Saint Anne's Hospital

2024 Community Benefits

Implementation Strategy

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Steward

Mission Statement

Steward Health Care is committed to providing the highest quality care with compassion and respect.

We dedicate ourselves to:

- *Delivering affordable health care to all in the communities we serve*
- *Being responsible partners in the communities we serve*
- *Serving as advocates for the poor and underserved in the communities we serve*

Values

Compassion:

Providing care with empathy in such a way that the person experiences acceptance, concern, hopefulness and sensitivity

Accountability:

Accepting responsibility for continuous performance improvement, embracing change and seeking new opportunities to serve

Respect:

Honoring the dignity of each person

Excellence:

Exceeding expectations through teamwork and innovation

Stewardship:

Managing our financial and human resources responsibly in caring for those entrusted to us.

About Saint Anne's Hospital –

Founded by the Dominican Sisters of the Presentation in 1906, Saint Anne's Hospital in Fall River, Massachusetts, is a full-service, acute care Catholic hospital with 211 beds and satellite locations in Dartmouth, Attleboro, Swansea, and New Bedford.

A member of Steward Health Care, Saint Anne's provides nationally recognized patient- and family-centered inpatient care and outpatient clinical services to patients from surrounding Massachusetts and Rhode Island communities. Saint Anne's key services include the Center for Orthopedic Excellence; bariatric surgery; multiple robotic-assisted surgical capabilities, including orthopedic surgery, spine surgery, bariatric surgery, and general surgery; Saint Anne's Hospital Regional Cancer Center; two ambulatory surgery centers; the Center for Pain Management; and inpatient geriatric psychiatry services. In addition to earning the Leapfrog Group's "Straight A's" for patient safety since 2012, Saint Anne's has earned national recognitions for cancer care, spine surgery, bariatric surgery, stroke care, patient experience and patient safety. Follow us on Facebook, Instagram, and LinkedIn.

More information about Saint Anne's Hospital is available at saintanneshospital.org.

Community Benefits Mission Statement

Saint Anne's Hospital is dedicated to serving the health care needs of our community by:

- Providing accessible, quality health care services to all within our culturally diverse community, including the poor, vulnerable and disadvantaged, regardless of their ability to pay.
- Providing preventive health, education, and wellness services.
- Working in collaboration with our community to identify and respond to unmet needs.
- Educating community members around prevention and disease management, particularly for chronic diseases such as diabetes, heart disease, cancer, and substance use disorder.

- Addressing the social determinants or root causes of health disparities, including substance abuse, poverty, unemployment, housing, homelessness, domestic violence, sexual abuse, and behavioral/mental health issues.

- Recommending to Senior Leadership and to the hospital Board of Directors the adoption of programs and services to address identified, prioritized, and unmet health care needs in the community.

Community Benefits Statement of Purpose

Saint Anne's Hospital, in voluntary compliance with the Massachusetts Office of the Attorney General's Guidelines for Non-profit Hospitals, is committed to serving our community and, as such, outlines the following aims for our community benefits for the 2024 calendar year:

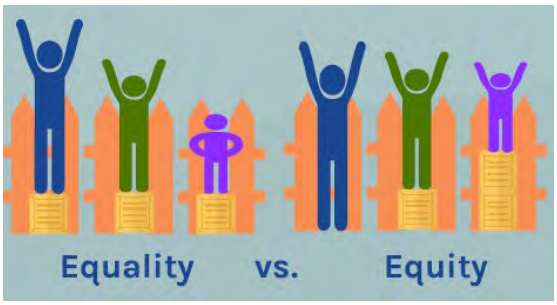
- Improve the overall health status of people in our service area through the lens of health equity.
- Provide accessible, high-quality care and services to all those in our community, regardless of their ability to pay.
- Collaborate with staff, providers, and community representatives to deliver meaningful programs that address statewide health priorities and local health issues.
- Identify and prioritize unmet needs and select those that can most effectively be addressed with available resources.
- Contribute to the well-being of our community through outreach efforts including, but not limited to, reducing barriers to accessing health care, preventive health education, screening, managing chronic health conditions, wellness programs, and community-building.
- Regularly evaluate our community benefits programs

Source: Saint Anne's Hospital Key Informant Survey, 2021

Adopting a Health Equity Lens

Health equity can be defined in many ways but is essentially a condition in which all people have the opportunity to be as healthy as possible, and in which no one is "disadvantaged from achieving this potential because of their social position or other socially determined circumstance."[1] 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 (see Figure 4). That is, while understanding the impact of social determinants of health within a community, it is also crucial to understand how underserved populations are disproportionately affected by social determinants (*source: Saint Anne's Hospital [SAH] 2021 Community Needs Assessment [CHNA])*

Figure 4
Equality Versus Equity



Community Health Needs Assessment

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

While the 2024 Community Health Benefits Implementation Strategy is based on the 2021 Community Health Needs Assessment (CHNA) in compliance with the Attorney General's Office (AGO) guidelines to conduct regular assessments on community health status, Saint Anne's Hospital will simultaneously conduct a CHNA in 2024. The goal of the 2024 assessment will be to identify still unmet and emergent community health needs, vulnerable, underserved populations, and gaps in existing community health services.

The 2024 CHNA will be completed by gathering and analyzing publicly available health indicators, conducting a review of the literature on population health, and assembling and reporting primary quantitative data. Community partner organizations such as Fall River Family Service Association, Child & Family Services, Steppingstone Incorporated, the United Way of Greater Fall River, and others will participate in the collection of primary qualitative data through key informant surveys and interviews, with the goal of achieving a high level of community engagement in the assessment process.

[1]Braveman, P.A., *Monitoring equity in health and health care: a conceptual framework*. Journal of Health, Population, and Nutrition, 2003. 21(3): p. 181.

As we continue to strive to be the premier regional choice for health care services in an evolving health care landscape, we must make significant investments in social determinants of health. It is well documented that race, ethnicity, and socio-economic factors are primary indicators of health status. SAH will collaborate with community partners to address social determinants of health, such as social and physical environments, housing, violence, and trauma, all of which place our community at greater risk for poor health outcomes. Together, with the leadership of our Community Benefits Advisory Committee (CBAC), we will work to improve the health and well-being of those in the targeted underserved population.

Targeted Underserved Populations

In 2024, Saint Anne's Hospital will focus our Community Benefits programs and initiatives on individuals and families who are most vulnerable due to:

- poverty
- homelessness
- trauma
- substance use disorder
- mental health disease
- chronic disease (i.e., diabetes, cancer, heart disease, substance use disorder)
- obesity/poor nutrition
- lack of access to health care
- lack of health insurance/under-insured/cost of health care
- Limited English Proficiency (LEP)/language barriers
- race
- ethnicity
- sexual orientation/gender identity/LGBTQ+
- at-risk elders
- at-risk veterans

Individuals/families displaced and/or disproportionately adversely affected by the pandemic (2020) have been identified as a specific targeted population. Data indicate that race, ethnicity, cultural diversity, and limited-English proficiency underlie health disparities. Additionally, in 2024, SAH will continue to address The Joint Commission's national patient safety goals to reduce health care disparities for patients as a quality and safety priority (NPSG16).

Building on our initiatives to embrace cultural diversity and inclusion, Saint Anne's Hospital will continue to promote person-centered, culturally competent care. This encompasses welcoming all and taking the extra time to engage patients while applying active listening skills. It may extend to learning more about a patient's culture to be able to connect. We will continue to ask our employees to increase their efforts, to "walk in our patients' shoes," to be able to support and care for them with even greater empathy and compassion. Saint Anne's Hospital/Steward Health Care is committed to learning new approaches in delivering care and to creating an environment of inclusion for all races, ages, religions, disabilities, ethnicities, sexual orientations, and gender identities.

Community Benefits Plan

In this Community Benefits Implementation Strategy, Saint Anne's Hospital has identified target populations it will support, specific programs or activities that attend to the needs identified in the 2021 Community Health Needs Assessment, and short- and long-term goals for each program or activity. SAH will identify opportunities for innovative community-clinical linkages, as well as policy, environmental and/or community-wide strategies, that will create self-sustaining community supported programs.

Saint Anne's Hospital will align its community benefits priorities and goals with guidance provided by the Massachusetts Attorney General's Office and the Department of Public Health. Our success in addressing community health issues present in the SAH service area will come from coordinated regional strategies with public health and population health management agencies, community partners, and community coalitions.

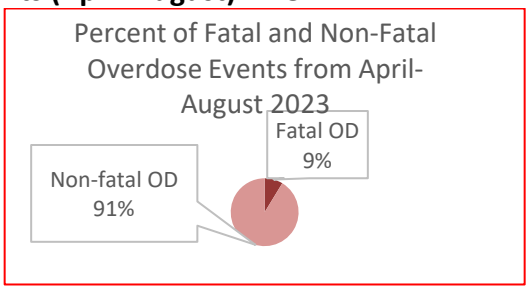
The priorities and the plan were approved by the Community Benefits Advisory Committee (CBAC).

Priority Issue	Sub-Categories
Behavioral Health	Mental Health, Substance Use Disorder, Trauma
Housing and Homelessness	Affordability and Stability, Barriers to Shelter/Housing
Wellness & Chronic Disease	Unhealthy behaviors, Health Outcomes, Prevention
Food Insecurity	Persons who are food insecure, SNAP Gap, Nutrition Literacy
Health Access and Equity	Underserved populations, Obstacles to Care, Health Literacy, Cultural Competency

The following Community Benefits Plan will be implemented and monitored for effectiveness.

Priority 1 - Behavioral Health-Mental Health, Substance Use Disorder & Trauma

- <u>Overdose Data in Fall River: April-August 2023</u>
  - **Total OD Events (April-August): 218**



  - Fatal OD: 9%
  - Non-Fatal OD: 91%

2023 Month	**Total OD Events**	**Rate per 10,000**
April	50	5.33
May	41	4.37
June	45	4.79
July	49	5.22
August	33*	3.52*

*Preliminary data, awaiting final review of fatal OD data from Medical Examiner

SAH, in collaboration with the Comprehensive Addiction and Recovery Act (CARA) team, provided ***FREE*** Narcan at discharge to patients and families who came through the SAH Emergency Department due to overdose.

Behavioral health/mental health issues were cited by key informants as the primary health challenge in the region, closely linked with many of the other health and community issues faced by residents. This is especially true of individuals with a substance use disorder, as evidenced by a growing population of patients with dual diagnosis, that is, individuals who experience a substance use issue along with a mental health issue. This patient population is also prone to chronic medical conditions due to and exacerbated by unhealthy behaviors and chronic neglect of self-care, such as COPD, lung cancer, hepatitis, malnutrition, Type 2 diabetes, obesity, and heart disease. Key informants and focus group members confirmed the link between substance abuse and mental health, noting that it is difficult to treat patients effectively if these issues are not addressed simultaneously.

For the SAH Primary Service Area (PSA), Fall River had significantly higher rates for alcohol and intravenous drug use. Focus group and community provider input revealed a concern for difficulty in accessing behavioral health resources, which often requires multi-disciplinary care coordination between primary care providers, patients, and mental health/substance use disorder specialists. Studies have shown that a coordinated approach to care management through specialized patient care navigators improves patient outcomes.

The opioid crisis of recent years has led to the creation of many task forces across Bristol County to address treatment, harm reduction, and overall services to adults with substance use disorders (SUD). This good work has seen a recent decrease in overdose deaths, but the incidence and negative impacts of substance use remain a significant concern. The negative impact of SUD on families and children is profound and multi-generational.

Program: Behavioral Health Navigation

Target Population: Patients with behavioral health disorders: mental illness, substance/alcohol use disorder or dual diagnosis
Responsible Party: Brittany M. Lynch, MSW, LICSW, Director of Patient Care Transitions/Social Work, Saint Anne's Hospital
Community Partners: Steward Health Care Network (SHCN)/Steward Choice, Community Counseling Services of Bristol County (CCBC) and other community agencies and providers to serve the complex needs of patients with behavioral health disorders.
Budget: includes salaries and administrative support for Behavioral Health Navigator role
Description: Provide screening/assessment, intervention, advocacy, and referrals to treatment/services for SAH Emergency Department patients and inpatients assessed/screened for substance/alcohol use disorder, mental illness, or dual diagnosis. Provide resources, education, and consultation on mental health and substance abuse services for patients and families.

Short Term Goals- 1 Year

1. Provide dedicated behavioral health patient navigation and advocacy to all frequent utilizers of emergency department services who screen positive for behavioral health needs.

2. Offer access to the SAH Addictions Nurse Specialist, the Peer Recovery Coach Program, and the Steward Health Care Network intensive care management programs to patients who present in the Emergency Department with behavioral and/or SUD in support of recovery.

3. Develop and maintain electronic care plans for frequent utilizers of the SAH Emergency Department to reduce recidivism, improve care coordination, and improve patient outcomes. Success of this goal depends upon providers accessing and updating the care plans.

4. Participate in at least 2 behavioral and mental health awareness meetings, events, or trainings in 2024.

Long Term Goals – 2-5 Years

1. In partnership with Steward Health Care Network (SHCN), improve patient outcomes and reduce cost for patients enrolled in Steward Health Choice (Medicaid and Medicare Accountable Care Organizations) by addressing the gaps in services for high-risk members with chronic disease, including behavioral health and/or substance use disorders.

2. Participate in the Massachusetts Department of Public Health-sponsored Emergency Department Information Exchange (EDIE) Program to improve care coordination for frequent utilizers of hospital-level EDs and to reduce ED recidivism caused by unmanaged chronic disease, including mental health or SUD.

Saint Anne's Hospital Aglow in Green in Recognition of May as Mental Health Awareness Month ~ joining the City of Fall River and other community partner organizations to raise awareness of Mental Health, Saint Anne's Hospital was lit in green the first week of May. ***May is National Mental Health Awareness Month.***

Fall River (69) had the fifth highest rate of opioid-related overdose deaths in the State, behind Boston (243), Worcester (105), Springfield (84) and New Bedford (81)

Source: MA DPH- June 2022

Program: Certified Addictions Nurse Specialist (CARN) –

Target Population: Patients and community members with substance/opioid/alcohol use disorder and/or dual diagnosis.
Responsible Party: RN, CARN, Addictions Nurse Specialist, Saint Anne's Hospital
Community Partners: Seven Hills Behavioral Health, Steppingstone Inc., Peer2Peer Recovery Project, SSTAR, HealthFirst Family Care Center, THRIVE for Humanity, FIRST Step Inn, Catholic Social Services, Police and Fire Departments in Primary Service Area (PSA), Departments of Public Health in PSA, School Districts in PSA, and other community-based agencies serving individuals with SUD or dual diagnosis.
Budget: Includes salary and administrative support for Addictions Nurse Specialist role.
Description: Integrates strong medical/surgical and mental/behavioral health nursing skills/judgment with knowledge of addiction and treatments to optimize patient care and recovery outcomes. Uses person-centered approach to care, including shared decision-making to promote patient self-determination. Serves as a resource to the community in educating on prevention; intervention strategies, including direct street outreach, overdose reversal and harm reduction; treatment options; and management of substance use disorder.

Short Term Goals – 1 Year

1. Recruit, hire and on-board the Addictions Nurse Specialist role, vacant since March 2022
2. Provide support, advocacy, and referrals to treatment for SAH ED patients and inpatients screened positive for SUD who consent to consultation.

3. Provide family and caregivers of those with SUD with recovery support educational materials.

Long Term Goals – 2-5 Years

4. Re-establish participation in community-wide "*Street Homeless Coalition*," with community partners including SSTAR's Mobile Health Treatment RV, the Fall River Police Department, and Thrive for Humanity, an ad-hoc committee to address barriers to treatment for those suffering from SUD, often with acute medical conditions including mental illness, and living in area encampments/unsheltered.

Program: Peer Recovery Coach Program

Target Population: Individuals with substance/opioid use disorder
Responsible Party: Tracy Ibbotson, M Ed., Administrative Director, Community Health Benefits, Saint Anne's Hospital
Responsible Clinical Partner: TBD, Addictions Nurse Specialist, Saint Anne's Hospital
Responsible Community Partner: Destinee Barnes, Director, Recovery Project, Steppingstone Incorporated
Budget: $12,000 annually
Description: In collaboration with Peer2Peer (P2P) Recovery Project, provide peer recovery support and services to patients with substance use disorder. Peer Recovery Coaches promote recovery by removing barriers and serving as role models and mentors. Guidance from a peer with similarly lived experience brings hope and a sense of belongingness that are critical to substance use recovery.

Fall River continues to be devastated by the opioid overdose epidemic in Massachusetts, and the pandemic served only to amplify this crisis. While this epidemic continues, persons seeking recovery in our community experience numerous barriers, including long wait lists for treatment, untreated symptoms of co-occurring health conditions, lack of financial resources to pay for treatment, and other challenges.

Saint Anne's Hospital is privileged to partner with P2P, not only by bringing Peer Recovery Coaching into the hospital, but also by supporting Peer Recovery Center to provide a safe space for individuals to work on their recovery goals, participate in one-on-one support, group support and education, as well as recovery, recreational and wellness groups, and activities.

Short Term Goals – 1 Year

1. Offer Recovery Coaching Services to 100% of SAH Emergency Department patients and inpatients assessed/screened positive for SUD.

2. Provide at least one health promotion workshops/trainings to Peer Recovery Coaches at the Peer Recovery Center or in the community (i.e., wound care, diabetes education, stroke awareness).

Long Term Goals – 2-5 Years

1. Increase health literacy among those recovering from substance use disorder by providing a least 2 health promotion activities at the Peer Recovery Center annually over 5 years. Goal delayed due to COVID.

SAH Changing the Culture of Caring for Patients with Substance Use Disorder in Action

SAH addiction nurse specialist presented "***Caring for Persons with Substance Use Disorder*"** as part of a 16-week, 400-hour training unit of Clinical Pastoral Education at Saint Anne's Hospital. The training program is accredited by the Association of Clinical Pastoral Education (ACPE) and provides training for multi-faith ministry in health care and community settings. It is conducted by Marika Hull, MDiv, board certified chaplain and ACPE certified educator. Marika wrote about the presentation, "*The experience and insights shared expanded the CPE students' awareness of, and compassion for, the difficulties and challenges faced by persons with substance use disorder."*

Program: Saint Anne's Hospital Clinical Pastoral Education (CPE) Program –

Target Population: Local clergy and lay persons of all faiths and spiritual beliefs with a Master 's degree in a theological or related discipline and/or significant experience related to faith community work.

Responsible Party: Marika H. Hull, MDiv, BCC, Board Certified Chaplain, ACPE Certified Educator

Responsible Clinical Partner: Sr. Carole Mello, O.P., BSN, MA, BCC, Administrator of CPE, Director of Spiritual Care and Mission Values

Responsible Community Partner: Tracy Ibbotson, M Ed., Administrative Director, Community Health Benefits, Saint Anne's Hospital

Budget: Tuition ($1,000 per unit) paid by student and credited to Spiritual Care Department budget. The following costs are accounted for in the Spiritual Care Department budget: per student registration fee for ACPE credit ($230); yearly membership fee for Certified CPE Educator ($500); yearly ACPE membership fee for CPE Program dues ($2,000); annual salary CPE Certified Educator; and incidental expenses.

Description: Clinical Pastoral Education (CPE) is a process-oriented and experiential method of training for spiritual care providers. The CPE model focuses on training spiritual care providers

in ways of meeting religious/spiritual needs in multi-faith settings. Spiritual Care is a discrete discipline that participates in the interdisciplinary care of the whole person that promotes spiritual well-being and recognizes that spiritual needs are affected by many factors including, but not limited to, socio-economic status, race, gender, culture, religion, belief system, emotions, disease, and socio-demographic factors. The CPE training process touches on all the priorities of the Community Benefits program at SAH; and for the purposes of this report, CPE has been placed under the "Behavioral Health" section in order to adhere to the current reporting format. Saint Anne's Hospital Clinical Pastoral Education (CPE) program is accredited by the Association of Clinical Pastoral Education (ACPE). ACPE is the only United States Department of Education (USDE) recognized accreditor for programs of CPE.

Short Term Goal – 1 year

1. Train 4-8 multi-faith chaplains.

Long Term Goal – 2-5 years

1. To extend educational opportunities for spiritual care and clinical staff to learn about best practices in multifaith chaplaincy.

Priority 2 – Housing Stability/Affordability and Homelessness

> ***"The interconnectedness between homelessness, mental health, and substance use disorder was a top issue among key informants. 36.3% of homeless adults have a serious mental illness and 30.8% have a substance use disorder. Providers noted that these issues need to be tackled simultaneously for maximum impact."***
>
> ***(Source: 2021 SAH CHNA)***

While not directly a health issue, housing stability and quality can have a great effect on health outcomes. Housing issues identified by key informants focused primarily on quality, affordability, and availability. A report conducted by the Public Policy Center in 2017 concluded that Fall River's existing housing stock consists largely of units occupied by renters in multifamily buildings constructed prior to 1940[2]. Stakeholder interviews revealed that older multifamily units in low-income neighborhoods were perceived to be deficient, and that a lack of code enforcement and low property values provide little incentive for landlords to meet the Commonwealth's minimum housing standards, which creates substandard living conditions for tenants.

In addition, while rents and home prices in Fall River are relatively affordable compared to statewide median housing costs, many families in the city still struggle to find affordable housing. In order to secure housing, some have to rent or buy at costs that are above their means, increasing the cost-of-living burden on these low-income households. Some key informants and focus group members identified homelessness as a significant issue in the

[2] Source: http://publicpolicycenter.org/wp/wp-content/uploads/2016/11/ Towards-an-Evidence-Based-Housing-Policy-in-Fall-River-Massachusetts.pdf.

region, which is partly a result of a shortage of affordable housing. Mental health and substance abuse issues, which are highly prevalent among the homeless population, are also key factors in the homelessness equation[3].

Fall River has participated in the U.S. Department of Housing and Urban Development's Point in Time (PIT) Counts for more than 22 years. This is an annual count of sheltered and unsheltered homeless persons on a single night in January[4].

Expanding on existing collaborative strategies and goals to further address the region's housing and homelessness issues are key components of this implementation strategy.

Program: Outreach and Advocacy – Housing Stability and Homelessness

Target Population: Individuals and families experiencing or at risk for housing instability or homelessness.
Responsible Party: Tracy Ibbotson, M.Ed., Administrative Director, Community Health Benefits
Responsible Community Partner: Mary Camara, Coordinator of Homeless Programs, Fall River Community Development Agency, City of Fall River, Chair, Mayor's Task Force to End Homelessness
Community Partners: City of Fall River, Fall River Police Department, Fall River Fire Department and EMS, Medical-Legal Partnership Boston (MLPB), Social Justice Center of Southeastern MA, Fall River Housing Authority (FRHA), Steppingstone Incorporated First Step Inn, Catholic Social Services, United Way of Greater Fall River, MDPH, Eliot Homeless Services, Steward Health Care Network, City of Fall River Department of Veterans Services, and other community non-profit service organizations, including faith-based.

SAH will continue to partner with organizations that actively implement programs promoting safe and stable housing, fostering education, promoting a skilled labor force, addressing issues of food insecurity, and providing social services to underserved populations. Specific attention will be focused on those who are more likely to have limited access to stable housing, safe and supportive environments, and opportunities for higher learning. Participate in the city-wide annual Point-In-Time (PIT) Study of Unsheltered Homelessness Population in Fall River.

Short Term Goals – 1 year

1. Remain an active member of the Mayor's City-Wide Task Force to End Homelessness to connect representatives from the City Task Force and Steward Health Care Network's Steward Choice Medicaid ACO Outreach Team, on a quarterly basis, to explore opportunities to share data, expand services, and prioritize resources to prevent homelessness.

2. Participate in the city-wide annual Point-In-Time (PIT) Study of Unsheltered Homelessness Population in Fall River, scheduled in January 2024.

[3] Source: https: //www.nationalhomeless.org/factsheets/addiction.pdf. Retrieved December 17, 2018.
[4] Source: https://www.hudexchange.info/resources/documents/2017-AHAR-Part-1.pdf

Long Term Goal -2-5 years

Leverage position as an anchor organization to engage the City of Fall River, other health care systems and community partner organizations, including the private sector through the Fall River Chamber of Commerce, to participate in large-scale community health improvement planning by developing and implementing a multi-year, multi-tiered Community Health Improvement Plan (CHIP) by 2027.

Priority 3 - Chronic Disease–Cancer, Heart Disease, and Wellness/Health Promotion

Primary data, as well as focus groups and provider input gathered during the 2021 Community Needs Assessment, recognized chronic disease as a major community health issue with a focus on addiction and mental health. Addiction or substance use disorder is a chronic, incurable but treatable brain disease. Patients with addiction or substance use disorders usually present with co-morbidities such as diabetes, hypertension, hepatitis, pancreatic disease, heart failure, HIV, mental illness, and poly-substance use. Given their early age of onset and poor rates of recognition and treatment, behavioral health conditions are arguably among the most chronic illnesses[5].

As noted in the Community Health Needs Assessment, health and wellness often compete with more immediate day-to-day priorities for many Greater Fall River residents. Consequently, chronic disease prevalence is much higher in comparison to state and national averages. This includes higher rates of cancer, diabetes, coronary heart disease, stroke, chronic obstructive pulmonary disease (COPD), and asthma. Data also suggest that people with chronic diseases are more likely to go to hospitals and emergency rooms. Transitioning from one care setting to another increases an individual's susceptibility to receive fragmented care. The SAH 2024 Implementation Strategy will address these chronic conditions through screenings: specialized care coordination and referrals to community-based health education, and disease management support services.

Cancer:

Saint Anne's Hospital Regional Cancer Center Psychosocial Services bring together expert clinicians and services to support all aspects of care – from health-related social needs (HRSN) like stable housing and income supports, to assistance with care navigation and access to treatment.

Program: Specialized Oncology Nurse Navigator

Target Population: Individuals with a cancer diagnosis, including family members and significant others.
Responsible Party: Oncology Nurse Navigator, Saint Anne's Hospital Regional Cancer Center
Budget: includes salary and administrative support for Oncology Nurse Navigator role
Description: As the patient's main contact for information and guidance, the oncology nurse navigator aids through care coordination, referrals for financial assistance, treatment planning, and other support as needed.

[5]Source: https://www.saintanneshospital.org/about-us/community-health-outreach

Short Term Goals- 1 –Year

1. Offer comprehensive cancer care navigation to 100% of cancer patients.

Long Term Goals – 2-5 Years

Through the development and implementation of strengths-based screening tool for HRSN, intervene upstream, reducing the number of cancer patients who self-report episodes of housing or income instability or other barriers to care.

Program: Psychosocial Oncology Social Work Services

Target Population: Individuals with a cancer diagnosis and their caregivers
Responsible Party: Carrie Mathers-Kurland, LICSW, Manager, Psychosocial Oncology Services, Saint Anne's Hospital Regional Cancer Center
Budget: includes salary and administrative/programmatic support for the Oncology Social Work roles and services.
Description: Specialized social workers assist patients and families with psychosocial support and resources, including increased assistance with health-related social needs, ranging from financial counseling to assistance in health insurance enrollment and/or expanded coverage; and transport services to reduce barriers to accessing health care/cancer treatments.

Short Term Goal – 1-year
Address HSRN and barriers to care for 100% of cancer patients screened positive for health-related social needs by helping with food insecurity, housing or income instability, prescription medication costs, and transportation concerns.

Long Term Goal – 2-5 years
Through the development and implementation of strengths-based screening tool for HRSN, reduce the number of oncology patients who self-report episodes of food, housing or income instability or other barriers to care.

Program: Cancer Support and Wellness Programs

Target Population: Individuals with a cancer diagnosis, including caregivers.
Responsible Party: Carrie Mathers Kurland, LICSW, Manager, Psychosocial Oncology Services, Saint Anne's Hospital Regional Cancer Center
Responsible Community Partner: American Cancer Society (ACS)
Budget: Expenses associated with programs
Description: Program offerings include cancer support groups (e.g., Life Part II, Facing Cancer Together); Gratitude Journaling; Mindfulness/Meditation Training; Fundamentals of Watercolor Painting and other creative arts; access at SAH to an American Cancer Society-supported wig boutique; a patient/community member resource room; and access to complimentary transportation for eligible oncology patients who would otherwise be unable to access care.

Short Term Goal – 1 year

1. Increase the number of individuals benefiting from our oncology support and wellness programs.

2. Provide transportation assistance to cancer treatment for 100% of hardship-eligible patients who would otherwise be unable to access care.

Long Term Goal – 2-5 years

Continue to provide complementary support and wellness programs for community members diagnosed and living with cancer.

Heart Disease/Stroke and Respiratory Disease – Chronic Obstructive Pulmonary Disease (COPD)

Smoking prevalence in Fall River and New Bedford remains higher than that of the state and country as a whole: 26.9% of Fall River residents and 25.9% of New Bedford residents report that they smoke, compared to 14.3% of Massachusetts residents and 16.8% of residents nationwide. In addition, 35.8% of Fall River and 36.4% of New Bedford residents report they have not engaged in any form of physical activity in the past 30 days, which is greater than both the statewide (26.0%) and national (25.2%) percentages. Although chronic conditions can be genetic, poor nutrition, tobacco use, lack of physical activity, and other unhealthy behaviors elevate the risk of developing chronic disease[6].

Target Populations: Those at risk for or diagnosed with heart disease, stroke, chronic obstructive pulmonary disease, asthma, or related co-occurring chronic diseases; smokers; and individuals who are sedentary, have high blood pressure and poor nutrition.
Responsible Parties: Tracy Ibbotson, M.Ed., Administrative Director of Community Health Benefits; Robert Folger, Clinical Director of Cardiac Services; Lisa DeMello, MSN, RN, ACNS-BC, Clinical Nurse Specialist/Stroke Coordinator
Responsible Community Partner(s): American Heart Association (AHA), American Cancer Society (ACS), American Lung Association, American Stroke Association (ASA), MA Department of Public Health's Quitworks Program, and other community organizations.
Budget: includes salary and administrative support for program
Description: Provide referrals for education, support and/or disease management for individuals with or at risk for developing heart disease/stroke and respiratory disease due to obesity, poor nutrition, sedentary lifestyle, adverse health behaviors, and other risk factors.

Short Term Goals – 1 year

1. Offer smoking cessation treatment and support to 100% of patients screened positive for tobacco use with co-occurring chronic diseases, such as heart disease, COPD, etc.

[6]Source: https://www.saintanneshospital.org/about-us/community-health-outreach

2. Participate in 2 health educational programs and offer at least 2 blood pressure screenings in partnership with community organizations to increase awareness of heart disease and stroke and other circulatory diseases.

Long-Term Goal – 2-5 years

1. Refer all patients who present in the Emergency Department and inpatient with chronic conditions to be enrolled in intensive coordinated outpatient care management programs.

2. Contribute to lowering the incidence rates of heart disease/stroke and respiratory disease/chronic obstructive pulmonary disease (COPD) through ongoing education and intervention supports. Offer at least 3 education programs annually on this topic in partnership with schools and other youth/family serving organizations.

Program: Breast Disease Management Patient Navigator

Target Population: Individuals diagnosed with/or at risk for breast disease.
Responsible Party: Linda Franco, MS, RT, CRA, Director of Diagnostic Imaging Services and Heather Czaja, RN, BSN, Breast Health Patient Navigator
Budget: includes salary and administrative support for the Breast Health Patient Navigator role
Description: As the patient's main contact for information and guidance, the patient navigator coordinates resources into a seamless model of access, care, and support that benefits patients, family members and participating clinicians; addresses patient needs throughout the care continuum to reduce gaps in the care process; provides education; improves timeliness of care; coordinates complex care processes; and develops plan for long-term and survivorship care. Serves as an educational resource and promotes awareness of programs and services, both hospital- and community-based, including assistance with health insurance navigation and other health-related social concerns.

Short Term Goals

1. Provide specialized, dedicated patient navigation support to 100% of referred patients, providing support and guidance through complex health care issues, including addressing barriers to care.

2. Screen for HRSN and refer patients as needed to the social worker to be assessed for additional service supports, including health insurance navigation and enrollment assistance, and transportation for care.

Long Term Goals – 2-5 Years

Offer specialized, dedicated patient navigation support to 100% of new patients and to those who return after surgery or extended time away from care, including screening for HRSN.

Program: Health Promotion and Disease Prevention Education and Outreach

Target populations: Under-served, hard-to-reach populations, including those who are experiencing homelessness, suffering from mental health and/or substance use disorders, members of the LGBTQA community, veterans, at-risk elders and youth, culturally diverse

individuals, Limited English Proficient (LEP) community, Black, Indigenous, and Persons of Color (BIPOC).

Responsible Parties: Tracy Ibbotson, M.Ed., Administrative Director, Community Health Benefits, Saint Anne's Hospital

Community Partners: Greater Fall River Partners for a Healthier Community (CHNA25), BOLD (Building Our Lives Drug-Free) Coalition, all area public schools, City of Fall River and all other PSA municipalities, Steward Health Care Network/Steward Choice ACO, Diabetes Association/People Incorporated Inc., Fall River YMCA, Fall River Boys and Girls Club, Steppingstone Inc., SSTAR, Health First Family Care Center, United Way of Greater Fall River, Bristol Elder Services, Coastline Elderly Services, Bristol County District Attorney Office, Veterans Administration, Immigrants Assistance Center (IAC), Fenway Health, LGBTQA+ SouthCoast Network, other community not-for-profits, and local businesses.

Budget: includes salary and administrative support for program goals

Description: Provide health education and screenings to target populations. Partner with Steward Health Care Network ACO and other community partners to engage primary care providers in community health training and initiatives to improve population health.

Short Term Goals

1. Provide a minimum of 2 free screenings for chronic diseases and provide educational material on high-risk behaviors that cause chronic disease.

2. Provide a minimum of 2 free education and wellness programs to target populations where they live, work, study, and worship. Focus program on topics such as substance use disorder, mental health, nutrition literacy, obesity/malnutrition, healthy aging, and chronic disease management.

Priority 4 - Food Insecurity & Social Determinants of Health (SDOH)

According to the Massachusetts Department of Public Health, underserved populations include individuals who have limited access to primary care services; face economic, cultural, or linguistic barriers to health care; and reside in specific geographic areas. Social determinants of health, including social, behavioral, and environmental influences, have become increasingly prevalent factors in addressing population health. A growing body of research indicates that living and working conditions, including housing quality, exposure to environmental pollution, worksite safety, access to healthy and affordable foods, and proximity to safe places to exercise, have a significantly greater effect on health than risky behaviors. Such associations increasingly support connecting health care systems and social service agencies as part of a comprehensive strategy to improve the quality of living and population health status.

In 2023, 85% of total sales at the SAH Market were made using HIP/SNAP benefits and 10% were made using Farmers Market Nutrition Coupons for the elderly and Women, Infants & Children (WIC). Total sales increased by 10% over 2022.

"My first 11 customers told me this was the first time they had used their SNAP benefits to purchase fruits and vegetables." (September 26) Laura Smith, Owner- "Farm her," Lane Gardens and Oakdale Farms

Program: Reducing Food Insecurity

Target Population: Greater Fall River residents living at or below the poverty line who are at risk for hunger, malnutrition, and chronic disease due to poor nutrition.

Responsible Party: Tracy Ibbotson, M.Ed., Administrative Director of Community Health Benefits

Responsible Community Partners: Greater Fall River Community Food Pantry, First Baptist Church, and other area food pantries; Fall River Mass-in-Motion, City of Fall River, Southeastern Massachusetts Agricultural Partnership (SEMAP), and Laura Smith, Farmer/Owner, Lane Gardens & Oakdale Farms, Rehoboth, MA

Description: Provide monthly cash allocation to the Greater Fall River Community Food Pantry and SAH employees to volunteer at area soup kitchens and proved other support as needed. Support community partners' efforts to provide access to fresh, locally grown produce by hosting on-site SAH farmer market that accepts the Massachusetts Supplemental Nutrition Assistance Program (SNAP) and Healthy Eating Program (HIP) benefits providing access to the residents of the South End of Fall River, an economically, disadvantaged neighborhood.

The City of Fall River continues to have a lower median income than the state average and a higher number of individuals and families who are dependent on some form of public assistance. Nearly 70% of children in the Fall River schools are identified as economically-

disadvantaged and eligible for the reduced/free lunch program[7]. For many families and individuals, buying sufficient, nutritious food is often not possible. Recognizing the link between poor nutrition and health status more than two decades ago, the hospital helped launch the Greater Fall River Community Food Pantry and continues to support this community-wide initiative to reduce food insecurity. Open several days a week and located at a stand-alone and improved location on Nashua Street, the Food Pantry staff distribute food to more than 10,000 families annually.

To ensure a wider distribution of its food subsidy and assist vulnerable community members with access to healthy, adequate food, Saint Anne's Hospital provides monthly financial subsidies to the Greater Fall River Community Food Pantry.

Short Term Goals - 1 year

1. Reduce food insecurity and support access to healthy food sources by providing financial support to the Greater Fall River Community Food Pantry. Track number of community members benefiting from program.

2. Maintain community engagement by SAH staff who volunteer their time by serving at least 4 dinners annually at the First Baptist Church Soup Kitchen.

3. Host an SAH on-site farmer market that accepts the Massachusetts Supplemental Nutrition Assistance Program (SNAP) and Healthy Eating Program (HIP) benefits**.** Year 3 of this program. Expand usage of HIP/SNAP benefits by 2% over 2023.

Long Term Goals – 2-5 years

Continue SAH-based and Steward Health Care Network (i.e., Steward Health Choice ACO) outreach programs to help patients and community members gain access to social services and navigate the health care system, and to facilitate healthy living programs. Expand the reach of these programs by 2% annually.

Program: Compassionate Care Program/Marie Poussepin Outreach Ministry (MPOM)

Target Population: Individuals who face barriers to care due to financial hardship/ poverty/stigma/racism.
Responsible Party: Tracy Ibbotson, M.Ed., Administrative Director of Community Health Benefits
Responsible Community Partner: Sister Glorina Jugo, OP, Dominican Sisters of the Presentation, Fund Administrator, Marie Poussepin Outreach Ministry (MPOM).
Community Partners: Standard Pharmacy, Greater Fall River Food Pantry, the Dominican Sisters of the Presentation, First Baptist Church, United Interfaith Action, Medical-Legal Partnership MLPB-Health, Social Justice Center of Southeastern MA, Bristol Elder Services, Coastline Elder Services, Fall River Housing Authority, Steppingstone Inc., Peer2Peer Recovery Project, Catholic

Social Services, City of Fall River, Veterans Services, and other community non-profit service organizations.

Budget: The Marie Poussepin Outreach Ministry is reported as a leveraged resource. Saint Anne's Hospital provides financial and administrative support. Saint Anne's Hospital fully funds its Compassionate Care Program.

Description: Saint Anne's Hospital Compassionate Care Program and the Marie Poussepin Outreach Ministry exist in response to the needs of the poor and indigent in our community. These programs provide vouchers for taxi services and bus passes for health care needs to persons who are vulnerable, disadvantaged and who would otherwise be unable to access care. Vouchers are also provided for food, clothing, emergency housing, and other emergent needs. With the city of Fall River being among the highest ranking for poverty and unemployment, the program sees an increase in requests year over year.

Short Term Goal – 1 Year

Reduce barriers to health care access caused by racism, poverty, unemployment, chronic diseases, language, lack of transportation and other factors by providing vouchers for basic needs including taxi services to persons who are otherwise unable to meet basic needs and/or access care.

Long Term Goals – 2-5 Years

Continue SAH-based and Steward Health Care Network (i.e., Steward Health Choice ACO) outreach programs to help patients and community members gain access to social services, facilitate healthy living programs, and navigate the health care system. Expand the reach of programs by 2% annually.

Priority 5 - Health Equity, Access and Cultural Competency

"I am frequently in area emergency departments helping individuals with complex medical issues, including diseases that present with symptoms labeled as 'difficult', 'non-compliant' and 'aggressive', and everyone at Saint Anne's Hospital is just kinder."

~ Clinical Outreach Worker, Jan. 2023~

Saint Anne's Hospital Primary Service Area (PSA) is culturally diverse and has lower levels of education and income and higher numbers of Limited English Proficient (LEP) speakers compared to the rest of the Commonwealth of Massachusetts.

Saint Anne's Hospital serves a large proportion of patients who are enrolled in government-subsidized health plans, as well as many uninsured or under-insured individuals presenting for care. Despite improvements in coverage, vulnerable populations, such as undocumented residents and the working poor, still experience barriers to accessing care.

In key informant surveys and community-based focus groups, the lack of confidence in and understanding of health insurance benefits and enrollment were consistently identified as barriers to care**.** Research indicates that individuals who have health insurance participate more actively in preventive care, reducing costly and avoidable emergency room visits. Saint Anne's

Hospital is committed to providing culturally and linguistically competent health insurance education and enrollment assistance to any person seeking access to health care and/or health benefits.

With the implementation of the Accountable Care Organization (ACO) model of care, it has become essential to have primary health care providers at the center of initiatives to improve community/population health. The success of this will be determined by the commitment from primary health care providers to learn more about the community they serve through cultural competency, population health education, and explicit attention to the social determinants of health. The benefits to primary health care providers would be in achieving the "Triple Aim," the *Institute for Healthcare Improvement* (IHI)'s term for "simultaneously improving the experience of care, the per capita costs of health care, and the health of populations."[8]

Program: The Joint Commission (TJC) National Patient Safety Goals to Reduce Health Care Disparities for Patients as a Quality and Safety Priority (NPSG16)

Target Population: Patients at-risk for disparities in health care due to race, ethnicity, age, gender, sexual orientation, gender identity, and/or other sociodemographic characteristics.
Responsible Party: Tracy Ibbotson, M.Ed., Administrative Director of Community Health Benefits; Kandace Vieira, RN, MSN, Director, Quality, Regulatory, and Patient Safety
Community Partners: Any organization in the catchment area serving the target population and advancing the health equity goals as identified and outlined in this Implementation Strategy.
Description: The development of standardized structures and processes to detect and address disparities in care. Strategies will be fully integrated with existing quality improvement activities elevating them to the level of other high priority patient safety issues, such as infection prevention and control, antibiotic management, and workplace violence. The implementation plan must include the following elements of performance: designating an individual (s) to lead activities to reduce health care disparities for patients; assessing patients' health-related social needs (HRSN) and providing information about community resources and support services; identifying health care disparities in the patient population by stratifying and analyzing quality and safety data by sociodemographic characteristics of the patients (examples include age, gender, preferred language and/or race & ethnicity); developing a written action plan that describes how at least one of the health care disparities identified will be addressed; initiating corrective action when identified health care disparities are not reduced; and informing, at a minimum annually, key stakeholders about progress made to reduce health care disparities within the patient population.

Goals – Program – second year - 2024

1. Assess patients' HRSN assessment by adding question(s) to the nursing assessment about food, housing, access to medications and transportation.

2. Provide patients with information about community resources and support services specific to their HRSN.

[7] Source: Donald M. Berwick, Thomas W. Nolan, and John Whittington, (2018). The Triple Aim: Care, Health, and Cost*, Health Affairs 27, 3.*

3. Stratify patient quality and safety data by selected sociodemographic characteristics.

4. Review data at 3-month mark and analyze for trends/opportunity to reduce disparities.

5. Based on data analysis develop a written action plan with ongoing monitoring.

6. Monitor progress and take corrective action as needed.

7. Report annually to stakeholders, including leaders, licensed practitioners. and staff, about progress made to reduce health care disparities within patient population.

Long-Term Goal – 2-5 years

1. The development of standardized structures and processes to detect and address disparities in care as part of standard level of care.

Program: Health Insurance Advocacy and Resource Liaison

Health Equity through Access Equity **to Health Insurance: Helping our patients and community members one person at a time.**

> ***"Hi, Naomi, I just connected a caller to your voicemail, she has questions about enrolling in MassHealth."*** Tracy Ibbotson, Administrative Director, Community Benefits

Naomi Patricio, Health Insurance Specialist Supervisor, responded,

> *"I* ***called her back and she will come see me so I can assist her to complete an application…***
>
> ***"She lives in a trailer on her elderly parents' property so she can look after them. She said she called so many people to assist her with applying for MassHealth and no one was able to assist her to get the coverage, not sure why since she is definitely eligible.***
>
> ***"By the time she left Saint Anne's Hospital, she and spouse were both approved for Mass Health. I explained to her she needed to establish herself and spouse with a Primary Care Physician (PCP) for medical services they both need. I advised her to call me back as soon as she chose a PCP.***
>
> ***"She called me back same day and gave me the name of the PCP she had chosen. I then called Mass Health and on a three-way conference call enrolled both of them with the Steward Health Choice ACO so they can both be seen asap.***
>
> ***"The next day I checked their eligibility to be sure the Steward Health Choice was listed correctly and then called her to tell her that both she and spouse were covered and emailed her the eligibility printout to use until they received their insurance cards.***

"She stated she is just so grateful to have met me and for all the assistance I gave them and how knowledgeable I am on these programs.

"I told her this is the most rewarding job anyone can have to be able to assist the community in such a small way but can go very far with medical coverage for all their health needs."

Health Insurance = Access to Health Care

Target Population: Individuals who face barriers to care due to financial hardship/poverty, language, lack of access to health insurance, low health literacy, and other health disparities.
Responsible Parties: Tracy Ibbotson, M.Ed., Administrative Director of Community Health Benefits; Naomi Patricio, Tri-lingual, Supervisor, Health Insurance Specialists, Saint Anne's Hospital
Community Partners: Steward Health Care, Steward Health Care Network (SHCN), City of Fall River Department of Veterans' Services, Medicare, Mass Health, all other health insurance payers, and all government and private human service agencies.
Budget: includes salary and administrative support for the Health Insurance Specialist/ Community Resource Liaison role
Description: Provide the target population with culturally and linguistically competent education, advocacy and assistance in enrolling uninsured and under-insured individuals and families in the most appropriate state/federally- funded health insurance plans. Support efforts to assist at-risk veterans and their families with obtaining eligible benefits. Resource Liaison role also includes health promotion outreach to targeted, under-served, hard-to-reach populations, including those who are experiencing homelessness, suffering from substance use disorder, at-risk elders, and/or members of the LGBTQA community.

Short Term Goals

1. Improve access to health care for target population by increasing the number of those assisted with health insurance enrollment, including access to emergent coverage as an approved site for Health Presumptive Eligibility (HPE).

2. Provide culturally and linguistically competent health-promotion outreach education and benefit assistance to culturally diverse community members. Increase efforts to offer this assistance in community-based settings by participating in at least 2 culturally and linguistically competent education programs.

Long Term Goals – 2-5 years

1. Continue to improve access to health care for the target population by helping with health insurance enrollment.

2. Increase the health literacy, including nutritional literacy, of at-risk, under-deserved target populations.

Community Strengthening/Cultural Competency

Health care organizations such as Saint Anne's Hospital need highly skilled staff to provide high-quality care. Quality health care is an essential component of a region's quality of life, as well as an economic advantage. Employers must be part of the education system, supporting students and their staff to further develop skills and knowledge. Doing so ensures new workers are prepared for today's jobs and continue to grow and learn in these roles to become leaders. We keep our best and brightest in the region to the benefit of all as they become parents and active community members.

Workforce development is a vital function of well-established community hospitals. SAH is committed to developing the skills of the workforce in our community, local schools, and among our employees. Saint Anne's Hospital/Steward Health Care is committed to learning new approaches in delivering care and to creating an environment of inclusion for all races, ages, religions, disabilities, ethnicities, sexual orientations, and gender identities. It is imperative that we ensure a culturally competent and diverse workforce that can provide the services needed to meet the demand brought on by policy changes in the health industry.

Program: Multicultural Health Scholarship Program

Target populations: Bicultural, bilingual students pursuing a degree and/or an advanced certification in health care or related field.
Responsible Parties: Denise Paulson, CMI, Manager, Interpreter Services**;** Tracy Ibbotson, M.Ed., Administrative Director Community Health Benefits
Responsible Community Partners: Tina Shorette, Youth Employment Specialist, MASS HIRE YOUTH CONNECTION and affiliated schools; Marcia Picard, Executive Director/School Wellness Coordinator, Greater Fall River Partners for a Healthier Community
Budget: $6,000
Description: The SAH Multicultural Health Committee (MHC), an ad-hoc sub-committee of the CBAC, will award $6,000 in scholarships to bilingual/bicultural students pursuing degrees in health care or a related field in the 2023-24 academic year. The scholarship program advances SAH Community Benefits' long-term goals to increase diversity and cultural competency in the health care workforce. The MHC program was recognized in 2021 by the MA AGO for advancing health equity.

Short Term Goal -1 year
1. Award 6 MHC scholarships in 2024

Long Term Goals- 2-5 years
2. Increase diversity and cultural competency in the health care workforce

Program: Student Preceptor Program

Target populations: Students in final phases of training in health care related fields
Responsible Parties: Cheryl Herman, Manager, Education, and Policies, Department of Professional Practice, Research and Development
Responsible Community Partners: Local colleges and universities that have clinical affiliations with SAH.
Budget: includes salary and administrative support for the program

Description: Provide a clinical learning environment for preceptor program, one-on-one training with a licensed experienced practitioner and other clinical training programs. The SAH Preceptor/Trainer participates in identification of learning needs of the student; sets goals with the student in collaboration with the faculty and curriculum; acts as a role model; provides patient care in accordance with established, evidence-based professional practice standards; fulfills duties according to hospital and unit policies and procedures; maintains mature and effective working relationships with other health care team members; demonstrates leadership skills in problem solving, decision-making, priority-setting, delegation of responsibility and accountability; provides the student with feedback on his/her progress, based on preceptor's observation of clinical performance, assessment of achievement of clinical competencies and patient care documentation; participates in educational activities to promote continued learning and professional growth; and participates in ongoing evaluation of the program. There are many aspects of being a preceptor to a student that require a long-term, focused commitment.

Short Term Goal – 1 year

1. Track number of students benefiting from this program in 2023 with goal to grow number in 2024.

Long Term Goal – 2-5 years

1. Sustain educational programs that further develop the local health care workforce.

Program: Job Shadow/Student Observer

Target populations: Individuals who wish to explore professions or satisfy direct observation requirements for applications to clinical programs (i.e., physician assistant programs, rehabilitation services programs).

Responsible Parties: Tracy Ibbotson, M.Ed., Administrative Director of Community Health Benefits

Budget: includes salary and administrative support for the program

Description: The Shadow/Observer is a direct observation experience for students or individuals who wish to explore professions, satisfy direct observation requirements for applications to clinical programs (e.g., PA School, Rehabilitation Programs in PT, OT and/or Speech Therapy), Medical School (e.g., DO programs), or at the request of credentialed physicians for medical students from unaffiliated medical schools for case observation and/or hospital patient rounding. The Shadow/Observer experience is typically one day or a cumulative 8-hour experience. Experiences lasting longer than one day or being completed over a series of observations can be arranged on a case-by-case basis and only at the request of the supervising clinician who always maintains responsibility for the Shadow/Observer while on-site at Saint Anne's Hospital. Shadow/Observer must be 18 years of age or older.

Short Term Goals - 1 year

Provide a clinical environment and clinical staff support for Observer/Job Shadow program and foster an increase in the number of individuals benefiting from this program by 2% over 2023.

Long Term Goals - 2-5 years

Develop an action plan to expand workforce development for our local workforce partnering with schools and universities, as well as employees, through job shadow and health career day programs.

Community Support/Sponsorships/Donations

Target Population: Programs and services to support underserved, vulnerable, at-risk populations.
Responsible Party: Tracy Ibbotson, M.Ed., Administrative Director of Community Health Benefits
Community Partners: Any organization in the catchment area serving the target population and advancing the health and wellness goals as identified and outlined in this Implementation Strategy.
Budget: Over $70,000 annually
Description: Provide cash support, in-kind donations, and volunteer support to organizations seeking to improve the health and well-being of targeted, under-served, at-risk populations. In 2024, include the sponsorship of economically disadvantaged students at the *Institut Catholique de Kabgayi,* Rwanda.

Community Benefits Advisory Committee (CBAC) -

Brittany Lynch, LICSW, Director, Transitions in Care/Social Work, Saint Anne's Hospital
Kandace Vieira, RN, MSN, Director, Quality, Regulatory and Patient Safety, Saint Anne's Hospital
Kristin Gill-Bonanca, DNP, RN, CCRN-K, NE-BC, Administrative Director, Critical Care Services, Saint Anne's Hospital
Destinee Barnes, Project Director, Peer2Peer Recovery Project, Steppingstone Incorporated
Joseph Botelho, Project Manager, Peer2Peer Recovery Project, Steppingstone Incorporated
Shannon Rooney, Administrative Assistant, Peer2Peer Recovery, Project, Steppingstone Incorporated
Michael Bushell, President, Saint Anne's Hospital
Stephanie Sayles, LICSW, Clinical Coordinator, Youth Trauma Program, a program of JRI, located at the Children's Advocacy Center of Bristol County, also a program of JRI.
Lisa Blanchette, Director, Revenue Cycle, Saint Anne's Hospital
Lisa DeMello, MSN, RN, ACNS-BC, Clinical Nurse Specialist/Stroke Coordinator, Saint Anne's Hospital
Marcia Picard, Executive Director & School Wellness Coordinator, Greater Fall River Partners for a Healthier Community (CHNA25)
Marin Woods, RD, LDN, Clinical Nutrition Manager, Saint Anne's Hospital
Tracy Ibbotson, M.Ed., Administrative Director, Community Health Benefits, Saint Anne's Hospital
Deborah Avila-Carreiro, Nutrition Services Manager**,** Bristol Elder Services
Naomi Patricio, Supervisor, Health Insurance Specialists, Saint Anne's Hospital
Kyla Farias, Coordinator, Education & Outreach Prevention, Bristol County Children's Advocacy Center, a program of JRI
Jessica Stone, Grant Writer and Community Liaison, Southeast Center for Independent Living
Ali Paull, LICSW, Program Manager, Opioid Triage Center (OTC), SSTAR
Denise Paulson, CMI, Manager, Interpreter Services, Saint Anne's Hospital

Sister Glorina Jugo, OP, Member, SAH Board of Directors; Chair, Mission Committee, Saint Anne's Hospital
TBD, RN, CARN, Addictions Nurse Specialist, Saint Anne's Hospital
Fanny Tchorz, Director of Interpreter Services, Health First Family Care Center
Mary-Lou Mancini, Member, SAH Board of Directors; Community Member & Liaison to the Patient & Family Advisory Council (PFAC), Saint Anne's Hospital
Barbra Tugman, Ambassador, Oncology Services, Saint Anne's Hospital
Paul Foster, Patient Financial Counselor, Oncology Services, Saint Anne's Hospital
Annemarie Medeiros, Membership Director**,** Fall River YMCA, Division of Southcoast YMCA
Aliya Steele, Coordinator, Mass-in-Motion, City of Fall River, MA
Lynn Iadicola, Volunteer Partners for a Healthier Community Substance Addiction Task Force, and Community Representative
Susan Remy, Vice President, Development & Community Engagement, Child & Family Services
David Perry, President, Greater Fall River Community Food Pantry
Rachael Sirois, Resource Development Director, Boys & Girls Club of Fall River
Tia Castellano, Director/CEO, Bristol Black Collective, Fall River
Patty Armstrong, Resource Development Director, United Way of Greater Fall River