

Saint Anne's Hospital

2023 SAH Community Health Benefits Programs and Outreach – Results

Health Access & Equity

- Provided health insurance education and enrollment assistance to **2,143** patients and community members, with **103** gaining immediate access to coverage through presumptive applications (Jan-Dec. 2023).

Behavioral Health – Mental Health, Substance Use Disorder (SUD)

- **Behavioral Health Navigation** - Provide assessment, resources, and referral to treatment for Emergency Department patients and inpatients with mental illness and/or substance use disorder. **Provided specialized behavioral health navigation to over 2,000 patients (2023)**
- **Peer Recovery Coach Program** - In collaboration with Steppingstone Peer2Peer Recovery Project, provide certified peer recovery coaching services to hospital patients with substance use disorder.
 - **Provided 49 patients access to a recovery coach (2023); 607 since program inception (Jan. 2018-Dec. 2023)**

Chronic Disease & Wellness

- Cancer and Breast Disease - Provide support all in aspects of care – from health-related social needs like food insecurity and income supports, to assistance with care navigation and access to treatment.
 - **Provided dedicated oncology patient navigation to 1,145 patients.**
 - **Provided dedicated breast patient navigation to 289 patients.**

Health-related Social Needs (HRSN)- Addressing Food Insecurity

- Implemented The Joint Commission National Quality & Patient Safety Goal to reduce health disparities - **screened 97.6% of inpatients for food insecurity (2023).**
- Provided monthly cash allocation to the Greater Fall River Community Food Pantry (\$20,000 annually); in 2023, served **23,000** individuals.
- Hosted on-site Community Farmers Market. **Over 85% sales used MA Healthy Incentive Program (HIP)/Supplemental Nutrition Assistance Program (SNAP) benefits, coupons for the elderly, and Women, Infants & Children (WIC) program.**

Workforce/Student Development and Diversity

- Over **700** Students from **50** schools completed clinical rotations (2022-2023); **36** shadowing experiences offering clinical observation.
- **Six** scholarships awarded to bi-cultural/lingual students pursuing advanced degrees in healthcare/related field. **Two** need-based scholarships awarded to students at the *Institut Catholique de Kabgayi*, Rwanda.

Saint Anne's Hospital Community Benefits 2024 Executive Summary

2024 Year of the Triennial Community Health Needs Assessment (CHNA) *Health Equity Blueprint for Saint Anne's Hospital Community Benefits Program (2025-2027)*

Saint Anne's Hospital maintains a Community Health Benefits Department that focuses on serving the needs of our most vulnerable, at-risk populations across the spectrum of hospital, primary and community-based care. The community health needs assessment (CHNA), conducted every three years, and a Community Health Benefits Advisory Committee (CBAC) comprising hospital leadership, representatives from local health and human service organizations and community non-profits inform and guide the planning and implementation of the Saint Anne's Hospital Community Health Benefits Implementation Strategy (IS).



The 2024 Community Benefits IS, consistent with the guidelines for community benefits established by the Massachusetts Attorney General, provides the health equity lens through which services and programs are reviewed annually.

Importantly, equity is not the same as equality. To equalize opportunities, those with worse health and fewer resources need more efforts expended to improve their health.

In 2024, SAH Community Health Benefits will be focused on the following priorities:

1. **Behavioral Health – Mental Health and Substance/Opioid Use Disorder/Trauma:** Provide behavioral health patient navigation; assess and refer individuals to treatment/community services when they are at risk for substance use disorder and mental/behavioral health conditions; and outpatient programming support. Access to supervised support of students in the Clinical Pastoral Education (CPE) program.
2. **Chronic Disease Management and Support:** Screen and provide referrals for education, treatment and/or disease management programs for at-risk population; offer hospital programs and services aimed at supporting some of our community's most prevalent health issues, including diabetes and obesity.
3. **Health-related Social Needs (HRSN):** Implement strategies to support The Joint Commission (TJC) national patient safety goal (NPSG16) to reduce health care disparities for patients as a quality and safety priority; reduce barriers to health care caused by poverty, unemployment, and lack of transportation and other HRSN; support access to healthy food sources associated with positive health status.
4. **Improve Access to Care/Health Equity:** Provide advocacy and assistance in enrolling in state/federal health insurance plans; continue efforts to link patients with a primary care provider prior to being discharged from the hospital; increase efforts to serve the unique needs and challenges faced by persons of limited-English proficiency, at-risk veterans, the elderly, and other target populations.

