St. Mary's Healthcare Amsterdam

IMPLEMENTATION STRATEGY

FY 2025-2028

St. Mary's Healthcare Implementation Strategy

This Community Health Needs Assessment (CHNA) was conducted in the summer of 2024 and is a follow-up to similar studies conducted in 2012, 2015, 2018, and 2021. 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 120- 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: Care for Poor and Vulnerable Persons, Reverence, Joyful Service, Integrity, Advocacy, and Creativity.

St. Mary's Healthcare provides a network of services across three counties that includes: a 130-bed acute care Medicare dependent hospital, a 14-bed inpatient chemical dependency unit, a 20-bed inpatient behavioral health unit, seven primary care health centers and ten 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 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
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 754 individuals ages 18 and older in the St. Mary's Healthcare Service Area, including 368 in Fulton County and 386 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 21, 2025, to determine the health needs to be prioritized for action. During a detailed presentation of the CHNA findings, participants were lead 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	Mental Health
2	Substance Use
3	Nutrition, Physical Activity, and Weight
4	Tobacco Use

5	Diabetes
6	Heart Disease and Stroke

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
- Disabling Conditions
- Access to Healthcare Services
- Infant Health and Family Planning
- Respiratory Disease

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:

- Mental Health
- Substance Abuse
- Nutrition, Physical Activity, and Weight

Needs That Will Not Be addressed:

Health Priorities Not Chosen for Action	Reason
Cancer	According to the CHNA, breast cancer screenings are above the national percentages, cervical cancer screenings are above statewide percentages, and Colorectal cancer screening rates have increased to meet the 2030 Healthy People Objective. SMH Cancer Services Program (CSP) offers free breast, cervical and colorectal cancer screenings, and diagnostic follow- up services.
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 6.5% 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 a Urology Health Center to focus 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 resumed after a brief pause related to the pandemic.
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 • 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 • Hometown Health Centers
Actions: • Provide quarterly nutrition education classes at Adult Behavioral 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 community events
Anticipated Impact: • Provide nutrition education to at least 25 Adult Behavioral Health patients each quarter • Provide nutrition education at 2 community events annually

- Increase total number of New OB patients seen annually for nutrition counseling by 10%
- Increase the percentage of adults aged 18 years and older who participate in adequate levels of physical activity by 3% (Baseline 21.3% per 2024 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
- 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 class for local schools within Fulton and Montgomery Counties and share healthy meal ideas
- Utilize teaching kitchen to host annual community cooking classes for children, adolescents and/or parents
- Host virtual cooking demos in teaching kitchen and promote on social media
- Host Yoga classes in the Carondelet Auditorium-at least one session annually

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 10 in person participants per year, at least 50 virtual participants per year.
- Increase adults who engage in leisure time activities 5% (Baseline: 24.6% reported no leisure time activities per 2024 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 fruit consumption by people aged 2 years and older
#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 Platform
- Chronic Care Management Staff
- IT support for SDoH build within EMR
- SMH Health Equity Taskforce

Collaboration:

- Healthy Alliance
- 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
- Integrate Behavioral Health Services in the OBGYN offices to assist expectant mothers
- Increase enrollment in Health Homes 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 1% (Baseline 10.0% from 2024 CHNA)

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

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 • 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 Behavioral Health staff trained in Trauma Informed Care as required by the NYS 1115 Waiver.
Anticipated Impact: • Decrease the percentage of adults with reported "Fair" or Poor" Mental Health by 2% (Baseline 19.2% from 2024 CHNA) • Increase knowledge of providers and clinical staff of resources to improve patient outcomes and 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 • Fulton and Montgomery Counties Drug Courts
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 ancillary services • Ongoing advocacy to link patients to primary care 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 2%

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 2024 CHNA, 7.0% 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: • Partner Collaboration with Alcoholics Anonymous • 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 • Rob Constantine Recovery Center-HFM Prevention Council • 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 offer Alcoholics Anonymous meetings as a support group for people struggling with alcohol addiction. • Creation of education materials with all community resources listed • Provide education to the community on available resources • Enhance communication of Plan of Safe Care between health care providers within Maternity and OB clinics-pregnant mothers are expedited into service line
Anticipated Impact: • Decrease the percentage of adults who reported prescription opioid use by 2% • 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: Prevent Mental and Substance Use Disorders	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
#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