South Shore Health

Implementation Strategy 2019

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SOUTH SHORE HEALTH
COMMUNITY HEALTH NEEDS ASSESSMENT AND PLANNING
Implementation Strategy

Once South Shore Health's Community Health Needs Assessment (CHNA) was complete, the Steering Committee and the Advisory Committee participated in a strategic retreat that allowed them to review the full-breadth of quantitative and qualitative findings from the assessment, as well as to begin the CHIP development process. The Steering and Advisory Committees discussed the full range of findings by community health domain (i.e., social determinants, chronic/complex conditions, mental health, substance use, elder health) and then participated in a process that identified the population segments and health-related issues that they believed should be prioritized for South Shore Health's Implementation Strategy. Once the priorities were identified, the Steering Committee discussed the range of community health/community benefit activities that were currently being implemented, as well as emerging strategic ideas that they believed should be included in SSH's Implementation Strategy to respond to the prioritized community health issues.

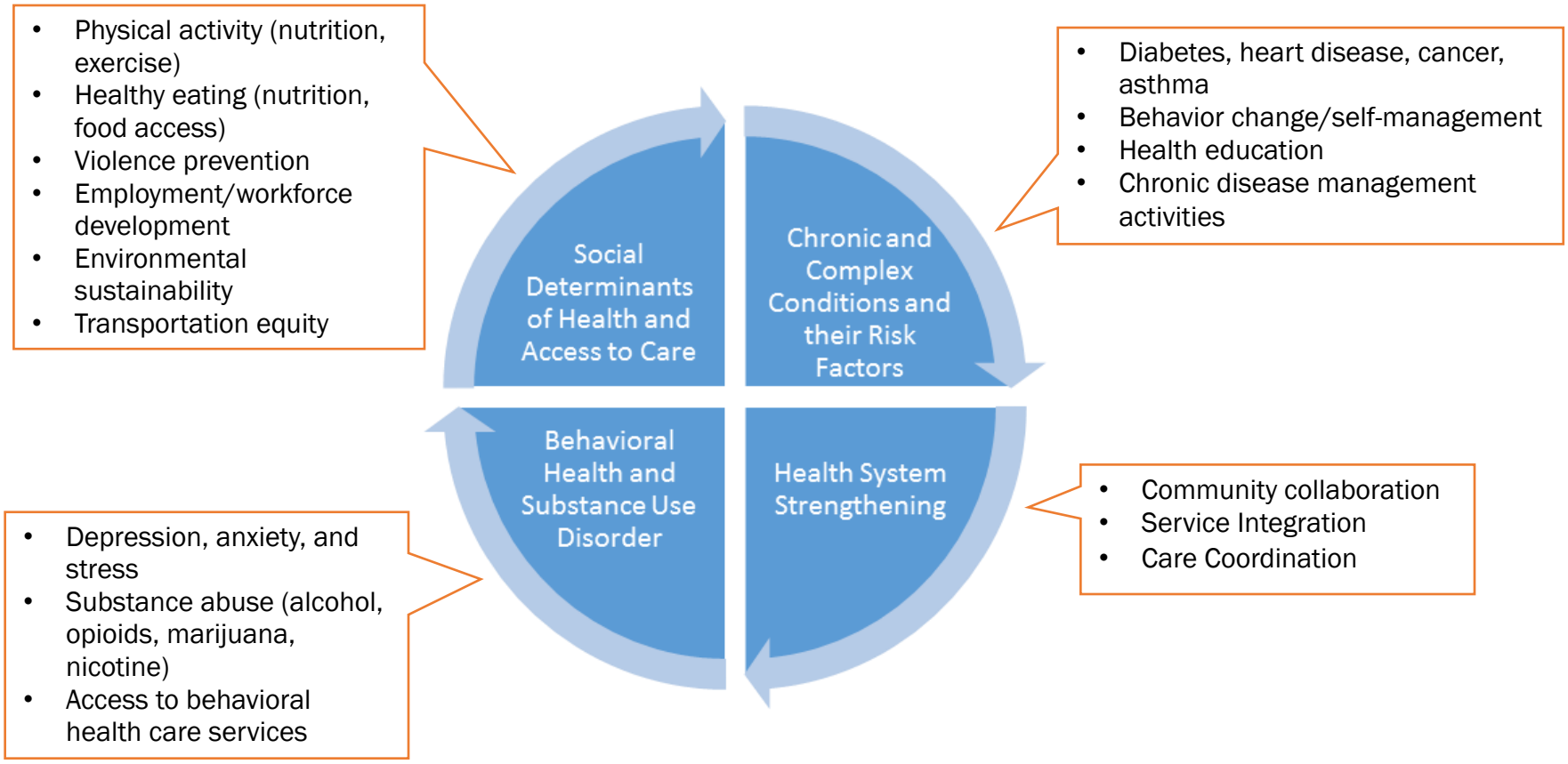
The following is a summary discussion of the priority populations and community health issues that were prioritized by the Steering Committee with input from the Advisory Committee and other stakeholders at SSH and in the community-at-large. The hospital and its leadership are committed to Community Benefit budget planning, which will ensure the funds and resources available to carry out its community benefit mission and to implement activities to address the needs identified by their Community Health Needs Assessment. Recognizing that community benefit planning is ongoing and will change with continued community input, the SSH community benefit plan will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies, and other issues may arise, which may require a change in the Implementation Strategy or the strategies documented within it. Senior management and the Board of Trustees are committed to assessing information and updating the plan as needed.

PRIORITY POPULATIONS

South Shore Health is committed to improving the health status and well-being of all residents living throughout its service area. Based on the assessment's quantitative and qualitative findings, including discussions with residents and community stakeholders, there was broad agreement that the Implementation Strategy should prioritize specific segments of the population that have complex needs or face significant barriers to care. The assessment identified youth and adolescents, older adults, individuals with chronic and complex conditions (e.g., cancer, diabetes, COPD), racial/ethnic minorities and non-English speakers, and low-to-moderate income individuals as key priority populations.

COMMUNITY HEALTH PRIORITIES

SSH's CHNA approach and process provided many opportunities to vet the quantitative and qualitative data compiled during the assessment. Based on this process, the Steering Committee, with the support of hospital leadership and the CHNA Advisory Committee, framed the community health needs into four priority strategic domains, which together encompass the broad range of health issues facing residents living in SSH's service area. Based on assessment findings, the Steering Committee identified sub-priorities within each strategic domain, which further guided the development of the Implementation Strategy.



IMPLEMENTATION STRATEGY

Priority Area 1: BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER			
Goal	**Target Population**	**Programmatic Objectives**	**Core Elements of CHIP / Implementation Strategy**
Develop outreach, education, and support programs for those with or at-risk of behavioral health and substance use issues	• Youth and Adolescents • Older Adults • Low-to-Moderate Income • Racial/ethnic minorities and Non-English speakers • Individuals with chronic/complex conditions	• Increase number of people who are outreached to and are educated about the risks, protective factors, and impacts of behavioral health and substance use in clinical, school-based, home-based, and other community-based settings • Reduce the stigma that those with behavioral health and substance use issues face in clinical, school-based, home-based, and other community-based settings • Increase the number of people who are engaged in appropriate primary care and specialty care services, including behavioral health and substance use services • Increase the number of people who are engaged in peer-to-peer programs geared to those with behavioral health and substance use issues targeting youth/adolescents, older adults, homeless, formerly incarcerated adults, and other high risk population segments	• Conduct behavioral health awareness, education and stigma reduction activities at health fairs, community events (e.g., councils on aging, YMCAs), and school-based settings, as well as in clinical settings (e.g., hospital outpatient and ED settings, outpatient primary care and specialty care settings, home-health, other post-acute settings) • Support the use of recovery coaches or peer counselors in community-based settings targeting those at high-risk including homeless, recently incarcerated, and those in recovery. Continue to support collaborative community based groups such as the South Shore Community Health Initiative. • Implement or promote support groups for caregivers, family members and those with behavioral health and substance use issues in clinical, school-based , home-based, other community-based settings • Promote initiatives to address hoarding in the community, continue to support South Shore Community Partnership (CHNA 23) which support local efforts to educate the community and combat hoarding.

Priority Area 1: BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER			
Goal	**Target Population**	**Programmatic Objectives**	**Core Elements of CHIP / Implementation Strategy**
Increase Access to Behavioral Health and Substance Use (BH/SU) Services	• Youth and Adolescents • Older Adults • Low-to-Moderate Income • Racial/ ethnic minorities and Non-English speakers • Individuals with chronic/complex conditions	• Increase BH/SU screening and referral activities in clinical, school-based , home-based, other community-based settings • Increase the number of primary care and specialty care providers who regularly screen for BH/SU issues • Increase the number of primary care and specialty care practices that have integrated BH/SU services or enhanced referral relationships with community-based BH/SU providers • Enhance BH/SU integration activities in hospital inpatient and emergency department settings with respect to screening, assessment, and referral. • Enhance partnerships with law enforcement and other first responders with respect to identifying, screening, assessing, and referring those in need to treatment. • Develop behavioral health and substance use telehealth programs for patient care and provider consults in primary medical care and medical specialty care settings • Increase the number of people at community organizations where those at high-risk of overdose spend time who are trained on the use of narcan • Increase the availability of narcan in key community settings	• Conduct BH/SU screening and referral activities in targeted community settings (e.g., councils on aging, school-based health centers, home health visits, etc.) • Work with SSH's owned and affiliated primary care practice sites to develop and expand integrated BH/SU programs • Implement screening, assessment, treatment and/or referral activities in hospital inpatient and emergency department settings • Continue to support or enhance activities conducted through Plymouth County Outreach to follow-up with substance users after an overdose episode and provide counseling at Drop-in locations • Supply and train use of Narcan in community-based settings (e.g., libraries, churches, shelters, etc.)

Priority Area 1: BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER			
Goal	**Target Population**	**Programmatic Objectives**	**Core Elements of CHIP / Implementation Strategy**
Decrease Depression and Social Isolation	• Older Adults • Low-to-moderate income	• Increase the number of residents who have access to affordable transportation • Increase the number of older adults who are screened for BH/SU issues • Increase the number of adults and older adults who are isolated who are outreached to and are encouraged or actively involved in positive social activities • Increase the number of people outreached to and educated about domestic violence. Develop a culture of awareness and action related to domestic violence, including elder abuse	• Support organizational and/or regional transportation resources that improve access to timely transportation services • Develop or support elder health screening initiatives that include depression screening with internal and external partners • Support Councils on Aging programs that support social interaction • Conduct staff training on identifying domestic violence/elder abuse situations • Advocate for policy changes that facilitate functional assessments in cases of self-neglect
Enhance Caregiver Support and Reduce Family/Caregiver Stress	• Older Adults • Individuals with chronic and complex conditions	• Increase the availability of evidence-based family/caregiver support • Increase the number of people participating in family and care giver support programs aimed at those who are caring for individuals with complex or chronic medical, behavioral, or substance use issues • Improve care coordination and care management	• Implement "Powerful Tools for Caregivers" Program (or some similar caregiver support program) with internal clinical and community-based partner to support patients, community residents, and caregivers who are dealing with a chronic illness or disability to reduce personal stress; improve patient/caregiver/family communication, better deal with difficult feelings; and make tough caregiving decisions. • Continue support of South Shore Health's Aphasia group for patients/family members struggling with Aphasia often following a stroke. • Continue support of caregiver groups held for family members/caregivers struggling with stress of caregiving or grief following the loss of a loved one. Goals are to provide support and education to the community.

Priority Area 2: SOCIAL DETERMINANTS OF HEALTH (SDOH) AND ACCESS TO CARE			
Goal	**Target Population**	**Programmatic Objectives**	**Core Elements of CHIP / Implementation Strategy**
Link those who face barriers to health care access or disparities in health outcomes due to social determinants of health to appropriate community-based services	• Youth and Adolescents • Older Adults • Low-to-Moderate Income • Racial/ ethnic minorities and Non-English speakers	• Increase the number of individuals in at-risk groups who are screened for social determinants in clinical, school-based, home-based, and other community-based settings • Increase the number of people who are screened positive for SDOH issues who are linked to community-based services that will address their social issues • Develop a social determinants of health resource inventory • Develop systems that actively link those who screen positive to services that are part of the regional service inventory	• Implement a SDOH screening and referral program similar to CMS' Accountable Health Communities (AHC) model (Aunt Bertha) (https://innovation.cms.gov/initiatives/ahcm/)
Enhance Access to timely transportation services for those in need who do not have access to a personal car	• Older Adults • Low-to-Moderate Income • Individuals with chronic/complex conditions	• Decrease the number of elders and low income individuals who face transportation barriers when trying to access health care services or other essential services or supports • Decrease no-show rates in clinical settings • Increase percentage of elders and low income individuals who have a primary care follow-up appointment after hospital discharge	• Continue to implement Help to Home Van Program providing transportation home to patients discharged from the hospital • Work with Councils on Aging (COA) and other community partners to explore how to best leverage and coordinate transportation resources

Priority Area 2: SOCIAL DETERMINANTS OF HEALTH (SDOH) AND ACCESS TO CARE			
Goal	**Target Population**	**Programmatic Objectives**	**Core Elements of CHIP / Implementation Strategy**
Address Food Insecurity for low- to moderate income individuals and families	• Older Adults • Low-to-Moderate Income • Racial/ ethnic minorities and Non-English speakers	• Increase access to healthy foods	• Support local food banks, meals on wheels, and farmers market programs • Support the use of "pop up" food pantries and other similar evidence-based food security programs • Support school-based and elder services organizations-based programs addressing food insecurity, such as the Pilot program at Weymouth High School, Boston Food Pantry provides healthy food choices at no cost to the community. • Support local farmer's markets to combat food insecurities in the community.
Enhance Access to Health Care Services for Low Income Individuals / Families	• Youth and Adolescents • Older Adults • Low-to-Moderate Income • Racial/ ethnic minorities and Non-English speakers • Individuals with chronic/complex conditions	• Increase access to insurance coverage • Increase access to appropriate primary care and specialty care services • Reduce reliance on hospital emergency department for primary care and other non-urgent conditions	• Support SHINE Program that provides counseling on insurance information to ensure that seniors receive their maximum coverage available • Implement Emergency Department Triage Program for low- to moderate-income segments of the population, supporting programs through patient navigation with federally funded community health centers such as Manet and South Cove in Quincy.

Priority Area 2: SOCIAL DETERMINANTS OF HEALTH (SDOH) AND ACCESS TO CARE			
Goal	**Target Population**	**Programmatic Objectives**	**Core Elements of CHIP / Implementation Strategy**
Support Workforce Development and Creation of Employment Opportunities	• Youth and adolescents • Older Adults • Low-to-Moderate Income • Racial/ ethnic minorities and Non-English speakers)	• Increase mentorship, training, and employment opportunities for youth, young adults, and adults	• Organize and support Pipeline Programs to enhance skills and career advancement • Provide opportunities through career initiatives or college-level courses for employees • Offer ESOL classes, GED classes, a basic computer skills course, citizenship classes, and a financial literacy class. Work with the vulnerable population providing opportunities to develop skills allowing for professional growth. • Provide job and career introductory opportunities for community residents, supporting programs that will provide a skill base and improve opportunities for growth. • Provide job and career introductory opportunities for middle and high school students
Increase Availability of Transitional Housing and Housing Supports for those Most At-risk	• Low-to-Moderate Income • Racial/ ethnic minorities and Non-English speakers	• Increase the availability of transitional housing for those in need with complex behavioral, cognitive, or developmental problems • Increase the number of people in low- to moderate- income brackets who receive housing supports and/or counseling	• Partner with community organizations to implement and outreach and referral program to help ensure that those in need of housing supports or counseling have access to the services they need • Expand availability of transitional housing • Support organizations who provide transition housing or housing supports

Priority Area 3: CHRONIC AND COMPLEX CONDITIONS AND THEIR RISK FACTORS			
Goal	**Target Population**	**Programmatic Objectives**	**Core Elements of CHIP / Implementation Strategy**
Promote Wellness, Behavior Change, and Engagement In Appropriate Care	• Youth and Adolescents • Older Adults • Low-to-Moderate Income • Racial/ ethnic minorities and Non-English speakers • Individuals with chronic/complex conditions	• Increase the number of people who are educated about the risks and protective factors of chronic health conditions as well as basic wellness with special emphasis on hypertension, diabetes, depression/anxiety, respiratory illness) • Increase the number of people screened for the leading health issues and link those who screen positive to the services and supports they need • Increase the number of people engaged in appropriate primary care and specialty are services • Increase the number of people who are trained in CPR and other life saving activities	• Participate in health fairs for enhanced screening, health literacy, and community education • Promote and organize community workshops and educational sessions on key health issues in community venues via Speakers Bureau with the goal of educating the public and engaging participants in appropriate primary care and specialty care services • Link patients to and provide free sessions of the American Lung Association's Freedom From Smoking program • Provide education and behavior change counseling as well as other treatments in school-based settings with respect to smoking and vaping • Conduct screening and referral activities with respect to targeted health-related issues and social determinant of health issues in hospital, outpatient, and other community settings. • Promote chronic disease education regarding risk and protective factors, and behavior change as well as promote access to appropriate care at health fairs and community events (school-based, community-based, and worksite settings) • Promote cancer screening, education, counseling, peer support and survivorship programs. • Reach out to the Brazilian community and provide primary care through the Brazilian Community Health Project with health screenings and other primary care services

Priority Area 3: CHRONIC AND COMPLEX CONDITIONS AND THEIR RISK FACTORS			
Goal	**Target Population**	**Programmatic Objectives**	**Core Elements of CHIP / Implementation Strategy**
Increase Physical Activity and Healthy Eating	• Youth & Adolescents • Older Adults • Low-to-Moderate Income • Racial/ ethnic minorities and Non-English speakers • Individuals with chronic/complex conditions	• Increase access to healthy diverse foods • Increase the number of youths, adults, families and elderly who are provided counseling & coaching on physical exercise, nutrition, and obesity • Increase access to services for individuals and families who suffer from food insecurity	• Partner with the YMCA to implement nutrition and weight loss classes facilitated by a registered dietician • Support programs to increase access to healthy foods and support nutritional education such as farmers markets, cooking classes etc. • Support and implement programs that increase opportunities for physical activity for those most at-risk
Reduce Falls in Elders	• Older Adults	• Increase balance training and physical activity; management of existing illness; and home modifications • Increase the number of individuals and families who receive home visits to assess safety	• Participate in MA Department of Public Health Matter of Balance Program with community-based partners (e.g., COAs, South Shore Elder Services, other elder services organizations, primary care providers) • Participate in evidence based Fall Reduction programs such as “Matter of Balance” to provide education to patients who have had a fragility fracture to prevent further falls

Priority Area 3: CHRONIC AND COMPLEX CONDITIONS AND THEIR RISK FACTORS			
Goal	**Target Population**	**Programmatic Objectives**	**Core Elements of CHIP / Implementation Strategy**
Improve Chronic Care Management	• Older Adults • Individuals with chronic/complex conditions	• Increase the number of primary care and specialty care practice sites who are engaged in evidence-based, chronic disease management services • Increase the number of people with chronic conditions who are referred from primary care and linked to needed, non-clinical community services • Increase access to chronic care case management services • Increase the number of adults with diabetes, hypertension, and other chronic diseases who receive evidence-based counseling/coaching and treatment	• Implement evidence-based protocols in primary care and specialty care settings (e.g., Million Hearts Campaign) • Explore geriatric care management programs with internal and external partners • Facilitate support groups for those with chronic conditions • Participate and support MA Department of Public Health Stanford Self-Management Support Program workshops in community-based settings, including Councils on Aging, YMCAs, and South Shore Elder Services.

Priority Area 4: HEALTH SYSTEM STRENGTHENING			
Goal	**Target Population**	**Programmatic Objectives**	**Core Elements of CHIP / Implementation Strategy**
Promote Collaboration with Community Health Partners (External Focus)	• State/Local Health Departments • Health, social service, and other health-related Community partners • Community Coalitions • SSH Patients • Community- At-large	• Increase or enhance information sharing with local health departments and other community health partners • Align SSH's CB/CH strategy with SSH's DoN Community Health Initiatives and SSH's broader hospital vision / business plan • Build workforce and organizational capacity with respect to information sharing, service integration, care coordination, and the quality of services provided • Increase the number of partnerships in the community within and across sectors to address priority health issues and improve overall community health	• Share needs assessment findings with local health departments and other community partners across sectors (e.g., clinical providers, social service providers, community-based organizations through tailored reports, data dashboards, and meeting presentations • Meet periodically with local health departments and other key community partners to share SSH vision and CB plans/accomplishments as well as discuss potential collaborations • Participate in community health task forces, community coalitions, and CHNA meetings • Distribute mini grant funds ($5-10K grants) to community health partners to support ad hoc activities that are aligned with SSH's CB priorities, through distribution of the Critical Care Expansion project-DoN. • Continue formal, substantive partnerships with at least 4 key, external community partners on activities tied to SSH's CB priorities and SSH's overall population health management strategy • Continue formal substantive, partnerships with the Community Health Network Areas (CHNAs) that operate in SSH service area
Promote Collaboration with Community Health Partners (Internal Focus)	• SSH Clinical and Administrative Staff	• Increase awareness of SSH's CB/CH plans and accomplishments • Increase the number of clinical and other hospital staff who participate in SSH's Speaker's Bureau • Align SSH's PHM/business strategy with CB strategy	• Report Community Benefit (CB) plans and accomplishments (orally and in writing) to SSH staff/clinicians • Present community health awards to staff and clinicians who have made exemplary contributions to CB and community health activities • Continue to support the development of the SSH "Speakers Bureau" as a resource for the community

Priority Area 4: HEALTH SYSTEM STRENGTHENING			
Goal	**Target Population**	**Programmatic Objectives**	**Core Elements of CHIP / Implementation Strategy**
Enhance Care Coordination, Counseling, and Referral Services During/After Hospital Discharge	• Older Adults • Individuals with chronic/complex conditions	• Reduce inappropriate hospital readmissions • Reduce fragmentation of services in the community • Improve discharge planning protocols, counseling, and care transition plans • Increase referral rates to primary care setting after discharge • Improve medication management	• Strengthen existing hospital care transition programs related to reducing inappropriate hospital readmissions, improving discharge planning/counseling, and improving care transitions • Build collaboration between primary care providers, elder services agencies, home health providers, and other community-based partners • Implement "Honoring Choices" Program (or some similar options planning counseling initiative) with internal and external clinical and community-based partners to help adults make a health care plan that honors their choices all through their lives (e.g., COAs and other elder services organizations, primary care providers) • Strengthen Caregiver support Program (or some similar caregiver support program) with internal clinical and community-based partner to support patients, community residents, and caregivers who are dealing with a chronic illness or disability to reduce personal stress