2017-2019

ST. MARY MEDICAL CENTER

COMMUNITY HEALTH IMPLEMENTATION PLAN 2017-2019

10/10/2016

St. Mary HEALTH

St. Mary Medical Center, Langhorne, PA
Community Health Needs Assessment
Implementation Strategy
Fiscal Years 2017-2019

St. Mary Medical Center (St. Mary) completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors on May 9, 2016. St. Mary Medical Center performed the CHNA in adherence with certain federal requirements for not-for-profit hospitals set forth in the Affordable Care Act and by the Internal Revenue Service. The assessment took into account input from representatives of the community, community members, and various community organizations. The complete CHNA report is available electronically at www.stmaryhealthcare.org/CommunityDashboard , or printed copies are available from St. Mary Community Health Services.

Community Health Implementation Plan was adopted by St. Mary Board of Directors on September 12, 2016.

Hospital Information and Mission Statement

Licensed for 373 beds, St. Mary Medical Center in Langhorne, PA, is the most comprehensive medical center in the area. St. Mary provides advanced care across four primary Centers of Excellence – cardiology, oncology, orthopedics, and emergency and trauma services. St. Mary's compassionate staff of more than 700 physicians, 3,000 colleagues, and 1,100 volunteers is committed to providing excellence in patient safety and quality care. As a faith-based organization, St. Mary has clearly defined its vision to serve the needs of those who entrust their lives to us, cherishing the whole person – physically, emotionally, and spiritually – with special commitment for the poor and underserved. St. Mary's outreach to the poor and underserved includes its Community Ministries in Bensalem - the Mother Bachmann Maternity Center, Children's Health Center and Family Resource Center - as well as ongoing support for the Adult Health Clinic operated by the Bucks County Health Improvement Partnership.

The original St. Mary Hospital was founded in Philadelphia in 1860 by the Sisters of St. Francis of Philadelphia. In 1973 St. Mary Hospital opened its doors in Langhorne, responding to a community need in the rapidly growing Lower Bucks County. St. Mary is the only Catholic Hospital in Bucks County. As a not-for-profit faith based organization, we take great pride in our commitment to reinvest our resources for the benefit of the community and to provide those less fortunate free access to medical care and other supportive services that can improve their health and empower them to become independent and self-sufficient. Our community benefit includes not only uncompensated medical care and financial assistance (charity care) for the uninsured and underinsured, but also community education and wellness programs, grants and in-kind donations to other nonprofit community partner organizations. The population of the hospital's primary service area is estimated at 445,513 persons.

Mission

We, St. Mary Health and Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. As a community of caring people, we are committed to extending and strengthening the healing ministry of Jesus.

Health Needs of the Community

The CHNA, conducted over a 6-month time period and Board approved May 9, 2016, identified five significant health needs within the St. Mary Medical Center community. Those needs were then prioritized based on both perceived and measured importance and alignment with St. Mary mission and objectives. The five significant health needs identified in our service area, in order of priority include:

Behavioral Health	▪ 16.2% of adults (56,800) diagnosed with a mental health condition (depression, anxiety, bipolar disorder) ▪ 35% of patients diagnosed with a mental health condition are not receiving treatment ▪ Social service provider focus groups noted that stress-related depression is often an underlying issue in the lower income population, placing them at increased risk for substance abuse, suicide, and more subtle behavior health issues that affect their relationships with people and their physical health ▪ Suicide rate in the St. Mary service area (12.3 per 100,000) is higher than SEPA as a whole (10.9), and does not meet the Healthy People 2020 goal of 10.2 or fewer
Cancer Screening & Awareness	▪ Leading cause of death in service area is all cancers combined at an average rate of 955 deaths annually ▪ Among all cancer deaths in the service area, lung cancer has the highest site-specific mortality rate (46 per 100,000; 253 deaths annually) followed by female breast (25 per 100,000; 78 deaths annually) ▪ 39.5% (55,105) of low income uninsured women age 40+ are not receiving routine mammogram screening annually ▪ 48% (87,542) of women ages 18 and up do not receive routine pap screening yearly

Heart Healthy Lifestyle Education	▪ Obesity-related conditions include heart disease, stroke and type-2 diabetes. Heart disease is second leading cause of death (85 per 100,000; 496 deaths annually) ▪ More than 1 in 5 adults (22%, age-adjusted, or 101,300 adults) have been diagnosed with high blood pressure ▪ Among adults with high blood pressure, 4% report not taking all or nearly all of their medication all of the time ▪ 51% (56,000) of older adults age 60+ have been diagnosed with high blood pressure ▪ 28.3% (102,800) of adults are obese ▪ 15.9% (9,700) of children are obese; children and adolescents who are obese are likely to be obese as adults and are therefore more at risk for adult health problems ▪ 12.7% (44,900) of adults have been diagnosed with diabetes ▪ More than 1 in 5 (21%) older adults (age 60+) have diabetes; this represents 23,300 older adults. ▪ 52% of adults (183,800) exercise fewer than 3 days a week ▪ 75% of adults do not reach the recommended goal of consuming 4-5 servings of vegetables and fruit daily
Access to Care	▪ 4.9% of adults lack of health insurance ▪ 9.7% of adults delay medical care due to cost ▪ 11.4% of adults have no prescription drug coverage ▪ 2.6% of children do not have a routine source of care
Homelessness	▪ 530 individuals reported as homeless during annual Point-in-Time Count (9% increase from PIT 2015 Count)

*Adults - Ages 18-64 years
Older Adults - Age 60+

Hospital Implementation Strategy

St. Mary Medical Center resources, and overall alignment with the hospital's mission, goals and strategic priorities, were taken into consideration along with the significant health needs identified through the most recent CHNA process.

Significant health needs to be addressed
St. Mary Medical Center will focus on developing and/or supporting initiatives and measure their effectiveness, to improve the following health needs:

- Behavioral Health – Detailed need specific Implementation Strategy on 5
- Cancer Screening & Awareness – Detailed need specific Implementation Strategy on 6-7
- Heart Healthy Lifestyle Education – Detailed need specific Implementation Strategy on 8-9
- Access to Care – Detailed need specific Implementation Strategy on 10
- Homelessness – Detailed need specific Implementation Strategy on 11

Significant health needs that will not be addressed

St. Mary Medical Center acknowledges the wide range of priority health issues that emerged from the CHNA process, and determined that it could effectively focus on those health needs which it deemed most pressing, under-addressed, and within its ability to influence. SMMC will not take action on the following health need:

- **Falls Older Adults** - Duplication of services, St. Mary Trauma Department provides balance education and home safety programs in the community.
- **Asthma in Adults** – 20% of adults have been diagnosed with asthma in their lifetime; however, this is the first time asthma has been shown to be significant and therefore, no trend can be established.
- **Affordable Food & Safe Places to Play** – Not area of expertise, this was noted at a community meeting and no trend can be established.

This implementation strategy specifies community health needs that St. Mary has determined to meet in whole or in part and that are consistent with its mission. St. Mary reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the three years ending 2019, other organizations in the community may decide to address certain needs, indicating that St. Mary then should refocus its limited resources to best serve the community.

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2017-2019			
HOSPITAL FACILITY:	St. Mary Medical Center, Langhorne, PA		
CHNA SIGNIFICANT HEALTH NEED:	Behavioral Health		
CHNA REFERENCE PAGE:	Electronic page #69	**PRIORITIZATION**	1

BRIEF DESCRIPTION OF NEED: Approximately 56,800 adults in the service area (16%) have been diagnosed with a mental health (MH) condition, of those 35% (~19,880) are not currently receiving treatment for the condition.

GOAL: Improve access to behavioral health services and programs for low income uninsured and underinsured vulnerable persons by ensuring access to behavioral health care/case management services and education programs.

OBJECTIVE: To increase access to quality behavioral health services and programs for 1,000 low income persons diagnosed with a behavioral health disorder.

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. Partner with Family Service Association (FSA) to offer mental health services for low income persons/families with a mental health condition at community clinics.
2. Partner with behavioral health providers (Gaudenzia, Inc. and Today, Inc.) to offer substance abuse stabilization/ recovery services for low income adolescents, adults and families cleared for rehab services.
3. Partner and provide permanent supportive housing for chronically homeless due to mental health diagnosis.
4. Partner/fund school-based initiatives: anti-bullying and suicide prevention programs.

ANTICIPATED IMPACT OF THESE ACTIONS:

1. ~50 low income persons with a mental health diagnosis referred by the Bucks County Health Improvement Partnership (BCHIP) Adult Clinic, Mother Bachmann Maternity Center (MBMC) and Children's Health Center (CHC) will receive mental health services in partnership with FSA.
2. ~50 Low income individuals on Medical Assistance in need of detox services will receive day detox and supportive services in partnership with Gaudenzia, Inc. / ~55 adolescents/young adults detox services Today, Inc.
3. 6 Families who have a head of household with a mental illness will receive permanent supportive housing in partnership with the Bucks County Housing Group (BCHG).
4. ~1,000 students will participate in suicide awareness and prevention (Minding Your Mind) and ~1,200 students will participate in conflict resolution (Peace Center) school-based education programs.

PLAN TO EVALUATE THE IMPACT:

1. Track the number of individuals referred from BCHIP Clinic/MBMC/CHC who are receiving mental and behavioral health services.
2. Count the number of individuals who complete detox stabilization program at Gaudenzia, Inc. /Today, Inc.
3. Monitor self-sufficiency statistics for families housed in permanent supportive housing program BCHG.
4. Monitor the number of individuals completing and quality metrics for school-based suicide awareness/prevention and relational aggression programs (Minding Your Mind and Peace Center).

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT (FY17):

Operational Support: $142,014 Grant Support: $279,125

COLLABORATIVE PARTNERS: St. Mary Spiritual Care, BCHIP Adult Clinic, CHC/MBMC, Family Service Association, Gaudenzia, Today, Inc., Minding Your Mind, Peace Center.

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2017-2019			
HOSPITAL FACILITY:	St. Mary Medical Center, Langhorne, PA		
CHNA SIGNIFICANT HEALTH NEED:	Cancer Screenings & Awareness		
CHNA REFERENCE PAGE:	Electronic page #69	**PRIORITIZATION**	2

BRIEF DESCRIPTION OF NEED: Cancer is the leading cause of death in the service area (958 deaths annually). Among all cancer deaths in the service area, lung cancer has the highest site-specific mortality rate (253 deaths annually) followed by female breast (78 deaths annually). Within the service area, 40% (55,100) of women age 40 or older did not have a mammogram in the past year.

GOAL: Increase routine cancer screening awareness in both the clinical and community setting; improve access to preventive cancer screenings for uninsured, with special emphasis on women's health and lung cancer screenings; and increase awareness of routine cancer screenings in older adults.

OBJECTIVE: To increase the proportion of low income uninsured women age 40+ who receive an annual mammogram; to reduce barriers for lung cancer screening for low income uninsured asymptomatic patients meeting US Preventive Services Task Force lung cancer screening criteria; and to increase the proportion of older adults (age 60+) who participate in routine recommended cancer screenings.

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. Partner with St. Mary: Regional Cancer Center, Chief Medical Information Officer, and Physician Liaison to increase awareness of lung cancer screening guidelines among health care providers using education platforms including St. Mary Regional Cancer Center Shared Decision Making Communications and Lung Cancer Screening Applications for handheld devices (Apple and Android Devices).
2. Reduce barriers to lung cancer screenings by providing low-dose computed tomography (LDCT) scanning of the chest at no cost for low income uninsured community members, as identified by partner organization Bucks County Health Improvement Partnership (BCHIP) and St. Mary Regional Cancer Center Navigator, who meet the US Preventive Services Task Force lung cancer screening criteria.
3. Increase in cancer screening awareness and outreach in collaboration with community partner organizations.
4. Continue to partner with St. Mary Breast Center to provide mammograms at no cost for low income uninsured women age 40+ annually through St. Mary Breast Health Initiative (BHI).
5. Continue to partner with St. Mary Regional Cancer Center and St. Mary Dermatologists to provide skin cancer screenings for colleagues and community.
6. Educate seniors on the frequency and benefits of participation in routine cancer screenings including breast, colon and lung through the "10 Keys™ to Healthy Aging" evidence-based program for Medicare eligible population.

ANTICIPATED IMPACT OF THESE ACTIONS:

1. Health care providers within St. Mary network will receive educational materials on lung cancer screening criteria and will refer eligible patients for annual lung cancer screening, as outlined in Medicare guidelines.
2. ~5 low income uninsured patients, who meet the US Preventive Services Task Force lung cancer screening criteria, will be screened for lung cancer using low dose CT testing.
3. ~5 Community events will highlight routine cancer screenings programs provided by St. Mary Medical Center for the broader and low income community members.
4. ~200 uninsured low income women 40+ will receive free mammogram screening through BHI program.
5. ~150 Colleagues and community members will participate in skin cancer screenings.
6. ~ 300 older adults will complete "10 Keys™" to Healthy Aging program and follow the recommended "Prevention in Practice" routine cancer screening Medicare guidelines.

PLAN TO EVALUATE THE IMPACT:

1. Monitor number of patients referred for lung cancer screening, including low income patients and those referred by St. Mary health care providers, and number of "early" stage cancers diagnosed each year.
2. Monitor numbers reached with cancer screening awareness information.
3. Monitor utilization of mammograms and number of cancers diagnosed each year.
4. Monitor number of colleagues and community members participating in skin cancer screenings and number of biopsies recommended.
5. Partner with Center for Aging and Population Health to monitor "10 Keys™" to Healthy Aging program participant's adherence to Prevention in Practice recommendations through 6 month and 1 year follow-up phone calls.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT (FY17):

1. **Operational Support:** $60,000
2. **Grant Support:** N/A

COLLABORATIVE PARTNERS:

Bucks County Health Improvement Partnership (BCHIP); St. Mary Radiology Team and Breast Surgeons and St. Mary Breast Center, St. Mary Regional Cancer Center, St. Mary Dermatologists, and Center for Aging and Population Health, University of Pittsburgh Graduate School of Public Health (A Centers for Disease Control Prevention Research Center).

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2017-2019			
HOSPITAL FACILITY:	St. Mary Medical Center, Langhorne, PA		
CHNA SIGNIFICANT HEALTH NEED:	Heart Healthy Lifestyle Education		
CHNA REFERENCE PAGE:	Electronic page #69	**PRIORITIZATION**	3

BRIEF DESCRIPTION OF NEED: Increased rates of obesity contributing to chronic disease risk (heart disease, stroke and type-2 diabetes). Children and adolescents who are obese are likely to be obese as adults and are therefore more at risk for adult health problems as noted above.

GOAL: Promote wellness through the consumption of balanced diets, recommended physical activity and achievement and maintenance of healthy body weights in adults and children.

OBJECTIVE: To engage ~2,500 children/families (ages 6-17 years) and ~120 colleagues/community members in St. Mary obesity prevention and weight management programs.

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. Partner with Bucks County School District Nurses to refer children to KidShape 2.0/Families Living Well Program (FLW) who have been identified as overweight or obese during annual BMI screening. Continue to provide FLW programs in Bucks County School Districts, with special emphasis in low income areas.
2. Maintain partnerships with local family and pediatric practices to identify and refer children who have been identified as overweight or obese using FLW prescription pad.
3. Continue to monitor outcomes data using validated survey tool for FLW.
4. Continue partnership with St. Christopher's Foundation for Children to provide professional education programs for local clinicians "Farm to Families" in 3 locations to increase access to fresh and affordable fruits/vegetables, with special emphasis in low income areas. Continue incentive program for Farm to Families SNAP participants to promote long-term participation.
5. Participate in Hunger Nutrition Coalition (HNC) and community partners to form comprehensive strategy to address Food Insecurity.
6. Partner/Fund Breast Feeding Resource Center to support breast feeding of infants up to 1 year for low income new mothers to reduce risk of childhood obesity.
7. Provide access to Way to Wellness Weight 10-Week Management Program for Diabetic Patients continue to monitor outcomes data using validated survey tool.
8. Partner with Penn State Extension to provide Dining with Diabetes program (adults), a 5-week program and 6 month follow-up at Community Ministries and other community locations.
9. Explore Partnership/Fund CDC National Diabetes Prevention Program at local Lower Bucks YMCA to prevent or delay onset of type-2 diabetes in at risk patients with pre-diabetes.
10. Provide 10 Keys to Healthy Aging program to promote successful aging through emphasis on prevention screenings and healthy lifestyle education for seniors enrolled in Medicare.
11. Establish/Partner to provide Strong Women Strong Hearts 12-week pilot program in collaboration with one St. Mary Cardiology Practice. Following completion of pilot, explore expansion of program to one Primary care practice.
12. Explore partnership with US Soccer Foundation (USSF) to implement Soccer for Success after school program to increase physical activity 3 days a week (24 weeks per year) in conjunction with USSF designated community partner (after school provider).
13. Continue to partner/fund Smoking Cessation counseling classes with Bucks County Health Improvement Partnership (BCHIP) for colleagues and community members.
14. Continue to advocate and support Tobacco control policies our community, including the Pennsylvania Clean Indoor Act.

ANTICIPATED IMPACT OF THESE ACTIONS:

1. District School nurses continue to refer children with BMI > 85 percentile to KidShape 2.0 FLW program. 8 School Districts have Families Living Well programs, with sites in 6 low income areas.
2. 10% pediatrician referral rate to FLW programs.
3. Children/Families in FLW will demonstrate 14%-20% increase in daily vegetable and fruit consumption; positive trend toward reduction in weekend screen time; >10% increase in physical activity; and increase in family cohesiveness (rules) at the conclusion of the 8-week program. W2W participants will continue to show positive trends in healthy behavior choices in the 10-week program.
4. 10% Increase in Farm to Families participation at all 3 St. Mary Farm to Families licensed sites. Professional education events attended by 100 local area clinicians and 1,000 individuals receive FLW and Farm to Families program information.
5. Increase in availability of healthy foods at local food pantries in partnership with HNC and community partners.
6. Breastfeeding duration rates at 3, 6 and 12 months from Breast Feeding Resource Center low income uninsured and Medicaid clients will be greater than the national and local average, as published by the Centers for Disease Control.
7. 120 colleagues, patients and community members will participate in the W2W sessions; increased healthy food choices and recommended physical activity will be maintained throughout the 10-week session. 10 Diabetic patients will complete the 10-Week Way to Wellness Weight Management Program.
8. Dining with Diabetes Program will demonstrate a decrease in HgbA1C at 6-month follow-up.
9. St. Mary will provide a grant to Lower Bucks YMCA as a National Diabetes Prevention Program Center in support of yearly pre-diabetic patients.
10. 300 patients will complete "10 Keys™" to Healthy Aging program.
11. 25 Women ages 55 to 75 years will participate in Strong Women Strong Hearts 12-week pilot program and show positive trend towards reduction in cardiovascular risk.
12. After school program provider will be selected by USSF to implement the Soccer for Success Childhood Obesity Prevention program in low income neighborhood.
13. 50 Colleagues/community members will participate in BCHIP smoking cessation classes with a 70% class completion rate.
14. St. Mary will engage State Legislators regarding PA Clean Indoor Air Act and other tobacco policies in our community.

PLAN TO EVALUATE THE IMPACT:

1. Track number of schools and referrals from school nurses to KidShape 2.0 program.
2. Track number of Family and Pediatric Practices who refer families to FLW Programs.
3. Review pre and post program evaluations for changes in healthy behaviors for FLW and W2W programs.
4. Track the number of Farm to Families initiative participants and number and length of time SNAP participants enrolled in incentive program. Track attendance at Childhood Obesity professional education events.
5. Track Food Insecurity efforts championed by Hunger Nutrition Coalition.
6. Track breast feeding rates at 3, 6 and 12 months for low income mothers enrolled in Breast Feeding Resource Center.
7. Track the number of patients and community members who have completed the Way to Wellness 10-Week Weight Management Program.
8. Monitor HgbA1C for Dining with Diabetes Program at 6 months post-completion of program.
9. Track number enrolled and progression to type-2 diabetes for community members enrolled in National Diabetes Prevention Program in partnership with Lower Bucks YMCA.
10. Evaluate participant questionnaires and monitor Prevention in Practice Report for 10 Keys to Healthy Aging participants.
11. Monitor Strong Women Strong Hearts cardiovascular risk profile to assess for potential shift to risk profile.
12. Monitor progress in after school site selection for Soccer for Success.
13. Monitor enrollment, completion, and long-term quit rate for colleagues/community members who complete BCHIP smoking cessation classes.
14. Monitor revised and new tobacco policies advocated for in our community.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT (FY17):

1. **Operational Support:** $634,568
2. **Grant Support:** $200,000

COLLABORATIVE PARTNERS:

Bucks County School District Nurses, St. Christopher's Foundation for Children "Farm to Families Initiative," Lancaster Farm Fresh, Breast Feeding Resource Center, Penn State University, St. Mary Wellness Center, Lower Bucks YMCA.

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2017-2019			
HOSPITAL FACILITY:	St. Mary Medical Center, Langhorne, PA		
CHNA SIGNIFICANT HEALTH NEED:	Access to Care		
CHNA REFERENCE PAGE:	Electronic page #69	**PRIORITIZATION**	4

BRIEF DESCRIPTION OF NEED: Lack of routine source of care for 10% of adults (~33,900) and 3% of children (2,400) in St. Mary service area.

GOAL: Improve access to primary and preventive health services for the uninsured adults and children in St. Mary service area.

OBJECTIVE: Increase the proportion of underserved adults and children who have ongoing source of care.

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. Enroll uninsured community members annually in Medicaid/Children's Health Insurance Program (CHIP), and St. Mary Financial Assistance program through hospital and community-based enrollment assistance centers, with special emphasis in low income areas.
2. Provide access to primary care services for Medicaid patients through St. Mary Physician Group Practices.
3. Continue to provide grant support for adult primary care clinics for managing ~1,000 patient lives annually (Bucks County Health Improvement Partnership Adult Clinic.
4. Increase annually primary care services for uninsured/underinsured low income children at the Children's Health Center (CHC) and access to parenting support services.
5. Provide access to prescription medications for low income uninsured patients at time of hospital discharge and through extended time period as noted in financial assistance guidelines.
6. Provide access to joint replacement surgeries (total knee or hip) for 5 low income US citizens or permanent residents of Bucks County in partnership with St. Mary Orthopedics Team and Operation Walk USA.

ANTICIPATED IMPACT OF THESE ACTIONS:

1. ~200 uninsured Bucks County residents will be enrolled into Medicaid/CHIP and St. Mary Financial Assistance program. Reduction in uninsured persons utilizing ED.
2. Increase in Medicaid patients utilizing St. Mary Physician Group Practices.
3. ~800 uninsured ineligible Medicaid patients will receive primary care services at BCHIP Adult Clinic.
4. 3,700 children are enrolled to receive ongoing source of care at CHC.
5. ~2,000 uninsured low income patients will receive financial assistance with prescriptions medications at no cost for up following hospital discharge and through extended time period as noted in Financial Assistance guidelines; uninsured BCHIP clinic patients will receive prescriptions medications at no cost as needed.
6. 5 patients will undergo charitable joint replacement surgery (total knee or hip) in partnership with St. Mary Orthopedics Team as a registered Operation Walk USA provider.

PLAN TO EVALUATE THE IMPACT:

1. Track the number of patients enrolled into Medicaid/CHIP and St. Mary Financial Assistance program. Monitor the change in uninsured persons through the 2015 & 2017 Public Health Management Household Healthy Survey. Monitor annual ED utilization by uninsured persons.
2. Monitor Medicaid patients receiving primary care at St. Mary Physician Group Practices.
3. Monitor number of patients receiving ongoing primary care services at CHC & BCHIP Adult Clinic.
4. Monitor utilization of prescription medication programs on a monthly basis.
5. Track number of charitable joint replacement surgeries provided by St. Mary Orthopedics Team, a registered Operation Walk USA provider.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT (FY17):

1. **Operational Support:** $5,454,561
2. **Grant Support:** $982,500

COLLABORATIVE PARTNERS: Bucks County Health Improvement Partnership (BCHIP); Children's Health Center, Public Health Management Corp.; St. Mary Radiology Team and Breast Surgeons and St. Mary Breast Center and St. Clare Pharmacy colleagues, St. Mary Orthopedics Team and Operation Walk USA.

CHNA IMPLEMENTATION STRATEGY FISCAL YEARS 2017-2019			
HOSPITAL FACILITY:	St. Mary Medical Center, Langhorne, PA		
CHNA SIGNIFICANT HEALTH NEED:	Homelessness		
CHNA REFERENCE PAGE:	Electronic page #69	**PRIORITIZATION**	5

BRIEF DESCRIPTION OF NEED: Lack of affordable housing in Bucks County.

GOAL: Improve access to eviction prevention resources and housing and case management services for homeless or those at risk of becoming homeless.

OBJECTIVE: Connect 500 homeless or those at risk of becoming homeless to emergency, transitional and sustainable housing.

ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. Support Emergency Housing Shelter managed by Family Service Association (FSA).
2. Partner/Fund Advocates for the Homeless and Those in Need (AHTN) to provide Emergency Shelter during Code Blue.
3. Continue to partner/fund Bucks County Housing Group (BCHG) to provide housing/case management services for low income families including access to: Transitional and Permanent Supportive Housing units, with incorporation of Housing First model.
4. Continue to partner/fund Bucks County Housing Group (BCHG) to provide expanded case management services for low income families experiencing a housing crisis (2 Diversion Case Managers).
5. Partner/Fund Sunday Breakfast Rescue Mission (SBRM) to provide basic services for unsheltered homeless individuals.
6. Partner/Fund Way Home, Inc. (WH), to house single adult homeless males in Bristol.

ANTICIPATED IMPACT OF THESE ACTIONS:

1. 250 Homeless individuals will be housed in the Emergency Shelter managed by FSA.
2. 125 Homeless individuals will be housed during Code Blue in local churches coordinated by AHTN.
3. 22 Families will be placed in BCHG managed transitional, permanent supportive housing and Housing First units and 80% of these families will progress to sustainable housing within 1 year.
4. 40% Reduction in BCHG supportive housing wait list.
5. 55 Unsheltered singles will receive basic services coordinated by SBRM.
6. 5-10 Homeless adult males will be placed in stable housing environment coordinated by WH.

PLAN TO EVALUATE THE IMPACT:

1. Track the number of persons served by each coordinating organization.
2. Monitor percent change in homeless shelter wait list.
3. Monitor percent that move onto sustainable housing and self-sufficiency.
4. Monitor percent change in BCHG supportive housing wait list. Monitor ratio of clients in and available housing units.
5. Monitor number of unsheltered singles served and number of basic services provided by SBRM.
6. Monitor number of homeless adult males in congregate living provided by WH.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT (FY17):

1. **Grant Support:** $1,221,986

COLLABORATIVE PARTNERS: Family Service Association, Advocates for the Homeless and Those in Need, Bucks County Housing Group, Sunday Breakfast Rescue Mission, Way Home, Inc.