St. Mary's Healthcare Amsterdam

FY 2020-2022 IMPLEMENTATION STRATEGY

ST. MARY'S HEALTHCARE

ASCENSION

St. Mary's Healthcare Implementation Strategy

This Community Health Needs Assessment (CHNA) was conducted in the summer of 2018 and is a follow-up to similar studies conducted in 2012 and 2015. The CHNA 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 (SMH). 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.

Implementation Strategy Narrative

Overview

Founded in 1903, by the Sisters of St. Joseph of the Carondelet, St. Mary's Healthcare has an over 116-year history of providing compassionate, clinically exceptional care, with special attention to those persons who are poor and vulnerable. As a Catholic Ministry, we commit ourselves to living the core values of: *Service 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: a 120-bed acute care Medicare Dependent Hospital, a 14 bed inpatient Addiction Rehabilitation unit, a 20-bed inpatient behavioral health unit, nine primary care health centers and six specialty care centers, more than 30 behavioral health services, four 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 loving ministry of Jesus as healer, we commit ourselves to serving all persons with special attention to those who are poor and vulnerable. Our Catholic health ministry is dedicated to spiritually-centered, holistic care, which sustains and improves the health of individuals and communities. We are advocates for a compassionate and just society through our actions and our words."

The objectives of the CHNA and subsequent implementation strategy are:
1.) To provide an unbiased comprehensive assessment of health needs in Fulton and Montgomery Counties;
2.) Use the CHNA to prioritize St. Mary's Healthcare's Community Benefit Program strategy; and
3.) Fulfill Internal Revenue Service regulations related to 501 (c)(3) non-profit hospital status for federal income taxes.

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.

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. 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 363 in Fulton County and 387 in Montgomery County. Once the interviews were completed, these were weighted in proportion to the actual population distribution to appropriately represent St. Mary's Healthcare Service Area as a whole. All administration of the surveys, data collection and data analysis were conducted by Professional Research Consultants, Inc. (PRC).

Needs That Will Be Addressed

After reviewing the Community Health Needs Assessment findings, the CHNA Steering Committee and Community Stakeholders met on February 12, 2019 to determine the health needs to be prioritized for action. During 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 considering 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:

1	**Substance Abuse**
2	**Mental Health**
3	**Diabetes**
4	**Cancer**
5	**Heart Disease & Stroke**
6	**Nutrition, Physical Activity & Weight**

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

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

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

- **Substance Abuse/Mental Health**
- **Nutrition, Physical Activity, and Weight (specifically Diabetes Prevention)**

Needs That Will Not Be Addressed

Health Priorities Not Chosen for Action	*Reason*
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 adults and children attending wellness visits. Only 5.5% of people in our service area un-insured. SMH employs a full-time Health Insurance Enroller and six Certified Application Counselors to provide individuals with appropriate health insurance. In addition, we have a full-time physician recruiter who is focusing on increasing providers in our area.
Respiratory Diseases	As part of SMH's collaboration with the Alliance for Better Health, a part of DSRIP (Delivery System Reform Incentive Payment Program) of New York State, Project 4.b.i. actions were completed in 2018 to address respiratory diseases. Primary Care patients are screened for tobacco use using the "5 A's" model and referrals to the NYS Smoker's Quitline are built into the EMR. Primary care sites have been supplied with spirometers and SMH employs an Asthma Educator.
Injury and Violence	According to the CHNA, our service area's mortality rate due to unintentional injury is similar to the Healthy People 2020 goal and lower than the national average. The rate of violent crimes in our service area has remained statistically unchanged.
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.

Summary of Implementation Strategy

Prioritized Need #1: Substance Abuse/Mental Health

GOAL: Utilize a trauma-informed model of care approach to promote, support, and treat patients across the continuum of care with collaboration among Behavioral Health, Substance Abuse, and Primary Care Providers.

Action Plan

STRATEGY 1: Expand collaboration to become a Trauma Informed Community to promote well-being
BACKGROUND INFORMATION: • Patients affected by Mental, Emotional, and Behavioral (MEB) Disorders • Social determinants of health addressed include childhood experiences, social supports and coping skills, education, and interpersonal and family dynamics • Strategy is evidence-based as addressing trauma is critical to promote healing-this strategy addresses systems approaches to improve outcomes
RESOURCES: • SMH Trauma Informed Work Group with Team Charter • Creation of Community Support Network to include community partners • Education for providers and clinical staff
COLLABORATION: • Greater Amsterdam School District • Montgomery County Social Services • Mental Health Association of Fulton and Montgomery Counties • Catholic Charities of Fulton and Montgomery Counties • Fulton and Montgomery Departments of Public Health • City of Amsterdam • Amsterdam Police Department
ACTIONS: 1. Expand Crisis Prevention (CPI) training to include all SMH clinical caregivers including nursing staff 2. Integrate ACEs (Adverse Childhood Experiences) screenings and support in prenatal and postnatal care

STRATEGY 1: Expand collaboration to become a Trauma Informed Community to promote well-being

3. Increase the number of Primary Care settings utilizing a Collaborative Care Model for Behavioral Health
4. Expand utilization of Depression Screenings (PHQ-2 & PHQ-9) in primary care settings
5. Develop curriculum to train providers and staff in delivery of Trauma Informed Care model
6. Increase staff trained in Mental Health First Aid program

ANTICIPATED IMPACT:

I. Reduce the percentage of adults in service area who reported they were unable to get mental health services when needed by 2% (Baseline: 6.3% from 2018 CHNA)

II. Increase knowledge of clinical providers to improve patient outcomes to reduce hospitalization and Emergency Department visits for mental health disorders

Action Plan

STRATEGY 2: Collaborate with community partners to provide treatment referrals, peer and recovery coach support, and relapse prevention and aftercare to patients using harm-reduction health resources.

BACKGROUND INFORMATION:

- The focus population are persons impacted by overdose including non-medical use of prescription drugs
- Several Social Determinants of Health are associated with substance abuse including gender, race and ethnicity, age, income level, educational attainment, and interpersonal, household, and community dynamics
- Strategy is evidence-based as community collaboration to prevent overdose strengthens comprehensive messaging. This strategy addresses systems approaches to improve outcomes

RESOURCES:

- Overdose Task Force Partner Collaboration
- Community Support Network comprised of community partners
- Education for community members at higher risk including those affected by MEB disorders
- Relocation of Inpatient Chemical Dependency Unit & Outpatient Behavioral Health at the 2nd floor of the Memorial Building

COLLABORATION:

- Montgomery County Public Health
- Catholic Charities of Fulton and Montgomery Counties
- Amsterdam Police Department
- Mental Health Association of Fulton and Montgomery Counties
- Prevention Council of Hamilton, Fulton, and Montgomery Counties
- Montgomery County Allies in Prevention
- Fulmont Community Action Agency
- Centro Civico
- Montgomery County Emergency Management
- Montgomery County Department of Social Services
- Fulton County Department of Social Services
- Montgomery County Office of the Aging

ACTIONS:

7. Creation of Overdose Task Force
8. Creation of education materials with all community resources listed
9. Educate community on task force activities and resources

STRATEGY 2: Collaborate with community partners to provide treatment referrals, peer and recovery coach support, and relapse prevention and aftercare to patients using harm-reduction health resources.
10. Increase availability of/access to medication-assisted treatment (MAT) including Buprenorphine to those in need of treatment for substance abuse 11. Increase availability of/access to overdose reversal (Naloxone) training to prescribers, pharmacists, and consumers 12. Establish additional permanent safe disposal sites for prescription drugs and organized take-back days in the community
ANTICIPATED IMPACT: III. Provide Naloxone utilization training to at least 50 individuals in the community to decrease the number of drug-induced deaths in the community by 5%

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #1)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2030" (or OTHER NATIONAL PLAN):
#1	2019-2021 Community Service Plan and Community Health Improvement Plan-Focus Area 2-Promote Well-Being and Prevent Mental and Substance Use Disorders	New York State Prevention Agenda Focus Area 1-Promote Well-Being and Prevent Mental and Substance Use Disorders	Healthy People 2030-Improve mental health through prevention and by ensuring access to appropriate, quality mental health services and reduce substance abuse to protect the health, safety, and quality of life for all
#2	2019-2021 Community Service Plan and Community Health Improvement Plan-Focus Area 2-Promote Well-Being and Prevent Mental and Substance Use Disorders	New York State Prevention Agenda Focus Area 1-Promote Well-Being and Prevent Mental and Substance Use Disorders	Healthy People 2030-Improve mental health through prevention and by ensuring access to appropriate, quality mental health services and reduce substance abuse to protect the health, safety, and quality of life for all

Prioritized Need #2: Nutrition, Physical Activity, and Weight (Prevent Diabetes)

GOAL: Decrease Obesity and Diabetes

Action Plan

STRATEGY 1: Increase availability of, access to, and enrollment in evidence-based diabetes prevention lifestyle change program (Diabetes Prevention Program-DPP)

BACKGROUND INFORMATION:

- This strategy addresses adults with diagnosis of pre-diabetes or adults at high risk for type 2 diabetes
- It fosters health literacy by helping the community make informed decisions about healthcare- and addresses access to care by providing access to a proven type 2 diabetes prevention lifestyle change program
- The strategy is evidence-based and has demonstrated that people who are at high risk for type 2 diabetes can prevent or delay the disease by losing a modest amount of weight through lifestyle changes (dietary changes and increased physical activity)

RESOURCES:

- SMH employed Registered Dietician trained as a certified lifestyle coach
- Space for classes
- Supplies and materials for classes
- Teaching kitchen

COLLABORATION:

- Fulton and Montgomery County Health Departments
- Montgomery County Office of the Aging
- Catholic Charities of Fulton and Montgomery Counties

ACTIONS:

1. Utilize grant funding for a Registered Dietician to become trained as a lifestyle coach for the DPP
2. Educate primary care providers on DPP program
3. Add referral to DPP in electronic medical record system
4. Obtain Centers for Disease Control (CDC) recognition for DPP
5. Administer Diabetes Risk Assessments at community events to increase awareness

ANTICIPATED IMPACT:

IV. Number of participants enrolled in DPP-goal is to complete at least 1 cohort each year with at least 10 participants in each cohort

STRATEGY 1: Increase availability of, access to, and enrollment in evidence-based diabetes prevention lifestyle change program (Diabetes Prevention Program-DPP)

V. Increased knowledge of providers educated by measuring the number of healthcare professionals educated on the evidence-based screening tool to increase referrals to the DPP-goal is for providers to refer at least 25 patients to the program each year

VI. Number of community members educated on pre-diabetes through outreach efforts, reaching at least 300 people each year

Action Plan

STRATEGY 2: Create community environments that support physical activity and healthy food and beverage choices

BACKGROUND INFORMATION:

- Community members in neighborhoods without access to healthy food-adults and children
- The strategy addresses access to healthy foods by helping those in the community make healthy food selections
- Community education is an evidence-based strategy to encourage organizational change

RESOURCES:

- Staff time for SMH Registered Dieticians and Community Educators
- Cooking supplies and food for Teaching Kitchen
- Space for Food Summit meetings and event for Fulton and Montgomery Counties
- Marketing materials for community education and promotion of events

COLLABORATION:

- Prevention Council of Hamilton, Fulton, and Montgomery Counties
- Catholic Charities
- Peer Educators-New York State Department of Health
- Montgomery Office of the Aging
- City of Amsterdam
- Fulmont Community Action Agency
- Fulton and Montgomery Counties Departments of Social Services
- Fulton and Montgomery Counties Departments of Public Health

ACTIONS: *(List main actions needed to implement strategy and achieve the SMART objectives above)*

STRATEGY 2: Create community environments that support physical activity and healthy food and beverage choices
6. Utilize teaching kitchen to host community cooking classes-classes held quarterly by Registered Dietician 7. Provide community education on healthy food and beverage choices at monthly food distribution events 8. Host a free walking program during the spring and summer months at the Mohawk Valley Gateway Overlook Bridge-supply education at these programs 9. Host a free walking program at the Riverfront Center during the winter months-supply education at these programs
ANTICIPATED IMPACT: VII. Increase participants in the walking program by 10% from 2018 baseline numbers VIII. Track education provided at Food Distribution and measure education provided-number of people educated-goal is 300 each year IX. Provide pre-assessments and post assessments to participants in quarterly cooking classes held in the teaching kitchen-track number of participants-goal is 100 each year

Alignment with Local, State & National Priorities (Long-Term Outcomes for Prioritized Need #2)

OBJECTIVE:	LOCAL / COMMUNITY PLAN:	STATE PLAN:	"HEALTHY PEOPLE 2030" (or OTHER NATIONAL PLAN):
#1	2019-2021 Community Service Plan & Community Health Improvement Plan-Fulton and Montgomery Counties-Focus area 4-Increase early detection of cardiovascular disease, diabetes, prediabetes, cancer, and obesity	New York State Prevention Agenda-Prevent Chronic Diseases' Focus Area: Preventative Care and Management Goal 4.2: Increase early detection of cardiovascular disease, diabetes, prediabetes, cancer, and obesity	Healthy People 2030-Increase prevention behaviors in persons at high risk for diabetes with prediabetes
#2	2019-2021 Community Service Plan & Community Health Improvement Plan Fulton and Montgomery Counties-Focus area 4-	New York State Prevention Agenda-Prevent Chronic Diseases' Focus Area: Preventative Care and	Healthy People 2030-Promote health and reduce chronic disease risk through the consumption of healthful diets and achievement

	Increase early detection of cardiovascular disease, diabetes, prediabetes, cancer, and obesity	Management Goal 4.2: Increase early detection of cardiovascular disease, diabetes, prediabetes, cancer, and obesity	and maintenance of healthy body weights