FY 2022-2025 IMPLEMENTATION STRATEGY ST. MARY'S HEALTHCARE

St. Mary's Healthcare Implementation Strategy

This Community Health Needs Assessment (CHNA) was conducted in the summer of 2021 and is a follow-up to similar studies conducted in 2012, 2015 and 2018. 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 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, six primary care health centers and nine 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, healing ministry of Jesus and inspired by the legacy of the Sisters of St. Joseph of Carondelet, we serve all with compassion and excellence"

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 757 individuals age 18 and older in the St. Mary's Healthcare Service Area, including 401 in Fulton County and 356 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 January 13th, 2022 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	Nutrition/Physical Activity/Weight
2	Mental Health
3	Substance Abuse
4	Tobacco Use

5	Heart Disease/Stroke
6	Diabetes

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

- Cancer
- Access to Health Care Services
- Respiratory Disease
- Infant Health/Family Planning
- Kidney Disease
- Potentially Disabling Conditions
- Injury

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:

- Nutrition/Physical Activity/Weight
- Mental Health
- Substance Abuse

Needs That Will Not Be addressed:

Health Priorities Not Chosen for Action	Reason
Cancer	According to the CHNA, breast and cervical cancer screenings fall below statewide percentages. However, Colorectal cancer screenings exceed the NYS average. SMH Cancer Services Program (CSP) offers free breast, cervical and colorectal cancer screenings and diagnostic follow- up services. In addition to CSP, the Cancer Prevention in Action Program(CPiA) helps to increase the adoption of worksite policies that establish paid time off benefits for employees to obtain cancer screenings.
Access to Health Care Services	As evidenced by the CHNA, we have fewer primary care providers than most of NYS. However, we are outperforming most areas when it comes to adults and children attending wellness visits. Only 7.8% of people in our service area un-insured, showing a lower percentage than what was found statewide. SMH employs a full-time Health Insurance Enroller 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 Disease	Primary Care patients are screened for tobacco use using the "5 A's" model. If a patient identifies using tobacco products, a referral to the NYS Smoker's Quitline can be made. SMH also employs a BSH facilitator to provide education and support to those who are current smokers. Virtual BSH classes are also offered.
Infant Health/Family Planning	Teen birth rates in SMH service area were above both states and national rates, however, SMH service area showed a lower percentage of low birth weights which outperformed both state and national findings. The annual average of infant deaths in the SMH service area was also lower than the national average. St. Mary's Healthcare continues to offer women's reproductive care at both the Amsterdam and Johnstown OB/GYN clinics.
Kidney Disease	The annual average age-adjusted kidney disease mortality rate and prevalence of kidney disease in SMH service area was much higher than state and national rates. Primary Care has adopted the Healthcare Effectiveness Data and Information Set (HEDIS) measurement which aims to improve kidney disease testing in people with diabetes, which is a key risk factor for developing kidney disease. SMH has two Urology Health Center locations focusing on conditions related to the bladder, kidneys, and other urological concerns for both men and women.
Potentially Disabling Conditions	SMH has partnered with local physicians and medical providers to offer free of charge educational programs on joint, bone and back health. SMH has an inter-disciplinary team that partnered with a local orthopedic practice to offer a "Joint School" which educates candidates for joint replacement on surgery, treatment, care and management of bone and joint issues. "Joint School" has been temporarily put on hold due to the COVID-19 Public Health Emergency but plans to resume sessions are in place.
Injury	According to the CHNA, our service area's age adjusted unintentional injury deaths fall below the national rate and are similar to the Healthy People 2030 goal. The rate of violent crimes in our service area has remained statistically unchanged and remains below the NYS rates.

Summary of Implementation Strategy:

Prioritized Need #1: Nutrition/Physical Activity/Weight

Goal: Increase skills and knowledge to support healthy food and beverage choices

Action Plan

Strategy 1: Increase availability of, and access to, nutrition and physical activity education programs
Background Information: • Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight. • Target population (s): Adults with mental health conditions, pregnant women and adults who are at increased risk for developing type 2 diabetes
Resources: • SMH employed Registered Dietitians and trained Program Coordinator/Certified Lifestyle Coach • Teaching Kitchen • Space for counseling sessions & group education classes • Supplies and materials for classes • Pre and post program surveys evaluating effectiveness of nutrition education • Marketing materials
Collaboration: • Catholic Charities of Fulton and Montgomery Counties • Montgomery County Office of the Aging • Fulton and Montgomery County Health Departments • New Dimensions in Healthcare • Home Town Health Centers
Actions: • Submit Medicare and Medicaid Diabetes Prevention Program applications. Once approved, implement evidenced based lifestyle change program to eligible members of the community. • Provide quarterly nutrition education classes at Adult Behavior Health Clinic • Offer nutrition counseling to all new OB patients, specifically those with a BMI indicating overweight or obesity. • Distribute quarterly nutrition education material to all SMH associates via monthly newsletter. • Provide community education on healthy food and beverage choices at monthly food distribution events
Anticipated Impact: • Medicare and Medicaid Diabetes Prevention Programs to have at least 10 participants complete 1 cohort each year. Participants will have at least 5-7% weight loss, decrease in A1c levels or at least 150 minutes of physical activity per week. • Provide nutrition education to at least 25 Adult Behavioral Health patients each quarter

- Increase total number of New OB patients seen annually for nutrition counseling by 15%
- Increase the percentage of adults aged 18 years and older who participate in leisure-time physical activity by 4% (Baseline 23.7% per 2021 CHNA)

Strategy 2: Enhance partnerships with community organizations and local school districts to better support programs focusing on physical activity and healthy food choices.

Background Information:

- Many people within Montgomery and Fulton Counties don't have the information they need to choose healthy foods, while others may not have access to healthy foods. Interventions to help the community choose healthy food and beverage options can help reduce their risk of chronic diseases and improve overall health.
- Target Population(s): Low-income children and adults

Resources:

- Cooking supplies and food for Teaching Kitchen
- Marketing materials for community education and promotion of events
- Staff time for SMH Registered Dietitians
- Space for community education
- Materials for in person and virtual nutrition education presentations

Collaboration:

- Catholic Charities of Fulton and Montgomery Counties
- Greater Amsterdam School District
- St. Mary's Institute
- Creative Connections Clubhouse
- Prevention Council of Hamilton, Fulton, and Montgomery Counties
- Montgomery County Office of the Aging
- Fulmont Community Action Agency
- Fulton and Montgomery Counties Departments of Public Health

Actions:

- Implement nutrition education series for local schools within Fulton and Montgomery Counties
- Utilize teaching kitchen to host quarterly community cooking classes for children, adolescents and parents
- Host virtual cooking demos in teaching kitchen
- Implement physical activity challenge for local schools, after school programs and pediatric clinics to encourage children to become more physically active

Anticipated Impact:

- Track education provided and measure education outcomes-number of people educated-goal is 200 per year
- Provide pre- assessments and post assessments to participants in quarterly cooking classes held in teaching kitchen, track number of participants- goal is at least 25 in person participants per year, at least 50 virtual participants per year.
- Increase self-reported number of physical activity minutes by 5% (Baseline: 64.5% per 2021 CHNA)

Alignment with Local, State & National Priorities

Objective	Local/Community Plan:	State Plan:	"Healthy People 2030" (or other National Plan)
#1	2022-2024 Community Service Plan & Community Health Improvement Plan- Fulton and Montgomery Counties- Focus Area 4- Preventative care and management. Goal Focus Area-4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	New York State Prevention Agenda- Prevent Chronic Diseases- Goal: 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes, cancer and obesity	Healthy People 2030- Increase the proportion of eligible people completing CDC-recognized type 2 diabetes prevention programs
#2	2022-2024 Community Service Plan & Community Health Improvement Plan- Fulton and Montgomery Counties- Focus Area 4- Preventative care and management. Goal Focus Area-4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes and obesity	New York State Prevention Agenda- Prevent Chronic Diseases- Goal: 4.2 Increase early detection of cardiovascular disease, diabetes, prediabetes, cancer and obesity	Healthy People 2030- Increase vegetable consumption by people aged 2 years and older

Prioritized Need #2: Mental Health

Goal: Improve the mental and behavioral health status of Fulton and Montgomery County residents by ensuring access to inpatient and outpatient mental health services

Action Plan

Strategy 1: Increase access to quality mental and behavioral health services with a focus on comprehensive, coordinated care.

Background Information:

- Mental and emotional well-being is essential to overall health. Mental disorders affect people of all ages and racial/ethnic groups, but some populations are disproportionately affected. Estimates suggest that only half of all people with mental disorders get the treatment they need. (Healthy People 2030)
- Target Population(s): Patients affected by Mental, Emotional and Behavioral (MEB) disorders

Resources:

- Education and training for providers and clinical staff
- Unite Us Healthy Together Platform
- Chronic Care Management Staff
- IT support for SDoH build within EMR

Collaboration:

- Alliance for Better Health
- Catholic Charities of Fulton and Montgomery Counties
- Centro Civico
- Montgomery County Office of the Aging
- Mental Health Association of Fulton and Montgomery Counties
- Montgomery County Department of Social Services
- Fulton County Department of Social Services
- Fulmont Community Action Agency

Actions:

- Continue to offer an Open- Access model of care for patients with mental health and substance use disorders through walk-in clinic.
- Explore opportunity to increase the number of Primary Care settings utilizing a Collaborative Care Model for Behavioral Health
- Expand utilization of Social Determinants of Health (SDoH) screenings in OB clinics
- Increase enrollment in Health Homes and HARP to improve overall care coordination of patients with two or more chronic conditions and a persistent mental health condition

Anticipated Impact:

- Reduce the percentage of adults in St. Mary's Healthcare service area who reported they were unable to get mental health services when needed by 4% (Baseline 10.9% from 2021 CHNA)
- Complete the adoption of the SDoH screening tool in OB clinics

Strategy 2: Expand behavioral health support groups and trauma informed care training

Background Information:

- Trauma-Informed Care understands and considers the pervasive nature of trauma and promotes environments of healing and recovery rather than practices and services that may inadvertently re-traumatize.
- Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur in childhood. ACEs can include violence, abuse, and growing up in a family with mental health or substance use problems.
- Target Population(s): Patients affected by Mental, Emotional and Behavioral (MEB) disorders, prenatal and postnatal patients

Resources:

- SMH Trauma informed work group with Team Charter
- Space for group mental health sessions and support group
- Education for providers and clinical staff
- IT support for ACEs screening build within EMR

Collaboration: • HFM BOCES • Montgomery County Public Health • Catholic Charities of Fulton and Montgomery Counties • Montgomery County Office of the Aging • Mental Health Association of Fulton and Montgomery Counties • Montgomery County Department of Social Services • Fulton County Department of Social Services • Fulmont Community Action Agency
Actions: • Create Trauma Informed Care Collaboration Team, continue training of Trauma Informed Care Model in HFM Nurse Residency Program • Increase participation in group mental health sessions and support groups • Explore opportunity to integrate ACEs (Adverse Childhood Experiences) screenings and support in prenatal and postnatal care • Increase the number of staff trained in Mental Health First Aid Program
Anticipated Impact: • Decrease the percentage of adults with reported "Fair" or Poor" Mental Health by 4% (Baseline 21.6% from 2021 CHNA) • Increase knowledge of providers and clinical staff to improve patient outcomes to reduce hospitalization and Emergency Department visits for mental health disorders

Alignment with Local, State & National Priorities

Objective	Local/Community Plan:	State Plan:	"Healthy People 2030" (or other National Plan)
#1	2022-2024 Community Service Plan & Community Health Improvement Plan- Fulton and Montgomery Counties- Focus Area 2: Prevent Mental and Substance User Disorders	New York State Prevention Agenda- Focus Area 1. Promote Well-Being	Healthy People 2030- Increase the proportion of adults with serious mental illness who get treatment
#2	2022-2024 Community Service Plan & Community Health Improvement Plan- Fulton and Montgomery Counties- Focus Area 2: Prevent Mental and Substance User Disorders	New York State Prevention Agenda- Focus Area 1. Promote Well-Being	Healthy People 2030- Increase the proportion of adults with serious mental illness who get treatment

Prioritized Need #3: Substance Abuse

Goal: Reduce the prevalence and negative impacts of substance use disorders within Fulton and Montgomery Counties

Action Plan

Strategy 1: Increase availability of, and access to, Medication- Assisted Treatment (MAT) and overdose reversal (Naloxone)
Background Information: • More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths. (Healthy People 2030) • Target Population(s): Patients with substance use disorders, persons impacted by overdose including non-medical use of prescription drugs
Resources: • Naloxone training materials • Location for safe disposal sites • Provider and clinical staff education related to Medication- Assisted Treatment
Collaboration: • Montgomery County Public Health • Catholic Charities of Fulton and Montgomery Counties • Amsterdam Police Department • Mental Health Association of Fulton and Montgomery Counties • 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: • Explore opportunities to offer MAT within primary care clinics • Establish additional safe disposal sites for prescription drugs and organized take-back days in the community • Increase availability of/access to overdose reversal (Naloxone) training to prescribers, pharmacists and consumers • Continue to offer outpatient walk-in detox services
Anticipated Impact: • 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%

Strategy 2: Collaborate with community partners to increase awareness and education of substance use disorders and treatment options
Background Information: • Effective treatments for substance use disorders are available, but very few people get the treatment they need. As evidenced by the CHNA, 5.3% of St. Mary's Healthcare Service area adults report seeking professional help for alcohol/drug-related problems • Target Population(s): Patients with substance use disorders, persons impacted by overdose including non-medical use of prescription drugs
Resources: • Overdose Task Force Partner Collaboration • Education for community members at high risk including those affected by MEB disorders • Materials for community education and outreach
Collaboration: • Montgomery County Public Health • Catholic Charities of Fulton and Montgomery Counties • Amsterdam Police Department • Mental Health Association of Fulton and Montgomery Counties • 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 • Greater Amsterdam School District
Actions: • SMH will actively participate in Montgomery County Overdose Task Force • Creation of education materials with all community resources listed • Provide education to the community on task force activities and resources • Enhance communication of Plan of Safe Care between health care providers within Maternity and OB clinics
Anticipated Impact: • Decrease the percentage of adults who reported prescription opioids use by 3% • Track education provided to the community- number of people educated- goal 100 per year

Alignment with Local, State & National Priorities

Objective	Local/Community Plan:	State Plan:	"Healthy People 2030" (or other National Plan)
#1	2022-2024 Community Service Plan & Community Health Improvement Plan- Fulton and Montgomery Counties- Focus Area 2:	New York State Prevention Agenda- Focus Area 1. Promote Well-Being	Healthy People 2030- Increase the rate of people with an opioid use disorder getting medications for addiction treatment

	Prevent Mental and Substance User Disorders		
#2	2022-2024 Community Service Plan & Community Health Improvement Plan- Fulton and Montgomery Counties- Focus Area 2: Prevent Mental and Substance User Disorders	New York State Prevention Agenda- Focus Area 1. Promote Well-Being	Healthy People 2030- Increase the proportion of people with a substance use disorder who got treatment in the past year