St. Mary's Healthcare, Amsterdam NY

Community Health Needs Assessment
2015-2018

The summer of 2015, St. Mary's Healthcare (SMH) embarked on a comprehensive Community Health Needs Assessment (CHNA) process to identify and address the key health issues for our community.

Founded in 1903, by the Sisters of St. Joseph of the Carondelet, St. Mary's Healthcare has over 113 year history of providing compassionate, clinically exceptional care, with special attention to those persons who are poor and vulnerable. As a Catholic Ministry, we are called to carry out our core values of *Services to the poor, Reverence, Integrity, Wisdom, Creativity and Dedication.*

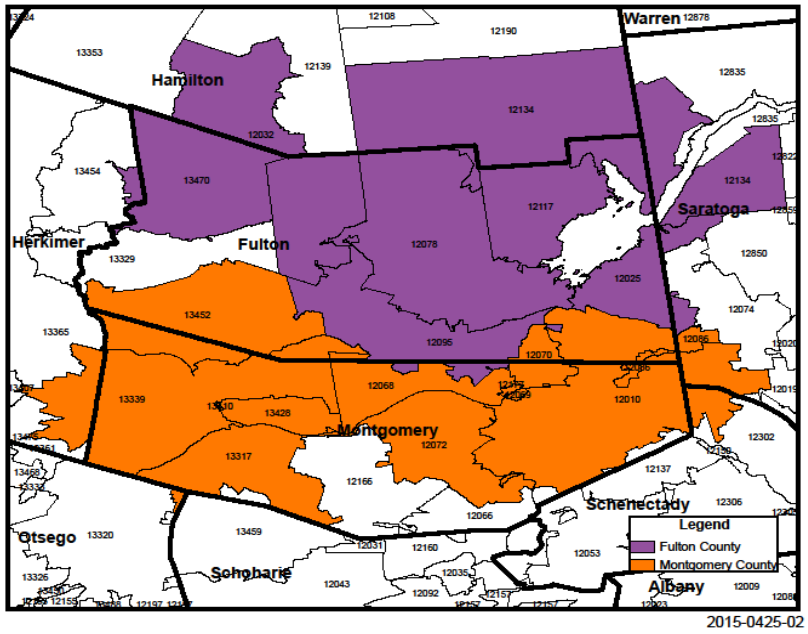
St. Mary's Healthcare, a member of Ascension, provides a network of services across three counties that includes: 120-bed acute care Medicare Dependent Hospital, a 14 bed inpatient Addiction Rehabilitation unit, a 20-bed inpatient behavioral health unit, nine primary care based health centers and six specialty care centers, more than 30 behavioral health services, three Urgent Care Centers; a 160-bed nursing home and a 10-bed inpatient Physical Rehabilitation Unit.

We are a nationally recognized, award-winning health care provider focused on our mission: "Rooted in the healing ministry of Jesus, we dedicate ourselves to serve all persons with compassion and excellence, especially those who are vulnerable and to help those who are most in need. St. Mary's Healthcare completed its last Community Health Needs Assessment in 2012.

Definition of the Community Served [IRS Form 990, Schedule H, Part V, Section B, 1a, 2, 2013]

CHNA Community Definition

The study area for the survey effort (referred to as "St. Mary's Healthcare Service Area" in this report) is defined by ZIP Code and roughly equates to the counties of Fulton, Montgomery, and lower Hamilton in New York (also referred to as such in this report). This community definition, determined based on the ZIP Codes of residence of recent patients of St. Mary's Healthcare, is illustrated in the following map.



Demographics of the Community

[IRS Form 990, Schedule H, Part V, Section B, 1b 2013]

Fulton and Montgomery counties (which approximate the St. Mary's Healthcare Service Area, the focus of this Community Health Needs Assessment) encompass nearly 900 square miles and house a total population of 105,184 residents, according to latest census estimates.

Total Population of St. Mary's Healthcare Service Area

(Estimated Population, 2009-2013)
Sources: US Census Bureau American Community Survey 5-year estimates (2009-2013).

	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Fulton County	55,165	495.34	111.37
Montgomery County	50,019	402.94	124.14
St. Mary's Healthcare Service Area	**105,184**	**898.27**	**117.1**
New York	19,487,052	47,113.98	413.62
United States	311,536,591	3,530,997.6	88.23

Population Change 2000-2010

A significant positive or negative shift in total population over time impacts healthcare providers and the utilization of community resources.

Between the 2000 and 2010 US Censuses, the population of St. Mary's Healthcare Service Area increased by just 969 persons, or 0.9%.

◊A lesser proportional increase than seen across the state.

◊ A fraction of the increase seen nationwide.

◊ Similar proportion increases by county.

Urban/Rural Population

Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

The service area is largely split between urban and rural populations, with 54.1% of the population living in areas designated as urban.

◊ Note that a much higher proportion of the state and national populations lives in urban areas.

◊ Montgomery County houses a larger urban population (59.1%) than does Fulton County, which is equally divided between urban and rural living.

Age

It is important to understand the age distribution of the population as different age groups have unique health needs which should be considered separately from others along the age spectrum.

In St. Mary's Healthcare Service Area:

- 22.4% of the population are infants, children or adolescents (age 0-17)
- 61.1% are age 18 to 64
- 16.6% are age 65 and older.

Median Age

Fulton and Montgomery counties are "older" than the state and the nation in that their median ages are higher.

Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 92.8% of service area residents are White and 1.7% are Black.

◊ The service area population is much less racially diverse in New York State and the US.

◊ Fulton County is nearly all White, while Montgomery County houses larger populations of "other" races and residents of multiple races

Ethnicity

A total of 6.8% of St. Mary's Healthcare Service Area residents are Hispanic or Latino.

◊ Much lower than found statewide.

◊ Much lower than found nationally.

◊ The proportion of Hispanics/Latinos is much larger in Montgomery County than in Fulton County.

Between 2000 and 2010, the Hispanic population in the St. Mary's Healthcare Service Area increased by 2,600, or 60.2%.

◊ Three times as high (in terms of percentage growth) as found statewide.

◊ Much higher (in terms of percentage growth) than found nationally.

◊ The proportion increase was much larger in Montgomery County than in Fulton County.

Linguistic Isolation

A total of 1.9% of the St. Mary's Healthcare Service Area population age 5 and older live in a home in which no persons age 14 or older is proficient in English (speaking only English, or speaking English "very well").

◊ Much lower than found statewide.

◊ Lower than found nationally.

◊ The prevalence is much higher in Montgomery County.

The latest census estimate shows 17.4% of the St. Mary's Healthcare Service Area population living below the federal poverty level. In all, 38.2% of service area residents (an estimated 39,184 individuals) live below 200% of the federal poverty level.

◊ Higher than the proportion reported statewide.

◊ Higher than found nationally.

◊ Comparable by county.

Children in Low-Income Households

Additionally, 52.2% of St. Mary's Healthcare Service Area children age 0-17 (representing nearly 12,000 children) live below the 200% poverty threshold.

◊ Above the proportion found statewide.

◊ Above the proportion found nationally.

◊ Comparable by county.

Education

Among the St. Mary's Healthcare Service Area population age 25 and older, an estimated 15.6% (over 11,000 people) do not have a high school education.

◊ Similar to that found statewide.

◊ Less favorable than found nationally.

◊ Less favorable in Montgomery County.

Resources Available to Address the Significant Health Needs

[IRS Form 990, Schedule H, Part V, Section B, 1c, 2013]

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment.

Access to Healthcare Services

- Access Transportation
- Adirondack Transportation
- Catholic Charities
- City of Amsterdam Transportation System
- Dial a Ride
- DSS Preventive Services
- Fulton County Office for the Aging
- Fulton County Public Health
- Gloversville Transit
- Kwiat Eye Center
- Maxx Transport
- Medicaid Transportation

- Mental Health Association
- Mohawk Valley Medical Arts
- Montgomery County Public Health
- Montgomery Mental Health Association
- Nathan Littauer Hospital
- Nonprofit Providers
- Montgomery County Office for Aging
- Personalized Recovery Oriented Services
- Pregnancy Care Center
- Private Providers
- St. Mary's Healthcare
- Taxi
- We Care Transport

Arthritis, Osteoporosis, and Chronic Back Conditions

- Blooming Lotus
- Hospital(s)
- Massage Therapy
- Mohawk Valley Orthopedics
- Nathan Littauer Hospital (NLH) HealthLink
- Outpatient Facilities
- Chiropractic Practices
- Physical Therapy
- Planet Fitness
- Primary Care Physicians
- Private Providers
- St. Mary's Hospital
- YMCA

Cancer

- Advancing Tobacco Free Communities
- American Cancer Society
- Bereavement and Grief Services
- St. Mary’s Cancer Medicine Center
- NYOH at Riverfront Center
- Cancer Screening Services
- Cancer Services Program
- Cancer Support Services
- Emergency Assistance Food

How CHNA Data Were Obtained [IRS Form 990, Schedule H, Part V, Section B, 1d, 2013]

CHNA Goals & Objectives

This Community Health Needs Assessment, a follow-up to a similar study conducted in 2012, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the service area of St. Mary's Healthcare. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

◊ **To improve residents' health status, increase their life spans, and elevate their overall quality of life.** A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.

◊ **To reduce the health disparities among residents.** By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.

◊ **To increase accessibility to preventive services for all community residents.** More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted on behalf of St. Mary's Healthcare by Professional Research Consultants, Inc. (PRC). PRC is a nationally recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

CHNA Methodology

St. Mary's Healthcare's CHNA was conducted by Professional Research Consultants, Inc. (PRC) and incorporated data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for trending and comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through an Online Key Informant Survey.

PRC Community Health Survey
Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by the St. Mary's Healthcare and PRC, and is similar to the previous survey used in the region, allowing for data trending.

Community Health Survey

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency, and random-selection capabilities.

The sample design used for this effort consisted of a stratified random sample of 750 individuals age 18 and older in the St. Mary's Healthcare Service Area, including 355 in Fulton County and 395 in Montgomery County. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent St. Mary's Healthcare Service Area as a whole. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

For statistical purposes, the maximum rate of error associated with a sample size of 750 respondents is ±3.5% at the 95 percent level of confidence.

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. And, while this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely gender, age, race, ethnicity, and poverty status) and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses may contribute to the whole the same weight as, for

example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household *(e.g., the 2014 guidelines place the poverty threshold for a family of four at $23,850 annual household income or lower)*. In sample segmentation: "**low income**" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice the poverty threshold; "**mid/high income**" refers to those households living on incomes which are twice or more the federal poverty level.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by St. Mary's Healthcare; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 148 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Key Informant Type	Number Invited	Number Participating
Community/Business Leader	93	60
Other Health Provider	69	45
Physician	28	6
Public Health Representative	3	2
Social Services Provider	58	35

Through this process, input was gathered from several individuals whose organizations work with low-income, minority populations (*including addiction population, African American, Amish, Asian, at-risk youth, Central American, children, Chinese, crime victims, disabled, elderly, Guyanese, Hispanic/Latino, homeless, immigrants, learning-disabled, LGBT, low-income, Medicaid, medically underserved, mentally ill, Middle Eastern, migrant workers, managed long-term care (MLTC) clients, Native American, non-English speaking, rural, single parents, students, underinsured/uninsured, undocumented immigrants, unemployed, vulnerable, young adults,* or other medically underserved populations (*including addiction population, adolescent and young adults, bariatric patients, caregivers of elders, children, homebound elderly, intellectual disability/developmental disability (ID/DD), receiving social services,, teen parents, transit workers, uneducated, veterans*).

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such, and how these might be better addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are based on perceptions, not facts.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the St. Mary's Healthcare Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

◊ Center for Applied Research and Environmental Systems (CARES)

◊Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

◊ Centers for Disease Control & Prevention, Office of Public Health Science Services, Center For Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)

◊ Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics

◊ Community Commons

◊ ESRI ArcGIS Map Gallery

◊ National Cancer Institute, State Cancer Profiles

◊ Open Street Map (OSM)

◊ US Census Bureau, American Community Survey

◊ US Census Bureau, County Business Patterns

◊ US Census Bureau, Decennial Census

◊ US Department of Agriculture, Economic Research Service

◊ US Department of Health & Human Services

◊ US Department of Health & Human Services, Health Resources and Services Administration

◊ US Department of Justice, Federal Bureau of Investigation

◊ US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect county-level data (Fulton and Montgomery counties).

Benchmark Data

Trending

A similar survey was administered in the St. Mary's Healthcare Service Area in 2012 by PRC on behalf of St. Mary's Healthcare. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

New York Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data are reported in the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trend Data* published by the Centers for Disease Control and Prevention and the US Department of Health & Human Services. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2013 PRC National Health Survey*; the methodological approach for the national study is identical to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020

Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. The Healthy People initiative is grounded in the principle that setting national objectives and monitoring progress can motivate action. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

◊ Encourage collaborations across sectors.

◊ Guide individuals toward making informed health decisions.

◊ Measure the impact of prevention activities.

Healthy People 2020 is the product of an extensive stakeholder feedback process that is unparalleled in government and health. It integrates input from public health and prevention experts, a wide range of federal, state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level) using question-specific samples and response rates. For secondary data indicators (which do not carry sampling error, but might be subject to reporting error), "significance," for the purpose of this report, is determined by a 5% variation from the comparative measure.

Information Gaps

[IRS Form 990, Schedule H, Part V, Section B, 1i, 2013]

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.
In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

Vulnerable Populations

[IRS Form 990, Schedule H, Part V, Section B, 1f. 2013]

The CHNA analysis and report yielded a wealth of information about the health status, behaviors and needs for our population. A distinct advantage of the primary quantitative (survey) research is the ability to segment findings by geographic, demographic and health characteristics to identify the primary and chronic disease needs and other health issues of vulnerable populations, such as uninsured persons, low-income persons, and racial/ethnic minority groups.

> For additional statistics about uninsured, low-income, and minority health needs please refer to the complete PRC Community Health Needs Assessment report, which can be viewed online at http://www.stmaryshealthcare.healthforecast.net/.

Public Dissemination

[IRS Form 990, Schedule H, Part V, Section B, 5-5c, 2013]

This Community Health Needs Assessment is available to the public using the following URL: http://www.stmaryshealthcare.healthforecast.net/. HealthForecast.net™ is an interactive, dynamic tool designed to share CHNA data with community partners and the public at large.

> This site:
>
> ◊ Informs readers that the CHNA Report is available and provides instructions for downloading it;
>
> ◊ Offers the CHNA Report document in a format that, when accessed, downloaded, viewed, and printed in hard copy, exactly reproduces the image of the report;
>
> ◊ Grants access to download, view, and print the document without special computer hardware or software required for that format (other than software that is readily available to members of the public without payment of any fee) and without payment of a fee to the hospital organization or facility or to another entity maintaining the website.

Links to this dedicated HealthForecast.net™ site are also made available at SMH'S hospital website at: http://www.stmaryshealthcare.healthforecast.net/.

St. Mary's Healthcare will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. SMH will also maintain at its facilities a hardcopy of the CHNA report that may be viewed by any who request it. SMH will also provide the CHNA and Implementation Strategy on their website: www.smha.org/st-marys/community-health-needs-assessment1.

Prioritized Health Needs

After reviewing the Community Health Needs Assessment findings, the CHNA Steering Committee met on January 7, 2016, to determine the health needs to be prioritized for action. During the a detailed presentation of the CHNA findings, a consultant from PRC used audience response system (ARS) technologies to lead steering committee members through a process of understanding key local data findings (Areas of Opportunity) and ranking identified health issues against the following established, uniform criteria:

- **Scope and Severity.** The number of persons affected, also taking into account variance from benchmark data and Healthy People targets, and to what degree does this health issue lead to death or disability, impair quality of life, or impact other health issues.
- **Ability to Impact.** The likelihood SMH would have of positive impact on health priorities, given available resources, and our ability to work in conjunction with other community based organizations (CBO's) to address health need.

From this exercise, the Areas of Opportunity were prioritized as follows by the committee:

Prioritization of Significant Health Needs	
1	**Substance Abuse**
2	**Mental Health**
3	**Nutrition/Physical Activity/Weight Management**
4	**Cancer**
5	**Heart Disease & Stroke**
6	**Diabetes**

Additional needs identified as "Areas of Opportunity" were not deemed as significant and did not rank highly enough to earn a prioritized ranking.

- **Access to Healthcare Services**
- **Respiratory Diseases**
- **Injury and Violence**
- **Potentially Disabling Conditions**

Community-Wide Community Benefit Planning

[IRS Form 990, Schedule H, Part V, Section B, 6c-6d, 2013]

As individual organizations begin to parse out the information from the 2015 Community Health Needs Assessment, it is SMH's hope and intention that this will foster greater desire to embark on a community-wide health improvement planning process. SMH has expressed this intention to partnering organizations and is committed to being a productive member in this process as it evolves. SMH has already begun discussions with: Catholic Charities, Montgomery County Department of Social Services, HFM Prevention Council, Montgomery County and Fulton County Public Health Departments, various Fulton and Montgomery school districts, Interfaith Partnership, Population Health Improvement Program (PHIP), American Heart Association, Mental Health Association (MHA) American Cancer Society, NYS Department of Health, Community Hospice, Mountain Valley Hospice, and local clergy, among other organizations, regarding how to meet and address the needs of community members in Fulton and Montgomery Counties. These programs and services will provide free education to our communities and interventions that will increase access to local resources. For example, SMH, Catholic Charities, Gloversville School District, MHA, local clergy, among others, are providing a free suicide awareness evening in the Spring, 2016. Vendors will be present to distribute information on available resources, along with a keynote speaker and a panel of local mental health experts for an abundance of information.

St. Mary's Healthcare
FY2016-FY2018 Implementation Strategy

For over 113 years, St. Mary's Healthcare has demonstrated its commitment to serve all persons with compassion and excellence, especially those who are vulnerable and to help those who are most in need.

This summary outlines St. Mary's Healthcare's plan (Implementation Strategy) to address our community's health needs by

1) sustaining efforts operating within a targeted health priority area;

2) developing new programs and initiatives to address identified health needs; and

3) promoting an understanding of these health needs among other community organizations and within the public itself.

Healthcare-Level Community Benefit Planning

Priority Health Issues To Be Addressed

In consideration of the top health priorities identified through the CHNA process — and taking into account SMH's resources and overall alignment with SMH's mission, goals and strategic priorities — it was determined that St. Mary's Healthcare would focus on developing and/or supporting strategies and initiatives to improve:

- **Substance Abuse/Mental Health**
- **Nutrition, Physical Activity & Weight Status**
- **Chronic Disease (heart disease/stroke, cancer, diabetes)**

Integration With Operational Planning [IRS Form 990, Schedule H, Part V, Section B, 6e, 2013]

Since 1999, SMH has included a Community Benefit section within its operational plan.

Priority Health Issues That Will Not Be Addressed & Why [IRS Form 990, Schedule H, Part V, Section B, 7, 2013]

In acknowledging the wide range of priority health issues that emerged from the CHNA process, St. Mary's Healthcare determined that it could only effectively focus on those which it deemed most pressing, most under-addressed, and most within its ability to influence.

- Access to Healthcare Services: As evidenced by the CHNA, we have fewer primary care providers than most of NYS. However, we are out-performing most areas when it comes to patients being screened for blood pressure and children attending wellness visits. We also only have 5% of our service area un-insured. SMH employs a full-time Health Insurance Enroller to provide individuals with appropriate health insurance.

- Respiratory Diseases: As part of SMH's participation in and leadership of the Alliance for Better Health, a part of DSRIP (Delivery System Reform Incentive Payment Program) of New York State, Project 4.b.i. will focus on tobacco cessation, contributing to respiratory diseases, including asthma and COPD.

- Injury and Violence: According to our CHNA, our service area's mortality rate has decreased over much of the past decade, despite some increases in recent years. Also, our rate of children and adults wearing seatbelts has increased significantly over time from 93.7% to 98.6%. We have also had a statistical decrease in violent crimes since 2012.

- Potentially Disabling Conditions: SMH continuously partners with local physicians and medical providers to offer free of charge educational programs on joint, bone and back health. Additionally, a SMH inter-disciplinary team partners with a local orthopedic practice to offer a "Joint School," which educates candidates for join replacement on surgery, treatment, care and management of bone and joint issues.

Implementation Strategies & Action Plans [IRS Form 990, Schedule H, Part V, Section B, 6f-6h, 2013]

The following pages depict SMH's plans to address those priority health issues chosen for action in the FY2017-FY2019 period:

SUBSTANCE ABUSE/MENTAL HEALTH	
Community Partners/ Planned Collaboration	• St. Mary's Healthcare Primary Care Centers • Local Community Healthcare Providers
Goal	**St. Mary's will have at least one behavioral health provider in four of SMH's primary care centers by December, 2018 to increase mental health services access.**
Timeframe	FY2017-FY2019
Scope	This strategy will focus on residents in both Fulton and Montgomery Counties along with St. Mary's Healthcare's Primary Care Center healthcare providers.
Strategies & Objectives	**Strategy #1: Get appropriate certification from New York State Department of Health and the Office of Mental Health (NYS).** **Strategy #2: Collaborate with primary care center healthcare providers.** **Strategy #3: Utilize internal appropriately licensed staff in primary care centers along with hiring new appropriately licensed associates.**
Financial Commitment	~$260,000
Anticipated Impact	• This will meet the DSRIP initiative of integrating behavioral health into primary care setting. • It will provide a continuity of care for all patients.
Plan to Evaluate Impact	• Tracking utilization of services
Results	*Pending*

SUBSTANCE ABUSE/MENTAL HEALTH	
Community Partners/ Planned Collaboration	N/A
Goal	**By December, 2016, the new ambulatory detox center (located on the St. Mary's Memorial Campus) will be taking patients in order to reduce the number of Emergency Department admissions and inpatient detox admissions by 10%.**
Timeframe	FY2017-FY2019
Scope	This strategy will focus on residents primarily in both Fulton and Montgomery Counties, but all across the Capital Region, as well.
Strategies & Objectives	**Strategy #1: Preparing the physical space** **Strategy #2: Gathering the necessarily licensing** **Strategy #3: Preparing for December 2016 opening**
Financial Commitment	$580,000 (awarded grant)
Anticipated Impact	• Decrease in Emergency Department visits and inpatient detox admissions by 10%. • Address the epidemic of opioid use (specifically, heroin).
Plan to Evaluate Impact	• Tracking the utilization of services
Results	*Pending*

SUBSTANCE ABUSE/MENTAL HEALTH	
Community Partners/ Planned Collaboration	• HFM Prevention Council • Catholic Charities • Mental Health Association • Montgomery County Public Health • Fulton County Public Health • Montgomery County Office for the Aging, Inc. • Fulton County Office for the Aging • Local school districts in Fulton and Montgomery Counties • Fulton-Montgomery Suicide Task Force
Goal	**We will have eight (8) community programs about substance abuse and/or mental health and we will perform pre- and post-test surveys in order to increase knowledge of these areas, collectively, by 10%, by December, 2018.**
Timeframe	FY2017-FY2019
Scope	This strategy will focus on residents primarily in both Fulton and Montgomery Counties.
Strategies & Objectives	**Strategy #1: Collaborate with local organizations/agencies to perform community-wide education programs.** • **Behavioral Health Implementation Plan (BHIP) committee at SMH.** **Strategy #2: Increase awareness of mental health illnesses and local resources** **Strategy #3: Reaching audiences in innovative ways, such as support groups or other local organizations that do not necessarily deal directly with mental health/substance abuse issues.** • **For example, speaking at a Diabetes support group about stress management.**
Financial Commitment	N/A
Anticipated Impact	• Increase public awareness of programs and services in our service for mental health and substance abuse. • Decrease stigma associated with mental health disorders.
Plan to Evaluate Impact	• Pre-and Post-test Surveys to assess knowledge of mental health, stigma associated with mental illness, and ways to prevent stigma. • Pre-and Post-test Surveys to assess knowledge on substance abuse issues, assessing if someone has a substance abuse issue and where to go if one is suspected.
Results	*Pending*

NUTRITION/PHYSICAL ACTIVITY/WEIGHT MANAGEMENT	
Community Partners/ Planned Collaboration	• Fulton County YMCA • Montgomery County Public Health • Fulton County Public Health • FulMont Head Start • Bassett Research Institute • FulMont Community Action Agency
Goal	**Decrease the incidence of overweight/obese individuals in Fulton and Montgomery Counties from 34.6% to 31.6% (3%) by implementing "5210" in 4 locations (healthcare, workplace, schools, etc.) by December 2018. 5210 is a childhood obesity prevention program, where the goal is to have children eat 5 servings of fruits and vegetables a day, 2 hours of less of recreational screen time, 1 hour or more of physical activity, and zero sugary sweetened beverages.**
Timeframe	FY2017-FY2019
Scope	This strategy will focus on residents primarily in both Fulton and Montgomery Counties.
Strategies & Objectives	**Strategy #1: Build collaborations with local community based organizations.** **Strategy #2: Educate providers about the services of St. Mary's Healthcare's Diabetes and Nutrition Education.** **Strategy #3: Work to address the needs of food insecure individuals in St. Mary's Healthcare service area.** **Strategy #4: Partner with the local Fulton County YMCA and schools to promote "open gym" time for students.**
Financial Commitment	N/A
Anticipated Impact	• Educate individuals on better food and beverage choices and the importance of physical activity. • Lower overweight/obesity rates in Fulton and Montgomery counties.
Plan to Evaluate Impact	• "5210" requires an assessment every spring. Each registered school participating in "5210" will receive an Implementation Survey to track which of the "5210" strategies the school has implemented. • For Healthcare Providers: Every spring, "5210" will survey the following: hanging "Let's Go!" poster in waiting room and all exam rooms where pediatric patients are seen, all providers accurately weighing and measuring patients by determining body mass index (BMI) percentile, and weight classification for all patients ages two and older at well-child visits, and all providers regularly engaging in respectful conversations with patients about weight by using the "5210" Healthy Habits Questionnaire at well-child visits.
Results	*Pending*

NUTRITION/PHYSICAL ACTIVITY/WEIGHT MANAGEMENT	
Community Partners/ Planned Collaboration	• Fulton County YMCA • Montgomery County Public Health • Fulton County Public Health • FulMont Head Start • Bassett Research Institute • FulMont Community Action Agency • 4H
Goal	**Increase awareness and education regarding healthy food and beverage choices in targeted areas likely affected by food insecurity by 5% by December, 2018.**
Timeframe	FY2017-FY2019
Scope	This strategy will focus on residents primarily in both Fulton and Montgomery Counties, who may be food insecure.
Strategies & Objectives	**Strategy #1: Implement the "5210" program in four sites across SMH service area.** **Strategy #2: Provide education and information at local farmer's market(s) regarding healthy food and beverage options.** **Strategy #3: Hold a "family fun run/walk" event for the community with a table of information.** **Strategy #4: Collaborate with the test kitchens at both Paul Nigra Center in Mayfield and Carmel's Free Diner, Inc. in Amsterdam to provide free, healthy cooking sessions for the public** **Strategy #5: Install an educational food pantry in St. Mary's Healthcare and Canajoharie Primary Care Center.** **Strategy #6: Educate providers on "hunger vital signs" to use during well/sick visits, urgent care centers, and ED.**
Financial Commitment	N/A
Anticipated Impact	• Decrease the number of food insecure individuals. • Increase individual knowledge on healthy cooking. • Increase individual knowledge on healthy food and beverage choices.
Plan to Evaluate Impact	• Tracking the number of people who attend the farmer's market(s) • Tracking the handouts given at wellness events ("5210") • Pre-and-Post test surveys to be done at teaching kitchen sessions to see if knowledge of healthy cooking increases.
Results	*Pending*

NUTRITION/PHYSICAL ACTIVITY/WEIGHT MANAGEMENT	
Community Partners/ Planned Collaboration	• Hometown Health • Montgomery County Public Health • Fulton County Public Health • FulMont Head Start • Bassett Research Institute • FulMont Community Action Agency-WIC • Women's Health of Amsterdam • Centro Civico • The Center for Elimination of Minority Health Disparities • Pediatric and Family Health Providers
Goal	**Promote breastfeeding to improve maternal-child health and child nutrition. We will increase the percent of women who initiate and exclusively breastfeed without medical reason for formula feeding to 78% or greater by May, 2019. (Baseline Rate for 2015- 68 %)**
Timeframe	FY07-FY19
Scope	This strategy will focus on residents in both Fulton and Montgomery Counties.
Strategies & Objectives	**Strategy #1**: Implement Baby Friendly Principles in the Hospital, Worksites and Provider Practices • Promote: Ten Steps to Successful Breastfeeding for Health Facilities to Ensure Successful Breastfeeding (World Health Organization): 1. Have a written breastfeeding policy that is routinely communicated to all health care staff. 2. Train all health care staff in the skills necessary to implement the policy. 3. Inform all pregnant women about the benefits and management of breastfeeding. 4. Help mothers initiate breastfeeding within half an hour of birth. 5. Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infant. 6. Give newborn infants no food or drink other than breast milk unless medically indicated. 7. Practice "rooming in"-allowing mothers and infants to remain together for 24 hours a day. 8. Encourage breastfeeding on demand, whenever the baby is hungry. 9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants. 10. Foster the establishment of breastfeeding support groups and refer mothers to them upon discharge from the hospital or clinic.
Financial Commitment	N/A
Anticipated Impact	• More new mothers will feel confident breastfeeding their babies. • Foster an environment for a support group for new breastfeeding mothers. • Raise awareness and education about the health benefits of breastfeeding for both mother and baby. • Increased rates of breastfeeding and exclusive breastfeeding decrease the risk of pediatric diseases. • Increased rates of breastfeeding positively impact maternal health due to the hormonal influences on the body during lactation.
Plan to Evaluate Impact	• Increase in breastfeeding imitation and exclusivity rates during the hospital stay • Meeting Baby Friendly evaluation criteria for implementation of Ten Steps.
Results	*Pending*

CHRONIC DISEASE	
Community Partners/ Planned Collaboration	• Local area healthcare providers
Goal	By June, 2017, St. Mary's will have a Medical Mission at Home that provides health access to the poor and vulnerable in our service area.
Timeframe	FY2017-FY2019
Scope	This strategy will focus on residents primarily in both Fulton and Montgomery Counties, who may be uninsured or under-insured.
Strategies & Objectives	**Strategy #1: Collaborate with local healthcare providers for services day of event.** **Strategy #2: Arrange transportation with local taxi service and other forms of public transportation. SMH will give out taxi vouchers to needing individuals.** **Strategy #3: Set-up day and time at the SMH Rao Outpatient Pavilion.** **Strategy #4: Collaborate with SMH's Health Insurance Enroller so she will be present day of to enroll individuals in health insurance, if necessary.**
Financial Commitment	N/A
Anticipated Impact	• Those who need health insurance will have the option of receiving it, therefore, being more apt to utilize local healthcare services.
Plan to Evaluate Impact	• Utilization of specific services given at time of Medical Mission • Conducting "PAM"'s, a tool used to survey uninsured, under-utilizing, and non-utilizing individuals about their self-efficacy in regards to attending to their health care needs • Tracking the number of participant at Medical Mission
Results	*Pending*

CHRONIC DISEASE	
Community Partners/ Planned Collaboration	• Cancer Services Program • Cancer Medicine at St. Mary's Healthcare • Nathan Littauer Hospital • Ellis Medicine • Local primary care practices, not limited to SMH • American Cancer Society
Goal	Adapt the CDC's National Colorectal Cancer Roundtable goal of screening 80% of recommended individuals for colorectal cancer by 2018 through implementation of a patient navigator program. We will increase our screening percentage from 63.5% to 80%, by December, 2018.
Timeframe	FY2017-FY2019
Scope	This strategy will focus on residents primarily in both Fulton and Montgomery Counties, and some outlying counties, such as Schenectady and Schoharie.
Strategies & Objectives	**Strategy #1: Hire a Colo-rectal Navigator for patient navigation. This navigator will need to develop a tracking tool for baseline purposes and end of intervention numbers.** **Strategy #2: Increase awareness activities, especially during March (Colo-rectal Cancer Awareness Month).** • **Community activities, such as a "fun run," etc.** **Strategy #3: Provide education to providers regarding different screening methods, including take-home kits and colonoscopies.** **Strategy #4: Cancer Services Program will provide multiple screening events in Fulton, Montgomery and Schenectady Counties.**
Financial Commitment	~$40,000
Anticipated Impact	• Increase colo-rectal screenings among the elder population. • Increase education and awareness for both providers and the community at large. • Reduce the stigma of colo-rectal cancer screenings through education and awareness.
Plan to Evaluate Impact	• Utilization of services • Number of people screened • Pre and Post-test surveys at education events
Results	*Pending*

Adoption of Implementation Strategy[IRS Form 990, Schedule H, Part V, Section B, 6a-6b, 2013]

On June 1, 2016, the Board of St. Mary's Healthcare, which includes representatives from throughout Fulton and Montgomery Counties, met to discuss this plan for addressing the community health priorities identified through our Community Health Needs Assessment. Upon review, the Board approved this Implementation Strategy and the related budget items to undertake these measures to meet the health needs of the community.

SMH Board Approval & Adoption:

By Name & Title

Date