Organization Information

Organization Name:	Saint Anne's Hospital
Address:	795 Middle Street
City, State, Zip:	Fall River, Massachusetts 02721-1798
Website:	www.saintanneshospital.org
Contact Name:	Tracy (Teresa) Gerety-Ibbotson
Contact Title:	Administrative Director of Community Health
Contact Department (Optional):	Office of Community Health Benefits
Phone:	(508) 235-5289
Fax (Optional):	(508) 235-5012
E-Mail:	tracy.ibbotson@steward.org
Contact Address: (Optional, if different from above)	795 Middle Street
City, State, Zip: (Optional, if different from above)	Fall River, Massachusetts 02721-1798

Organization Type:	Hospital
For-Profit Status:	For-Profit
Health System:	Steward Health Care System
Community Health Network Area (CHNA):	Partners for a Healthier Community (Fall River)(CHNA 25),
Regions Served:	Other-Southeastern MA,

Mission and Key Planning/Assessment Documents

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
Providing preventative health education and wellness services
Working in collaboration with our community to identify and respond to unmet needs
Recommending to the Board of Directors of Saint Anne's the adoption of needed programs and services to address identified, prioritized, and unmet health care needs in the community.

Target Populations:

Name of Target Population	Basis for Selection
Poor, disadvantaged, or medically underserved individuals and families	Community Health Needs Assessment; Community Benefits Advisory Committee
Underinsured and uninsured	Community Health Needs Assessment; Community Benefits Advisory Committee
Those at risk for, screened for substance abuse or behavioral health	Community Health Needs Assessment; Community Benefits Advisory Committee
Children who are at risk for, or who have been involved with, domestic violence, sexual abuse, or other forms of violence	Community Health Needs Assessment; Community Benefits Advisory Committee
Individuals who need health education, disease prevention, and health screening to promote healthier lifestyles and the earlier detection of	Community Health Needs Assessment; Community Benefits Advisory Committee

disease.	
Individuals who are living with, or are at risk for developing diabetes and cancer	Community Health Needs Assessment; Community Benefits Advisory Committee
Limited English Proficient (LEP)	Community Needs Assessment,Community Benefits Advisory Committee
At-risk Veterans	Community Needs Assessment, Community Benefits Advisory Committee

Publication of Target Populations:
Annual Report

Community Health Needs Assessment:

Date Last Assessment Completed:

2018

Data Sources:

Community Focus Groups, Community Health Network Area, Consumer Groups, Hospital, Interviews, MA Population Health Information Tool (PHIT), Other, Public Health Personnel, Surveys, Centers for Disease Control and Prevention, 500 Cities Project
MA Bureau of Substance Abuse Services
MA Center for Health Information and Analysis
MA Department of Elementary and Secondary Education
MDPH, Bureau of Environmental Health
MDPH, Environmental Public Health Tracking
MA Executive Office of Energy and Environmental Affairs
MA Executive Office of Labor and Workforce Development
MA Health Insurance Survey
U.S. Census Bureau and U.S. Census Bureau Community Survey

CHNA Document: 2018 SAINT ANNE'S HOSPITAL CHNA - FINAL.PDF

Implementation Strategy:

Implementation Strategy Document: 2019 SAH IMPLEMENTATION STRATEGY_ FINAL.PDF

Key Accomplishments of Reporting Year:

Provided health coverage enrollment support to 4,135 individuals and increased community visibility and outreach efforts in service areas. Participated in numerous community-based health education outreach programs to over 2,500 community members. Offered free skin cancer screenings for community members and provided skin cancer prevention education to 350 students in Fall River public schools, Pre K-middle school age. Continued to support local HIP/SNAP farmers market in low income neighborhood to promote healthy nutrition and produce intake. Served 466 children and their families who experienced trauma and or abuse. Continued Addictions Nurse Specialist role filled by a Certified Addictions Nurse (CARN) who facilitated trainings in opioid overdose prevention and completed 385 consults for inpatients with addiction issues for referral to outpatient follow up. Continued hospital-based and community-based campaign to reduce stigma associated with substance use disorder - Continued to offer Peer Recovery Coaching Services providing over 200 patients immediate access to a Peer Recovery Coach. Conducted 1,979 psychological/behavioral health assessments offering specialized behavioral health patient navigation within the behavioral health suite demonstrating increased commitment to the unique needs of patients with behavioral health disorders. The Behavioral Health Suite with in the ED was designed in response to the nationwide trend of a growing number of behavioral health patients being cared for in Emergency Departments, and the longer stays these patients experience awaiting a bed in an appropriate treatment facility. Provided dedicated navigation support and services to 2,278 oncology patients. Allocated $36,000 in financial support to the Greater Fall River Community Food Pantry and Marie's Place providing free food, clothing and small durable goods to over 10,000 households. Provided over $100,000 in financial support to more than 35 community organizations helping those in most need. Printed over 4,000 copies of the Greater Fall River Resource Guide (tri-lingual: English, Spanish, Portuguese) for distribution to the community as a collaborative project with Partners for a Healthier Community/CHNA25

Plans for Next Reporting Year:

In response to the 2018 SAH Community Health Needs Assessment (CHNA), the hospital will continue its focus on implementing programs to address health equity and access, behavioral health including resources for navigation, chronic

disease management, substance use disorders and health-related social issues (e.g. homelessness, poverty, unemployment) and other Social Determinants of Health (SDOH). Primary prevention activities and interventions to re-educate the community on health-related behaviors will remain priorities. SAH will leverage its resources to conduct a comprehensive community health needs assessment to better inform community partners of service gaps and disparities. The role of a Certified Addictions Nurse Specialist (CARN) to the Saint Anne's Hospital care team will continue to provide an additional resource to address the opioid crisis. In 2020 collaboration with Steppingstone Inc.Peer2Peer Recovery Project providing on-site, bedside access to a Peer Recovery Coach will continue and hopefully expand reach. At-risk Veterans and Limited-English Proficient (LEP) will continue to be included in the target population and added attention will be given to the complex care needs of the Lesbian Gay Trans-sexual Bi-sexual Queer (LGBTQ) community. Addressing the increased role SDOH play in health equity, literacy and access will continue to be reflected in the reporting year.

Self-Assessment Form: Hospital Self-Assessment Update Form - Years 2 and 3

Community Benefits Programs

Addictions Nurse Specialist	
Program Type	Direct Clinical Services
Program is part of a grant or funding provided to an outside organization	No
Program Description	Implemented by Certified Addictions Nurse (CARN) to change culture of caring for patients with addiction, understand addiction as a chronic disease, reduce stigma, serves as a hospital & community resource for education, prevention & treatment. Refer patients to community-based resources/treatment.
Program Hashtags	Community Education, Health Professional/Staff Training, Prevention,
Program Contact Information	Stephanie Perry, RN, CARN, Addictions Nurse Specialist, Saint Anne's Hospital,774-644-5025

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Serve as a resource to the hospital and to the community for the education, prevention, and treatment of addiction	Participated in 120 training programs and community outreach events addressing the education, prevention and treatment of addiction in response to the opioid crisis	Process Goal	Year 2019 of 1
Serve as a resource to the hospital and to the community for the education, prevention, and treatment of addiction	Provided 385 consults to patients with SUD assisting with referrals to treatment and providing ongoing support & resources to patients & family members	Process Goal	Year 2019 of 1
Facilitate training in opioid overdose prevention	Provided training in opioid overdose prevention/reversal to 50 community members	Process Goal	Year 2019 of 1
Serve as a resource to community members who are homeless and suffering from substance use disorder (SUD)	In collaboration with community partners provided bi-weekly street outreach offering harm reduction and recovery resources to 137 individuals experiencing homelessness and suffering from substance use disorder (SUD)	Outcome Goal	Year 2019 of 1
Reduce the stigma associated with substance use disorder and change the culture of caring for patients with SUD to better manage their acute care medical needs	SAH participated in International Overdose Awareness Day (8/31) & over 20 SAH staff volunteered & distributed over 4,000 door-hanging resource materials to targeted areas and neighborhoods (8/29).Continue long term goal to reduce stigma associated with SUD	Process Goal	Year 2019 of 5
Reduce the stigma associated with substance use disorder and change the culture of caring for patients with SUD to better manage their acute care medical needs	Continued implementation of the Clinical Opiate Withdrawal Scale (COWS) for better medical management and facilitated trainings to SAH clinical staff on the disease of addiction to reduce stigma and change culture of caring for patients with SUD	Process Goal	Year 2019 of 5

Establish a pilot program to assist primary care physicians in initiating office-based Medical - Assisted (Medical Assisted) Treatment (MAT) for patients with SUD	Identified a primary care physicians willing to participate in the pilot program with program launch anticipated by 2022	Process Goal	Year 2019 of 5

EOHHS Focus Issues	Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities	Social Environment,
Health Issues	Health Behaviors/Mental Health-Physical Activity, Infectious Disease-Hepatitis, Other: Alcohol and Substance Abuse, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Homelessness, Substance Addiction-Alcohol Use, Substance Addiction-Opioid Use, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Other-Southeastern MA, • **Environments Served:** Not Specified • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
City of Fall River	Not Specified
Community Counseling Center of Bristol County	Not Specified
Partners for a Healthier Community (CHNA25)	Not Specified
Peer2Peer Recovery Project, Steppingstone, Inc.	Not Specified
Seven Hills Behavioral Health	Not Specified
SSTAR	Not Specified
Hearts of Hope	Not Specified

Behavioral Health Collaborative Care

Program Type	Direct Clinical Services
Program is part of a grant or funding provided to an outside organization	No
Program Description	Assist patients who have complex needs and great difficulty navigating the health and social service systems with dedicated behavioral health navigation. Provide intervention, advocacy and referrals to treatment or services for patients and community members who are screened and detected for substance, alcohol and tobacco use; mental illness, and/or domestic violence.
Program Hashtags	Community Education, Health Screening,
Program Contact Information	Brittany Lynch LICSW, Manager, Behavioral Health Services, Saint Anne's Hospital, 508-675-5600, ext 5514

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide dedicated behavioral health patient navigation to			

patients with complex needs and who have difficulty navigating the health care and social services systems to improve health outcomes	Provided dedicated behavioral health patient navigation and advocacy for all patients presenting with complex behavioral health needs including weekends and nights	Process Goal	Year 2019 of 1
Provide assessment intervention, resources and referrals to treatment or services for patients who are screened positive for substance, alcohol and tobacco use; mental illness, and/or domestic violence.	Completed psychological/behavioral health assessments and referral to treatment for 1,979 patients	Process Goal	Year 2019 of 1
Reduce number of emergency department visits by individuals who have conditions which are more appropriate for treatment in primary care and/or community care settings.	Plan to voluntarily pilot the Emergency Department Information Exchange (EDIE) Program to reduce recidivism related to chronic disease management, including behavioral health and SUD and optimize care coordination delayed until 2020	Process Goal	Year 2019 of 5
Reduce number of emergency department visits by individuals who have conditions which are more appropriate for treatment in primary care and/or community care settings.	Support Steward Health Care Network (SCHN) efforts to improve patient outcomes and reduce costs for Steward Health Choice Medicaid ACO patients by addressing gaps in services and supports for conditions that can be treated in primary care and/or community care settings	Process Goal	Year 2019 of 5

EOHHS Focus Issues	Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities	, Social Environment, Violence,
Health Issues	All,
Target Populations	• **Regions Served:** Other-Southeastern MA, • **Environments Served:** All, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Bristol Elder Services	Not Specified
Community Counseling of Bristol County	www.comcounseling.org
Community Not-For-Profits	Not Specified
Steward Health Care Network, Steward Choice Medicaid ACO	Not Specified
Stanley Street Treatment and Resource Family Care Center (SSTAR)	Not Specified
Corrigan Mental Health	Not Specified
Arbor Mental Health Services	Not Specified
Bay Cove Crisis Services	Not Specified
Steppingstone Inc.	Not Specified

Cancer Support and Wellness Programs

Program Type	Direct Clinical Services
Program is part of a grant or	No

funding provided to an outside organization	
Program Description	Provide psychosocial support and wellness programs to those diagnosed, in treatment, or recovering from/living with cancer.
Program Hashtags	Support Group,
Program Contact Information	Kelly Sheehan, LICSW,OSW-C,Program Manager Psychosocial Oncology Services, Saint Anne's Hospital Regional Cancer Center, 508-675-5600

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide dedicated patient navigation support driven by community needs assessment to address disparities and barriers to care	Provided dedicated navigation support and services to 2,278 oncology patients	Process Goal	Year 2019 of 1
Provide support for individuals diagnosed with, in treatment for or recovering from-living with cancer.	Provided individualized psycho-social support and resources for all aspects of care- from health-related social needs like stable housing and income supports, and free transportation to reduce barriers to care for hardship eligible, to access to free assistance with legal matters.	Process Goal	Year 2019 of 5
Provide support and wellness programs to those in the community diagnosed with, in treatment for or recovering from-living with cancer.	Support groups and programs (Life -Part II, Coping with a Cancer Diagnosis, Gratitude Journaling, Book Club, Water Color Classes), including access to a wig boutique provided to over 95 patients/community members in 2019.	Process Goal	Year 2019 of 5

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities	Social Environment,
Health Issues	Cancer-Breast, Cancer-Cervical, Cancer-Colorectal, Cancer-Lung, Cancer-Multiple Myeloma, Cancer-Other, Cancer-Ovarian, Cancer-Prostate, Cancer-Skin, Health Behaviors/Mental Health-Depression, Health Behaviors/Mental Health-Mental Health, Health Behaviors/Mental Health-Stress Management, Other: Cancer, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Environmental Quality, Social Determinants of Health-Homelessness, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Nutrition, Substance Addiction-Opioid Use,
Target Populations	• **Regions Served:** Other-Southeastern MA, • **Environments Served:** All, • **Gender:** All, • **Age Group:** Adult, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
American Cancer Society (ACS)	Not Specified

Chronic Disease Management Patient Navigator

Program Type	Direct Clinical Services
Program is part of a grant or funding provided to an outside organization	No
Program Description	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 (SDOH) needs.
Program Hashtags	Community Education, Health Screening, Prevention,
Program Contact Information	Priscilla Carreiro, Patient Navigator, Saint Anne's Hospital, 795 Middle Street, Fall River, MA 508-675-5600

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide dedicated patient navigation to individuals at risk for complex and/or chronic disease of the breasts or lungs	Provided dedicated patient navigation support and services to 94 patients (74 breast and 21 lungs). Program piloted in 2019	Process Goal	Year 2019 of 1
Serve as a resource to the community in chronic disease management and prevention education	Participated in 3 community -based outreach events in the prevention of chronic disease - including education on the risk factors associated with chronic disease including poor nutrition, lack of physical activity, and tobacco use and vaping.	Process Goal	Year 2019 of 1

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities	Social Environment,
Health Issues	Cancer-Breast, Cancer-Lung, Cancer-Other, Chronic Disease-Hypertension, Chronic Disease-Pulmonary Disease, Chronic Disease-Stroke, Health Behaviors/Mental Health-Stress Management, Other-Cultural Competency, Other-Senior Health Challenges/Care Coordination, Other: Diabetes, Other: Nutrition, Other: Smoking/Tobacco, Other: Stress Management, Overweight and Obesity, Physical Activity, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Transportation, Substance Addiction-Smoking/Tobacco Use, Tobacco Use,
Target Populations	• **Regions Served:** Other-Southeastern MA, • **Environments Served:** All, • **Gender:** All, • **Age Group:** Adult, • **Race/Ethnicity:** All, • **Language:** All, Portuguese, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Prima-CARE	Not Specified
American Heart Association (AHA)	Not Specified
American Lung Association	Not Specified
American Cancer Society (ACS)	Not Specified
Hawthorn Medical Associates	Not Specified

Community Giving

Program Type	Infrastructure to Support CB Collaboration
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	Cash, in-kind or pro-bono support to organizations working together on implementing Community Benefits programs

Program Hashtags	Community Education, Health Professional/Staff Training, Health Screening, Prevention,
Program Contact Information	Tracy (Teresa) Gerety-Ibbotson, MEd, Administrative Director of Community Health Benefits, Saint Anne's Hospital, 508-235-5289

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Print pro-bono, as needed, color copies of the Greater Fall River Resource Guide in English, Spanish and Portuguese for community-wide distribution. The Greater Fall River Resource Guide is a collaborative effort between Greater Fall River Partners for a Healthier Community, United Neighbors of Greater Fall River and Saint Anne's Hospital	Printed over 4,000 copies of the tri-lingual Resource Guide for distribution community-wide a 50% increase in printing from 2018	Process Goal	Year 2019 of 5
Provide cash, in-kind or pro-bono support to organizations promoting & supporting health. Increase capacity building and collaboration with community partners in support of community health priorities.	Provided over $100,000 in financial support to more than 35 community organizations working together to advance the goals of Community Benefits Programs	Process Goal	Year 2019 of 5

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities	Built Environment, Education, Employment, Housing, Social Environment, Violence,
Health Issues	All,
Target Populations	• **Regions Served:** Other-Southeastern MA, • **Environments Served:** All, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Local not-for-profit agencies addressing health improvement	Not Specified
Partners for a Healthier Community (CHNA25)	Not Specified

Compassionate Care/Blessed Marie Poussepin Outreach Ministry

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	Saint Anne's Compassionate Care Program and Blessed Marie Poussepin Outreach Ministry exist in response to the needs of the poor and indigent in our community. This outreach program provides vouchers for prescriptions, supplements, non-durable medical supplies, taxi service, food, and clothing.
Program Hashtags	Not Specified
Program Contact Information	Sister Glorina Jugo, Director of Mission, Saint Anne's Hospital, 508-675-5600

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Reduce barriers to health care caused by poverty, unemployment and lack of transportation.	2,428 taxi vouchers were distributed to those requiring transportation for medical care needs, $33,708 expended for taxi vouchers, prescriptions, medical supplies and basic living essentials/emergency needs of the target population.	Outcome Goal	Year 2019 of 1

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities	Housing, Social Environment, Violence,
Health Issues	Access to Health Care, Cancer-Other, Chronic Disease-Cardiac Disease, Chronic Disease-Diabetes, Health Behaviors/Mental Health-Depression, Health Behaviors/Mental Health-Mental Health, Other-Cultural Competency, Other: Elder Care, Other: Homelessness, Other: Nutrition, Other: Safety, Other: Uninsured/Underinsured, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Environmental Quality, Social Determinants of Health-Homelessness, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Nutrition, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of Health-Violence and Trauma, Substance Addiction-Alcohol Use, Substance Addiction-Opioid Use, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Other-Southeastern MA, • **Environments Served:** All, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Blessed Marie Poussepin Outreach Ministry	Not Specified
Marie's Place	Not Specified
Standard Pharmacy	Not Specified
Town Transportation	Not Specified
Fall River Taxi	Not Specified

Health Insurance Advocacy

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	No
Program Description	Improve access to healthcare for target population by assisting with enrollment in health insurance programs and assisting as able with access to other health-related benefits. Provide culturally and linguistically competent health promotion outreach & benefit assistance education to increase health literacy in target population including LEP
Program Hashtags	Community Education,
Program Contact Information	Naomi Patricio, Lead Financial Counselor, Saint Anne's Hospital 508-675-5600 ext 5398

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Improve access to healthcare for target population by providing health insurance education and enrollment assistance, including access to emergent coverage as an approved site for Presumptive Eligibility Determination (HPE)	4,135 individuals enrolled and/or supported with health insurance coverage, assisting 252 to immediate coverage, a 5% increase in the number of individuals screened and/or enrolled in 2018	Outcome Goal	Year 2019 of 1
Provide culturally and linguistically competent health-promotion outreach education and benefit assistance to culturally diverse community members	Participated in 10 community-based culturally competent health education programs to increase health literacy and health equity for target population	Process Goal	Year 2019 of 1

EOHHS Focus Issues	Not Specified
DoN Health Priorities	Not Specified
Health Issues	Access to Health Care, Other-Cultural Competency, Other: Uninsured/Underinsured, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Uninsured/Underinsured,
Target Populations	• **Regions Served:** Other-Southeastern MA, • **Environments Served:** Not Specified • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Fall River Public Housing	Not Specified
Mass Department of Public Health	Not Specified
Marie's Place	Not Specified
Partners For Healthier Community	Not Specified
Local Non-profit Organizations/Human Service Agencies	Not Specified

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Health Screenings, Education and Wellness

Program Type	Total Population or Community-Wide Interventions
Program is part of a grant or funding provided to an outside organization	No
Program Description	Promote health and wellness through screenings and education outreach to improve health literacy of the target population with a focus on cancer, heart disease and diabetes
Program Hashtags	Community Education, Health Screening, Prevention,
Program Contact Information	Tracy (Teresa) Gerety-Ibbotson MEd, Administrative Director of Community Health Benefits, Saint Anne's Hospital 508-235-5289

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
	Obtained over 350 signed skin cancer prevention - safe		

School-based skin cancer prevention education to increase awareness and protection	sun behavior pledge cards for students K-8, students commit to use sunscreen, protective clothing, limit sun exposure time and not to use tanning beds. Plan to continue school-based health promotion education in 2020.	Process Goal	Year 2019 of 1
Promote health and wellness through screenings and education prevention and disease management with a focus on cancer, heart disease and diabetes	Provided health education outreach to over 2,500 community members with a focus on the prevention and/or management of cancer, heart disease/stroke and diabetes at more than 80 community-based events; screened over 60 individuals for skin cancer and high blood pressure	Process Goal	Year 2019 of 1

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities	Social Environment,
Health Issues	All,
Target Populations	• **Regions Served:** Other-Southeastern MA, • **Environments Served:** All, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Community not-for-profits; faith communities	Not Specified
Fall River Public Schools	Not Specified
Westport Public Schools	Not Specified
Greater Fall River Partners for a Healthier Community (CHNA25)	Not Specified
Blount Fine Foods	Not Specified
Stop N Shop Distribution Center & Corporate Offices	Not Specified
Liberty Utilities	Not Specified
Area Businesses Employee Wellness Departments	Not Specified

Medical Legal Partnership (MLP)

Program Type	Infrastructure to Support CB Collaboration
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	Provide income-eligible (low-income) and elderly with free legal advocacy to address social determinants of health. Provide team-facing training and technical assistance in social determinants of health (SDOH) problem-solving involving patients' legal risks, rights and remedies.
Program Hashtags	Health Professional/Staff Training,
Program Contact Information	Tracy (Teresa) Gerety-Ibbotson; Administrative Director Community Health; Brittany Lynch, Manager Behavioral Health

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame

Increase access to care by mitigating social determinants of health through legal advocacy	11 unique individuals for 13 unique legal needs were referred to MLP with 4 cases requiring full legal intake. Access to free legal assistance will continue in 2020	Outcome Goal	Year 2019 of 1
Strengthen SAH staff knowledge and skills in SDOH problem-solving involving patients' legal risks, rights and remedies through SDOH-themed trainings. Trainings open to community providers	MLP provided 3 trainings- (2) on Housing Laws & advocacy (1) on Immigration Law Update. Free CEU's were provided. SDOH- themed trainings will continue in 2020	Process Goal	Year 2019 of 1

EOHHS Focus Issues	Housing Stability/Homelessness, Mental Illness and Mental Health,
DoN Health Priorities	Employment, Housing,
Health Issues	Access to Health Care, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Education/Learning, Social Determinants of Health-Environmental Quality, Social Determinants of Health-Homelessness, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Nutrition, Social Determinants of Health-Public Safety, Social Determinants of Health-Racism and Discrimination, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of Health-Violence and Trauma,
Target Populations	• **Regions Served:** Other-Southeastern MA, • **Environments Served:** Not Specified • **Gender:** All, • **Age Group:** Adult, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Justice Resource Center of Southeastern MA	Not Specified
Medical Legal Partnership (MLP)	Not Specified
South Coastal Counties Legal Services	Not Specified
Local Not-for Profit Agencies	Not Specified

Multicultural Health Scholarship Program

Program Type	Infrastructure to Support CB Collaboration
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	Awards scholarships to bilingual/bicultural students pursuing studies in health care or a related field in the 2019 academic year. The program is aligned with efforts to reduce barriers and improve access to higher education to our culturally diverse community and support the long term goal of a culturally diverse health care workforce.
Program Hashtags	Mentorship/Career Training/Internship,
Program Contact Information	Tracy Ibbotson, Administrative Director of Communty Benefits, 508-235-5289; Saint Anne's Hospital, 795 Middle St. Fall River, MA

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Through an application process award scholarships to			

bilingual/bicultural students pursuing college degrees/advanced studies in health care or a related field.	In 2019 awarded (3) one thousand dollar scholarships to 3 bilingual/bicultural student awardees	Process Goal	Year 2019 of 1

EOHHS Focus Issues	N/A,
DoN Health Priorities	Education, Employment,
Health Issues	Other-Cultural Competency,
Target Populations	• **Regions Served:** Fall River, Somerset, Swansea, Westport, • **Environments Served:** All, • **Gender:** All, • **Age Group:** Adults, Teenagers, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Partners for a Healthier Community (CHNA25)	Not Specified

Peer Recovery Coach Program

Program Type	Community-Clinical Linkages
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	Provide ED patients and inpatients with SUD access to a peer recovery coach who provides support and services to promote recovery by removing barriers and serving as a role model
Program Hashtags	Support Group,
Program Contact Information	Stephanie Perry, CARN, Addictions Nurse Specialist, Saint Anne's Hospital, 774-644-5025

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Provide all patients with SUD access to a Peer Recovery Coach. Program to be offered in 2020	Offered access to Peer Recovery Coach to all patients screened positive for SUD; 207 patients participated in Outreach & Engagement sessions which are funded by SAH. Program will be offered in 2020	Process Goal	Year 2019 of 1
In collaboration with Steppingstone Inc., Peer2Peer Recovery Coach Project increase health literacy and support long term recovery by providing at least 2 health promotion activities/trainings/events annually over 5 years	In 2019 held two community events introducing the concept of the Spiritual Pillar as a strategy to improve health literacy and support long term recovery.	Process Goal	Year 2019 of 5

EOHHS Focus Issues	Substance Use Disorders,
DoN Health Priorities	Social Environment,
Health Issues	Health Behaviors/Mental Health-Depression, Health Behaviors/Mental Health-Mental Health, Other-Cultural Competency, Other: Alcohol and Substance Abuse, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Access to Transportation, Social Determinants of Health-Affordable Housing, Social Determinants of Health-Domestic Violence, Social Determinants of Health-Education/Learning, Social Determinants of Health-Environmental Quality, Social Determinants of Health-Homelessness, Social

	Determinants of Health-Income and Poverty, Social Determinants of Health-Language/Literacy, Social Determinants of Health-Uninsured/Underinsured, Social Determinants of Health-Violence and Trauma, Substance Abuse, Substance Addiction-Alcohol Use, Substance Addiction-Opioid Use, Substance Addiction-Substance Use,
Target Populations	• **Regions Served:** Other-Southeastern MA, • **Environments Served:** All, • **Gender:** All, • **Age Group:** All Adults, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Steppingstone Inc., Peer - to - Peer Recovery Project	Not Specified
Steward Health Care Network (SHCN)	Not Specified
Health & Human Service Agencies	Not Specified

Physician/Provider Engagement in Community Health Continuing Medical Education (CME) Program

Program Type	Infrastructure to Support CB Collaboration
Program is part of a grant or funding provided to an outside organization	No
Program Description	It is essential to have primary health care providers engaged in the initiatives to improve population health. Success of the program will depend on commitment from the providers to learn more about the communities they serve through trainings in cultural competency and community health needs with explicit attention to the social determinants of health (SDOH) in vulnerable populations. In 2019, SAH CME program was awarded 6 year accreditation with Commendation by MA Medical Society for excellence in provider community health education
Program Hashtags	Health Professional/Staff Training, Physician/Provider Diversity,
Program Contact Information	Denise Marques, Coordinator, CME Program, Saint Anne's Hospital

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Engage primary care providers (i.e. physicians, mid-levels, nurses, social workers, other) in community health to address high -risk health & health-related social issues disproportionately impacting vulnerable/target populations	Provided 3 CME trainings on topics related to the health needs of vulnerable populations including individuals with substance use disorder and mental health issues	Process Goal	Year 2019 of 1
Improve cultural competency in caring for culturally diverse individuals and at-risk, hard-to-reach populations.	Provided professional development training for culturally diverse hard to reach populations topics included: "Medication-assisted Treatment (MAT) for SUD" to increase provider competency (2/26); "Immigration Status & Health and How to Help Individuals in the Current Policy Landscape" (5/1) & "Providing Medical Care to Patients with Mental Health & Compliance Issues" (10/29)	Process Goal	Year 2019 of 1

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes, Housing Stability/Homelessness, Mental Illness and Mental Health, Substance Use Disorders,
DoN Health Priorities	Built Environment, Education, Housing, Social Environment, Violence,

Health Issues	All,
Target Populations	• **Regions Served:** Other-Southeastern MA, • **Environments Served:** All, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Hawthorn Medical Associates	Not Specified
Steward Health Care Network (SHCN)	Not Specified
Steward Medical Group (SMG)	Not Specified
SSTAR - Family Care Center	Not Specified
Prima-CARE	Not Specified
Health First Family Care Center	Not Specified
Pediatric Associates	Not Specified
Highland Pediatrics	Not Specified
Other Physician & Provider Groups in the South Coast region	Not Specified
Community Non-profits serving target population	Not Specified

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Reducing Food Insecurity

Program Type	Infrastructure to Support CB Collaboration
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	Reduce number of families and children suffering from food insecurity and lack of clothing
Program Hashtags	Not Specified
Program Contact Information	Teresa (Tracy) Gerety-Ibbotson MEd, Administrative Director, Community Health Benefits

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Reducing hunger and addressing food security.	$1,500 monthly donations to the Greater Fall River Community Food Pantry and Marie's Place. This assisted with the distribution of food, clothing and small household items to 40,474 individuals (10, 441 families); 4% increase over 2018	Outcome Goal	Year 2019 of 1

EOHHS Focus Issues	N/A,
DoN Health Priorities	Social Environment,
Health Issues	Other: Nutrition, Social Determinants of Health-Access to Healthy Food, Social Determinants of Health-Income and Poverty, Social Determinants of Health-Nutrition,
Target Populations	• **Regions Served:** Other-Southeastern MA, • **Environments Served:** All, • **Gender:** All, • **Age Group:** All, • **Race/Ethnicity:** All,

	• **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Greater Fall River Community Food Pantry	Not Specified
Marie's Place, distribution center for food and clothing	Not Specified

Transport Service

Program Type	Access/Coverage Supports
Program is part of a grant or funding provided to an outside organization	No
Program Description	Transport service, including a handicap accessible van, is offered to those who would otherwise be unable to access care due to physical limitations, lack of a personal vehicle, or limited or no financial resources to pay for transportation.
Program Hashtags	Not Specified
Program Contact Information	Kelly Sheehan, LICSW, Oncology Social Work, Erin McGough, Director, Oncology Services, 508-675-5600

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Reduce barriers to health care caused by lack of transportation	Provided transport for 181 patients for a total of 2,894 trips, service will continue in 2020	Outcome Goal	Year 2019 of 1

EOHHS Focus Issues	Chronic Disease with focus on Cancer, Heart Disease, and Diabetes,
DoN Health Priorities	Social Environment,
Health Issues	Access to Health Care, Cancer-Other, Social Determinants of Health-Access to Health Care, Social Determinants of Health-Access to Transportation,
Target Populations	• **Regions Served:** Other-Southeastern MA, • **Environments Served:** All, • **Gender:** All, • **Age Group:** All Adults, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Not Specified	Not Specified

Youth Trauma Program

Program Type	Direct Clinical Services
Program is part of a grant or funding provided to an outside organization	Yes
Program Description	A program of the Justice Resource Institute (JRI) and the Fernandes Center for Children & Families (FCCF) of Saint Anne's Hospital providing specialized evidence-based trauma-focused assessment and outpatient therapy services for child and adolescent victims of sexual abuse, physical abuse, neglect and other trauma, including loss of a loved one due to homicide, dating violence or violence at home. Program services children and

	adolescents from birth to 21. Services are free.
Program Hashtags	Not Specified
Program Contact Information	Stephanie Sayles, LICSW, Coordinator, Youth Trauma Program (YTP) 508-235-5285

Program Goals:

Goal Description	Goal Status	Goal Type	Time Frame
Address infant mental health needs of children from birth - 3 y/o who have witnessed or have been victims of trauma and/or abuse, including substance exposed newborns & infants living with parents with substance use disorder	Continued to facilitate the Southeastern Infant Mental Health Task Force to increase awareness of infant mental health and the impact of trauma on infants and young children and offer resources to address; participated in 3 provider-facing trainings and will continue this work as a long term goal	Process Goal	Year 2019 of 5
Provide diagnostic evaluation and psychotherapy to children who have witnessed or have been victims of trauma and/or abuse	In 2019, program served 466 children, services included telephone information, referral assistance and direct services (individual, group and family therapy). Hired bilingual Portuguese clinician enhancing competency in LEP population.	Process Goal	Year 2019 of 1

EOHHS Focus Issues	Mental Illness and Mental Health,
DoN Health Priorities	Social Environment, Violence,
Health Issues	Access to Health Care, Injury and Violence, Mental Health, Other: Domestic Violence, Other: Parenting Skills,
Target Populations	• **Regions Served:** Other-Southeastern MA, • **Environments Served:** All, • **Gender:** All, • **Age Group:** All Children, • **Race/Ethnicity:** All, • **Language:** All, • **Additional Target Population Status:** Not Specified

Partners:

Partner Name and Description	Partner Website
Children's Advocacy Center of Bristol County	Not Specified
MA Department of Children & Families	Not Specified
Fall River Public Schools	Not Specified
Local Pediatric Practices	Not Specified
Justice Resource Institute (JRI)	Not Specified

Expenditures

Total CB Program Expenditure	**$2,054,338.70**

CB Expenditures by Program Type	Total Amount	Subtotal Provided to Outside Organizations (Grant/Other Funding)
Direct Clinical Services	$1,435,312.33	$100,155.00
Community-Clinical Linkages	$135,498.65	$14,438.00

Total Population or Community-Wide Interventions	$177,007.59	$0.00
Access/Coverage Supports	$127,723.23	$0.00
Infrastructure to Support CB Collaborations Across Institutions	$178,796.90	$169,497.00

CB Expenditures by Health Need	Total Amount
Chronic Disease with a Focus on Cancer, Heart Disease, and Diabetes	$755,044.61
Mental Health/Mental Illness	$855,858.49
Housing/Homelessness	$70,891.39
Substance Use	$135,231.49
Additional Health Needs Identified by the Community	$237,312.72

Other Leveraged Resources	$403,370.00

Net Charity Care Expenditures	Total Amount
HSN Assessment	$1,271,383.00
HSN Denied Claims	$574,285.00
Free/Discount Care	($444,827.00)
Total Net Charity Care	$1,400,841.00

Total CB Expenditures:	$3,858,549.70

Additional Information	Total Amount
Net Patient Service Revenue:	$288,805,187.00
CB Expenditure as Percentage of Net Patient Services Revenue:	1.54%
Approved CB Program Budget for FY2020: (*Excluding expenditures that cannot be projected at the time of the report.)	$3,935,721.00
Comments (Optional):	In 2019,unreimbursed Medicare and Medicaid was $5,704,351.00 In FY2019, reported the approved 2020 CB program budget as total CB expenditures (hospital-wide) in 2019, increased by 2%. In prior years reported approved CB program budget for the CB department/ cost center only which did not include overall hospital costs/budgets for all CB programs. In 2019, SAH had an increase in CB program expenditures due to the addition of Chronic Disease Patient Navigator roles, the Behavioral Health Navigator roles being fully staffed and the expansion of the Youth Trauma Program services. In FY2020, SAH anticipates a decrease from FY2019 in CB program expenditures due to COVID-19

Optional Information

Hospital Publication Describing CB Initiatives:	Not Specified
Bad Debt:	Not Specified
Bad Debt Certification:	Not Certified
Optional Supplement:	Not Specified