise be unable to access care.

Short Term Goal – 1 year

1. Increase the number of individuals benefiting from our oncology support and wellness programs

2. Provide transportation assistance to cancer treatment for 100% of hardship-eligible patients who would otherwise be unable to access care.

Long Term Goal – 2-5 years

Continue to provide complementary support and wellness programs for community members diagnosed and living with cancer. Goal to increase the number served each year by 2%.

Type 2 Diabetes:

Target Population: Individuals who have, or are at risk of developing, type 2 diabetes
Responsible Party: Tracy Ibbotson, M.Ed., Administrative Director of Community Health Benefits
Responsible Community Partner(s): Steward Health Care Network/Steward Choice ACO, Fall River Diabetes Association of People Incorporated
Community Partners: Steward Health Care Network, Prima CARE, SSTAR, HealthFirst Family Care Center, and other community health and human service agencies.
Description: Provide referrals for education, support and/or disease management for individuals with or at risk for developing type 2 diabetes due to obesity, poor nutrition, or other risk factors.

Short-Term Goals
Increase education to patients and community members about healthy eating. Offer at least 2 nutrition education programs/seminars.

Long Term Goals

Contribute to lowering the incidence rates of obesity and diabetes through ongoing education and intervention supports. Offer at least 2 education programs annually on this topic in partnership with schools and other youth/family serving organizations.

Heart Disease/Stroke and Respiratory Disease – Chronic Obstructive Pulmonary Disease (COPD)

Smoking prevalence in Fall River and New Bedford remains higher than that of the state and country as a whole: 26.9% of Fall River residents and 25.9% of New Bedford residents report that they smoke, compared to 14.3% of Massachusetts residents and 16.8% of residents nationwide. In addition, 35.8% of Fall River and 36.4% of New Bedford residents report they have not engaged in any form of physical activity in the past 30 days, which is greater than both the statewide (26.0%) and national (25.2%) percentages. Although chronic conditions can be genetic, poor nutrition, tobacco use, lack of physical activity, and other unhealthy behaviors elevate the risk of developing chronic disease[6].

Target Populations: Those at risk for or diagnosed with heart disease, stroke, chronic obstructive pulmonary disease, asthma, or related co-occurring chronic diseases; smokers; and individuals who are sedentary, have high blood pressure and poor nutrition
Responsible Parties: Tracy Ibbotson, M.Ed., Administrative Director of Community Health Benefits; Robert Folger, Clinical Director of Cardiac Services; Lisa Demello, MSN, RN, ACNS-BC, Clinical Nurse Specialist/Stroke Coordinator
Responsible Community Partner(s): American Heart Association (AHA), American Cancer Society (ACS), American Lung Association, American Stroke Association (ASA), MA Department of Public Health's Quitworks Program, and other community organizations.
Budget: includes salary and administrative support for program
Missing Description

Short Term Goals – 1 year

1. Offer smoking cessation treatment and support to 100% of patients screened positive for tobacco use with co-occurring chronic diseases, such as heart disease, COPD, etc.

2. Participate in 2 health educational programs and offer at least 2 blood pressure screenings in partnership with community organizations to increase awareness of heart disease and stroke and other circulatory diseases.

Long-Term Goal – 2-5 years

1. Refer all patients who present in the Emergency Department and inpatient with chronic conditions to be enrolled in intensive coordinated outpatient care management programs.

2. Contribute to lowering the incidence rates of heart disease/stroke and respiratory disease/chronic obstructive pulmonary disease (COPD) through ongoing education and

[6]Source: https://www.saintanneshospital.org/about-us/community-health-outreach

intervention supports. Offer at least 3 education programs annually on this topic in partnership with schools and other youth/family serving organizations.

Program: Breast Disease Management Patient Navigator

Target Population: Individuals diagnosed with/or at risk for breast disease.
Responsible Party: Linda Franco, Director of Diagnostic Imaging Services and Heather Czaja, RN, BSN, Breast Health Patient Navigator
Budget: includes salary and administrative support for the Patient Navigator role
Description: As the patient's main contact for information and guidance, the patient navigator coordinates resources into a seamless model of access, care, and support that benefits patients, family members and participating clinicians; addresses patient needs throughout the care continuum to reduce gaps in the care process; provides education; improves timeliness of care; coordinates complex care processes; and develops plan for long-term and survivorship care. Serves as an educational resource and promotes awareness of programs and services, both hospital- and community-based, including assistance with health insurance navigation and other health-related social concerns.

Short Term Goals

1. Provide specialized, dedicated patient navigation support to 100% of referred patients, providing support and guidance through complex health care issues, including addressing barriers to care.
2. Screen and refer patients as needed to the social worker to be assessed for additional service supports, including health insurance navigation and enrollment assistance, free legal assistance, and transportation for care.

Long Term Goals – 2-5 Years

Offer specialized, dedicated patient navigation support to 100% of new patients and to those who return after surgery or extended time away from care.

Program: Health Promotion and Disease Prevention Education and Outreach

Target populations: Under-served, hard-to-reach populations, including those who are experiencing homelessness, suffering from mental health and/or substance use disorders, members of the LGBTQA community, veterans, at-risk elders and youth, culturally diverse individuals, Limited English Proficient (LEP) community, and those disproportionately impacted by COVID-19

Responsible Parties: Tracy Ibbotson, M.Ed., Administrative Director, Community Health Benefits; and Stephanie Rocha, Tri-lingual Health Insurance Specialist and Community Resource Liaison

Community Partners: Greater Fall River Partners for a Healthier Community (CHNA25), BOLD (Building Our Lives Drug-Free) Coalition, all area public schools, City of Fall River and all other PSA municipalities, Steward Health Care Network/Steward Choice ACO, Diabetes Association/People Incorporated Inc., Fall River YMCA, Fall River Boys and Girls Club, Steppingstone Inc., SSTAR, Health First Family Care Center, United Way of Greater Fall River, Bristol Elder Services, Coastline Elderly Services, Bristol County District Attorney Office, Veterans Administration, Immigrants Assistance Center (IAC), Fenway Health, LGBTQA+ SouthCoast Network, other community not-for-profits, and local businesses.

Budget: includes salary and administrative support for program goals

Description: Provide health education and screenings to target populations. Partner with Steward Health Care Network ACO and other community partners to engage primary care providers in community health training and initiatives to improve population health. A growing concern requiring attention is vaping among youth. It is estimated that in 2018, more than 3.6 million U.S. youth, including 1 in 5 high school students and 1 in 20 middle school students, used e-cigarettes. Use among high school students increased 78% during the past year, from 11.7%

in 2017 to 20.8% in 2018. This represents the largest one-year percentage increase of all substance use in the 43-year history of the Monitoring the Future survey[7].

Short Term Goals

1. Provide a minimum of 2 free screenings for chronic diseases and provide educational material on high-risk behaviors that cause chronic disease.

2. Provide a minimum of 2 free education and wellness programs to target populations where they live, work, study, and worship. Focus program on topics such as substance use disorder, mental health, nutrition literacy, obesity/malnutrition, healthy aging, and chronic disease management.

3. Provide a minimum of one school and/or community–based health education training on the risks and harmful health effects of vaping, with added focus on vaping in minors.

State Rep Alan Silvia visited the Community Famers Market at Saint Anne's Hospital in recognition of National Farmers Market Week *(8-3-21)*

(L-R) Sydney Roth, Intern, Fall River Health Department, Tracy Ibbotson, Administrative Director Community Benefits SAH, State Rep Alan Silvia and Krista Chauvin & David Larrimer of Lane Gardens & Oakdale Farms.

[7] Source: Cullen KA, Ambrose BK, Gentzke AS, Apelberg BJ, Jamal A, King BA. *Notes from the Field: Increase in use of electronic cigarettes and any tobacco product among middle and high school students – United States, 2011-2018.* MMWR

Priority 4- Food Insecurity & Social Determinants of Health (SDOH)

According to the Massachusetts Department of Public Health, underserved populations include individuals who have limited access to primary care services; face economic, cultural, or linguistic barriers to health care; and reside in specific geographic areas. Social determinants of health, including social, behavioral, and environmental influences, have become increasingly prevalent factors in addressing population health. A growing body of research indicates that living and working conditions, including housing quality, exposure to environmental pollution, worksite safety, access to healthy and affordable foods, and proximity to safe places to exercise, have a significantly greater effect on health than risky behaviors. Such associations increasingly support connecting health care systems and social service agencies as part of a comprehensive strategy to improve the quality of living and population health status.[8]

Program: Reducing Food Insecurity

Target Population: Greater Fall River residents living at or below the poverty line who are at risk for hunger and malnutrition.
Responsible Party: Tracy Ibbotson, M.Ed., Administrative Director of Community Health Benefits
Responsible Community Partners: Greater Fall River Community Food Pantry, First Baptist Church, and other area food pantries; Fall River Mass-in-Motion, and Southeastern Massachusetts Agricultural Partnership (SEMAP) and the City of Fall River
Description: Provide monthly cash allocation to the Greater Fall River Community Food Pantry and SAH employees to volunteer at area soup kitchens and proved other support as needed. Support community partners' efforts to provide access to fresh, locally grown produce by hosting on-site SAH farmer market that accepts the Massachusetts Supplemental Nutrition Assistance Program (SNAP) and Healthy Eating Program (HIP) benefits providing access to the residents of the South End of Fall River, an economically, disadvantaged neighborhood.

The City of Fall River continues to have a lower median income than the state average and a higher number of individuals and families who are dependent on some form of public assistance. Nearly 70% of children in the Fall River schools are identified as economically-disadvantaged and eligible for the reduced/free lunch program[8]. For many families and individuals, buying sufficient, nutritious food is often not possible. Recognizing the link between poor nutrition and health status more than two decades ago, the hospital helped launch the Greater Fall River Community Food Pantry and continues to support this community-wide initiative to reduce food insecurity. Open several days a week and located at a stand-alone and improved location on Nashua Street, the Food Pantry staff distribute food to more than 10,000 families annually.

[8] Economically disadvantaged students are defined as those who participate in one or more of the following state-administered programs: The Supplemental Nutrition Assistance Program (SNAP); the Transitional Assistance for Families with Dependent Children (TAFDC); the Department of Children and Families' (DCF) foster care program; and Mass Health (Medicaid).

In an effort to ensure a wider distribution of its food subsidy and assist vulnerable community members with access to healthy, adequate food, Saint Anne's Hospital provides monthly financial subsidies to the Greater Fall River Community Food Pantry.

Short Term Goals - 1 year

1. Reduce food insecurity and support access to healthy food sources by providing financial support to the Greater Fall River Community Food Pantry. Track number of community members benefiting from program.

2. Maintain community engagement by SAH staff who volunteer their time by serving at least 4 dinners annually at the First Baptist Church Soup Kitchen.

3. Host an SAH on-site farmer markets that accepts the Massachusetts Supplemental Nutrition Assistance Program (SNAP) and Healthy Eating Program (HIP) benefits**.** Year 2 of this program. Expand usage of HIP/SNAP benefits by 2% over 2021.

Long Term Goals – 2-5 years

Continue SAH-based and Steward Health Care Network (i.e., Steward Health Choice ACO) outreach programs to help patients and community members gain access to social services and navigate the health care system, and to facilitate healthy living programs. Expand the reach of these programs by 2% annually.

Program: Compassionate Care Program/Blessed Marie Poussepin Outreach Ministry

Target Population: Individuals who face barriers to care due to financial hardship/poverty
Responsible Party: Tracy Ibbotson, M.Ed., Administrative Director of Community Health Benefits
Responsible Community Partner: Sister Glorina Jugo, OP, Dominican Sisters of the Presentation, Fund Administrator, Blessed Marie Poussepin Outreach Ministry
Community Partners: Standard Pharmacy, Greater Fall River Food Pantry, the Dominican Sisters of the Presentation, First Baptist Church, United Interfaith Action, Medical-Legal Partnership Boston, Social Justice Center of Southeastern MA, Bristol Elder Services, Coastline Elder Services, Fall River Housing Authority, Steppingstone Inc., Peer2Peer Recovery Project, Catholic Social Services, City of Fall River, Veterans Services, and other community non-profit service organizations.
Budget: The Blessed Marie Poussepin Outreach Ministry is reported as a leveraged resource. Saint Anne's Hospital provides financial and administrative support. Saint Anne's Hospital fully funds its Compassionate Care Program.
Description: Saint Anne's Hospital Compassionate Care Program and the Blessed Marie Poussepin Outreach Ministry exist in response to the needs of the poor and indigent in our community. These programs provide vouchers for taxi services and bus passes for health care needs to persons who are vulnerable, disadvantaged and who would otherwise be unable to access care. Vouchers are also provided for food, clothing, emergency housing, and other emergent needs. With the city of Fall River being among the highest ranking for poverty and unemployment, the program sees an increase in requests year over year.

Short Term Goal – 1 Year

Reduce barriers to health care access caused by poverty, unemployment, chronic diseases, language, and lack of transportation by providing vouchers for taxi services for health care needs to persons who are otherwise unable to access care.

Long Term Goals – 2-5 Years

Continue SAH-based and Steward Health Care Network (i.e., Steward Health Choice ACO) outreach programs to help patients and community members gain access to social services, facilitate healthy living programs, and navigate the health care system. Expand the reach of programs by 2% annually.

Program: Medical-Legal Partnership

Target Population: SAH Care Teams who are working to address the health-related social needs of the target population

Responsible Party: Tracy Ibbotson, M.Ed., Administrative Director of Community Health Benefits; Brittany Lynch MSW, LICSW, Director of Patient Care Transitions/Social Work, Saint Anne's Hospital

Responsible Community Partner: Samantha Morton, CEO, MLPB-Health, 200 Portland Street, Boston, MA and Jeff Gilbert, Partnership & Project Manager, MLPB-Health

Community Partners: The Justice Center of Southeastern MA (JCSM) subsidiary of South Coastal Counties Legal Services, the Fall River Police Department, and the US Department of Justice and other legal aid non-profit agencies in service to the target population.

Budget: $18,750 annually

Description: MLPB partners with Saint Anne's Hospital (SAH) to strengthen its workforce's ability to meet patients' HRSN (health-related social needs) and improve population-level SDOH (structural drivers of health) through human-centered, strengths-based legal education and problem-solving strategies. MLPB offers SAH staff access to standing monthly Zoom training series (and recordings); enrolling/maintaining up to 25 SAH staff in MLPB's *Unlocking Access* Hub where they can access on demand training and many MA/RI/federal legal problem-solving tools; and access to 20 rapid-response consults over the course of the year. MLPB equips communities of care with legal education and problem-solving insight that foster prevention, health equity and human-centered system change. Through training, consultation, and technical assistance, MLPB helps teams and organizations better connect people to the resources and legal protections they seek.

Short Term Goals - 1 year

1. To strengthen SAH staff problem-solving involving patients' legal risks, rights and remedies relative to their health-related social needs (HRSN)

2. To increase health equity for patient population served by tracking demographics of rapid response consultations

Long Term Goal – 2-5 years

Pilot a community of practice environment that involves an Interdisciplinary Team Meeting (IDTM) in which MLPB embeds to provide real-time legal education and problem-solving insight to the care team.

Priority 5- Health Care Access, Health Equity and Cultural Competency

"[SAH Financial Counselors] did a fabulous job and their work is greatly appreciated. You and your team are a crucial bridge in our community to supporting individuals in accessing appropriate health care". - Judith Aubin, case manager for the MA Department of Mental Health

Saint Anne's Hospital Primary Service Area (PSA) is culturally diverse and has lower levels of education and income and higher numbers of Limited English Proficient (LEP) speakers compared to the rest of the Commonwealth of Massachusetts.

Saint Anne's Hospital serves a large proportion of patients who are enrolled in government-subsidized health plans, as well as many uninsured or under-insured individuals presenting for care. Despite improvements in coverage, vulnerable populations, such as undocumented residents and the working poor, still experience barriers to accessing care. Given the uncertain future of the federal Affordable Care Act, they are now at increased risk to be uninsured or under-insured.

In key informant surveys and community-based focus groups, the lack of confidence in and understanding of health insurance benefits and enrollment were consistently identified as barriers to care**.** Research indicates that individuals who have health insurance participate more actively in preventive care, reducing costly and avoidable emergency room visits. Saint Anne's Hospital is committed to providing culturally and linguistically competent health insurance education and enrollment assistance to any person seeking access to health care and/or health benefits.

With the implementation of the Accountable Care Organization (ACO) model of care, it has become essential to have primary health care providers at the center of initiatives to improve community/population health. The success of this will be determined by the commitment from primary health care providers to learn more about the community they serve through cultural competency, population health education, and explicit attention to the social determinants of health. The benefits to primary health care providers would be in achieving the "Triple Aim," the *Institute for Healthcare Improvement* (IHI)'s term for "simultaneously improving the experience of care, the per capita costs of health care and the health of populations."[9]

[9] Source: Donald M. Berwick, Thomas W. Nolan, and John Whittington, (2018). The Triple Aim: Care, Health, and Cost*, Health Affairs 27, 3.*

Program: Health Insurance Advocacy and Resource Liaison

Target Population: Individuals who face barriers to care due to financial hardship/poverty, language, lack of access to health insurance, low health literacy, and other health disparities.
Responsible Parties: Tracy Ibbotson, M.Ed., Administrative Director of Community Health Benefits; Stephanie Rocha, Tri-lingual Health Insurance Specialist and Community Resource Liaison
Community Partners: Steward Health Care, Steward Health Care Network (SHCN), City of Fall River Department of Veterans' Services, Medicare, Mass Health, and all other health insurance payers, and all government and private human service agencies.
Budget: includes salary and administrative support for the Health Insurance Specialist/ Community Resource Liaison role
Description: Provide the target population with culturally and linguistically competent education, advocacy and assistance in enrolling uninsured and under-insured individuals and families in the most appropriate state/federally- funded health insurance plans. Support efforts to assist at-risk veterans and their families with obtaining eligible benefits. Resource Liaison role also includes health promotion outreach to targeted, under-served, hard-to-reach populations, including those who are experiencing homelessness, suffering from substance use disorder, at-risk elders, and/or members of the LGBTQA community.

Short Term Goals

1. Improve access to health care for target population by increasing the number of those assisted with health insurance enrollment, including access to emergent coverage as an approved site for Health Presumptive Eligibility (HPE) by 2% over 2021.

2. Provide culturally and linguistically competent health-promotion outreach education and benefit assistance to culturally diverse community members. Increase efforts to offer this assistance in community-based settings by participating in at least 5 culturally and linguistically competent education programs. (i.e., Steward Diversity and Inclusion Education Series, 2022)

Long Term Goals – 2-5 years

1. Continue to improve access to health care for the target population by providing assistance with health insurance enrollment. The goal is to increase assistance by 2% year over year.

2. Increase the health literacy, including nutritional literacy, of at-risk, under-deserved target populations

Community Strengthening /Cultural Competency

Healthcare organizations such as Saint Anne's Hospital need highly skilled staff to provide high-quality care. Quality health care is an essential component of a region's quality of life, as well as an economic advantage. Employers must be part of the education system, supporting students and their staff to further develop skills and knowledge. Doing so ensures new workers are prepared for today's jobs and continue to grow and learn in these roles to become leaders. We

keep our best and brightest in the region to the benefit of all as they become parents and active community members.

Workforce development is a vital function of well-established community hospitals. SAH is committed to developing the skills of the workforce in our community, local schools, and among our employees. Saint Anne's Hospital/Steward Health Care is committed to learning new approaches in delivering care and to creating an environment of inclusion for all races, ages, religions, disabilities, ethnicities, sexual orientations, and gender identities. It is imperative that we ensure a culturally competent and diverse workforce that can provide the services needed to meet the demand brought on by policy changes in the health industry.

Program: Multicultural Health Scholarship Program

Target populations: Bicultural, bilingual students pursuing a degree and/or an advanced certification in health care or related field.
Responsible Parties: Denise Paulson, Manager, Interpreter Services**;** Tracy Ibbotson, M.Ed., Administrative Director Community Health Benefits
Responsible Community Partners: Tina Shorette, Youth Employment Specialist, MASS HIRE YOUTH CONNECTION and affiliated schools, Marcia Picard, Executive Director/School Wellness Coordinator, Greater Fall River Partners for a Healthier Community
Budget: $4,000
Description: The SAH Multicultural Health Committee, an ad-hoc sub-committee of the CBAC, will award $4,000 in scholarships to bilingual/bicultural students pursuing degrees and/or advanced certifications (e.g., medical interpretation) in health care or a related field in the 2022 academic year. The program is aligned with efforts to reduce barriers and improve access to higher education for our culturally diverse community and support the long-term goal of a culturally diverse workforce.

Short Term Goal -1 year
1.Increase the number of scholarships to 4 in 2022

Long Term Goals- 2-5 years

1. Work to expand the scholarship program to reach a more diverse population of students.

2. Participate in a minimum of 2 cultural competency training programs annually.

Program: Student Preceptor Program

Target populations: Students in final phases of training in health care related fields
Responsible Parties: Cheryl Herman, Manager, Education, and Policies, Department of Professional Practice, Research and Development
Responsible Community Partners: Local colleges and universities that have clinical affiliations with SAH
Budget: includes salary and administrative support for the program
Description: Provide a clinical learning environment for preceptor program, one-on-one training with a licensed experienced practitioner and other clinical training programs. The SAH

Preceptor/Trainer participates in identification of learning needs of the student; sets goals with the student in collaboration with the faculty and curriculum; acts as a role model; provides patient care in accordance with established, evidence-based professional practice standards; fulfills duties according to hospital and unit policies and procedures; maintains mature and effective working relationships with other health care team members; demonstrates leadership skills in problem solving, decision-making, priority-setting, delegation of responsibility and accountability; provides the student with feedback on his/her progress, based on preceptor's observation of clinical performance, assessment of achievement of clinical competencies and patient care documentation; participates in educational activities to promote continued learning and professional growth; and participates in ongoing evaluation of the program. There are many aspects of being a preceptor to a student and requires a long-term, focused commitment.

Short Term Goal – 1 year

1. Track number of students benefiting from this program in 2021 with goal to grow number in 2022

Long Term Goal – 2-5 years

1. Sustain educational programs that further develop the local health care workforce.

Program: Job Shadow/Student Observer

Target populations: Individuals who wish to explore professions or satisfy direct observation requirements for applications to clinical programs (i.e., physician assistant programs, rehabilitation services programs).
Responsible Parties: Tracy Ibbotson, M.Ed., Administrative Director of Community Health Benefits
Budget: includes salary and administrative support for the program
Description: The Shadow/Observer is a direct observation experience for students or individuals who wish to explore professions, satisfy direct observation requirements for applications to clinical programs (e.g., PA School, Rehabilitation Programs in PT, OT and/or Speech Therapy), Medical School (e.g., DO programs), or at the request of credentialed physicians for medical students from unaffiliated medical schools for case observation and/or hospital patient rounding. The Shadow/Observer experience is typically one day or a cumulative 8-hour experience. Experiences lasting longer than one day or being completed over a series of observations can be arranged on a case-by-case basis and only at the request of the supervising clinician who maintains responsibility for the Shadow/Observer at all times while on-site at Saint Anne's Hospital. Shadow/Observer must be 18 years of age or older.

Short Term Goals - 1 year

Provide a clinical environment and clinical staff support for Observer/Job Shadow program and foster an increase in the number of individuals benefiting from this program by 2% over 2021.

Long Term Goals - 2-5 years

Develop an action plan to expand workforce development for our local workforce partnering with schools and universities, as well as employees, through job shadow and health career day programs.

Community Support

Target Population: Programs and services to support underserved, vulnerable, at-risk community members
Responsible Party: Tracy Ibbotson, M.Ed., Administrative Director of Community Health Benefits
Community Partners: Any organization in the catchment area serving the target population and advancing the health and wellness goals as identified and outlined in this Implementation Strategy.
Budget: Over $70,000 annually
Description: Provide cash support, in-kind donations, and volunteer support to organizations seeking to improve the health and well-being of targeted, under-served, at-risk populations.

Community Benefits Advisory Committee (CBAC) -

Allison Hague, LICSW, Program Manager, Family Resource Center, Family Service Association
Brittany Lynch, LICSW, Director, Transitions in Care/Social Work, Saint Anne's Hospital
Michael Bryant, Project Director, Peer2Peer Recovery Project, Steppingstone Incorporated
Michael Bushell, President, Saint Anne's Hospital
Stephanie Sayles, LICSW, Clinical Coordinator, Youth Trauma Program, a program of JRI, located at the Fernandes Center for Children & Families of Saint Anne's Hospital
Lisa Blanchette, Director, Revenue Cycle, Saint Anne's Hospital
Lisa DeMello, MSN, RN, ACNS-BC, Clinical Nurse Specialist/Stroke Coordinator, Saint Anne's Hospital
Jeff Gilbert, Partnership Manager, Medical Legal Partnership Boston (MLPB-Health)
Marcia Picard, Executive Director & School Wellness Coordinator, Greater Fall River Partners for a Healthier Community (CHNA25)
Marin Woods, RD, LDN, Clinical Nutrition Manager, Saint Anne's Hospital
Tracy Ibbotson, M.Ed., Administrative Director, Community Health Benefits, Saint Anne's Hospital
Sandra Frechette, RN, Chief Programs Officer, Bristol Elder Services
Stephanie Rocha, Health Insurance Specialist/Community Liaison, Saint Anne's Hospital
Andrea Souza, Coordinator, Education & Outreach Prevention, Bristol County Children's Advocacy Center, a program of JRI
Jessica Stone, Grant Writer and Community Liaison, Southeast Center for Independent Living
Julie Sanders, LICSW, Program Director, SSTAR
Denise Paulson, Manager, Interpreter Services, Saint Anne's Hospital
Sister Glorina Jugo, OP, Member Board of Directors, Chair, Mission Committee, Saint Anne's Hospital
Jason Bouffard, Director of Marketing and Community Relations, Saint Anne's Hospital
Stephanie Perry, RN, CARN, Addictions Nurse Specialist, Saint Anne's Hospital
Fanny Tchorz, Director of Interpreter Services, Health First Family Care Center
Carol Verrochi, Community Member & Liaison to the Patient & Family Advisory Council (PFAC), Saint Anne's Hospital

Rebecca Frias, LICSW, Social Worker**,** Oncology Services Saint Anne's Hospital
Adam Coderre, Director, Diabetes Association/SMILES Mentoring Program for People Inc.
Micki Poulton, Wellness Director, Fall River YMCA, Division of Southcoast YMCA
Nikki Fontaine, Community Liaison Recovery Coach, Homeless Advocate, Fall River Police Department
Sarah Labossiere, Coordinator, Mass-in-Motion, City of Fall River, MA
Lynn Iadicola, Volunteer Partners for a Healthier Community Substance Addiction Task Force, and Community Representative
Susan Remy, Director, Development, Child & Family Services

*Saint Anne's Hospital participated in the second annual **National Agent Orange Awareness Day**, August 10, 2021*