Lourdes

Implementation Strategy for the 2022-2025 CHNA
Broome County, NY

Lourdes

Our Lady of Lourdes Memorial Hospital, Inc.
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The 2022-2025 Implementation Strategy was approved by the Lourdes Board of Directors on October 21, 2022 (2021 tax year), and applies to the following three-year cycle: July 2022 to June 2025. This report, as well as the previous report, can be found at our public website.

We value the community's voice and welcome feedback on this report. Please visit our public website (Guthrie.org) to submit your comments.

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Introduction

Lourdes

Lourdes is a non-profit hospital governed by a local board of trustees represented by residents, medical staff, and sister sponsorships, and has been providing medical care to Broome County and the Southern Tier. Lourdes operates 1 hospital campus, 36 related healthcare facilities, and employs 244 primary and specialty care clinicians.

Serving New York State since 1925, Lourdes is continuing the long and valued tradition of addressing the health of the people in our community. The Mission, Vision, and Values are embodied in the organization's culture. These core tenants are foundational to the work aimed to transform healthcare and express identified priorities when providing care and services, particularly to those most in need.

For more information about Lourdes visit: www.Guthrie.org

Overview of the Implementation Strategy

Purpose

This implementation strategy (IS) is Lourdes response to the health needs prioritized from its current Community Health Needs Assessment (CHNA). It describes the actions Lourdes will take to address prioritized needs, allocate resources, and mobilize hospital programs and community partners to work together. This approach aligns with Lourdes commitment to offer programs designed to address the health needs of a community, with special attention to persons who are underserved and vulnerable.

IRS 501(r)(3) and Form 990, Schedule H Compliance

The CHNA and IS satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection and Affordable Care Act of 2010, more commonly known as the Affordable Care Act (ACA). As part of the ACA, all not-for-profit hospitals are required to conduct a CHNA and adopt an implementation strategy every three years. Requirements for 501(c)(3) Hospitals Under the Affordable Care Act are described in Code Section 501(r)(3), and include making the CHNA report (current and previous) widely available to the public. In accordance with this requirement, electronic reports of both the CHNA and the current implementation strategy can be found at www.Guthrie.org

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Process to Prioritize Needs

Included in Code Section 501(r)(3) is the requirement that hospitals must provide a description of the process and criteria used to determine the most significant health needs of the community identified through the CHNA, along with a description of the process and criteria used to determine the prioritized needs to be addressed by the hospital. Accordingly, Lourdes used a phased prioritization approach to identify the needs within Broome County, NY. The first step was to determine the broader set of identified needs. Through the CHNA assessment, identified needs were then narrowed to a set of significant needs which were determined most crucial for community stakeholders to address.

Following the completion of the CHNA assessment, significant needs were further narrowed down to a set of prioritized needs that the hospital will address within the implementation strategy. To arrive at the prioritized needs, Lourdes used the following process:

- The Community Health Needs Assessment (CHNA) Steering Committee convened a workshop with an expanded group of associates from all levels of the organization—a group of 25 that included Executives, Senior Leaders, Directors, Managers and Support Staff.
- Following a CHNA overview, all 25 members were given an unranked listing of all needs themes that emerged during the CHNA process.
- All members were given time to review each theme in detail and ask any questions.

Due to the amount of time and resources each of the themes would individually require to make a noticeable and sustained impact in the community, the objective for the workshop was to have the workshop group identify the top five (5) most critical issues that, 1) were most appropriate for the hospital to address, and 2) the hospital had the capacity to address. Participants were then asked to use the scorecard to grade each of the needs themes (a scale was provided) based on the following eight criteria:

1) The extent of the health need theme issue is sensitive or political.
2) The estimated financial costs to make a positive impact.
3) There is attention or focus already underway to address by other organizations/institutions.
4) The extent that the need theme will impact multiple stakeholder groups.
5) Multiple hospital departments have vested interest in the outcome.
6) Failure to act or address will exacerbate the issue significantly.
7) The community perceives the healthcare needs to be significant.
8) Addressing the healthcare needs falls within the scope of the Lourdes Hospital capabilities.

Results of the ranking exercise were reviewed with the entire group and discussion was had to finalize the list of needs to be addressed.

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Needs That Will Be Addressed

Following the completion of the current CHNA, Lourdes has selected the prioritized needs outlined below for its 2022-2025 implementation strategy. Lourdes has defined "prioritized needs" as the significant needs which have been prioritized by the hospital to address through the three-year CHNA cycle:

1) Improve access to specialty care providers, with specific attention to those specialists providing care to patients ages 60 and older.
    - This need was selected due to the hospital's focus on improving health among the senior (60+ years) population served. Broome County's population is aging and with this, a number of age-specific health concerns must be addressed to keep our communities healthy and thriving.

2) Improve availability and access of mental/behavioral health services, including substance use services, with focus on community collaboration.
    - Mental/behavioral health services were consistently mentioned (through all primary data collection modalities) as lacking in the Broome County area. Research indicated that individuals (and families) struggled to find providers of mental health services and substance use support in Broome County.

3) Improve access and infrastructure for health services in rural communities.
    - Community residents point to access as being a major contributor to exacerbated health disparities and health equity issues seen in rural areas. By providing improved access, Lourdes seeks to impact health outcomes across rural populations served.

4) Improve health outcomes by focusing on prevention and wellness.
    - Primary research collected during the CHNA process suggests a need for improved education and knowledge about prevention and wellness. This also aligns with national research and goals of the NYS Prevention Agenda.

5) Address services needed for vulnerable populations, including the medically indigent and homeless populations, integrating social care with prevention and medical care for a more person-centered approach to care through community collaboration.
    - Vulnerable populations are disproportionately affected by Social Determinants of Health (SDOH) which further exacerbate the fragile stability of this population. Addressing social care needs along with medical care needs within this population is necessary for sustained positive health outcomes.

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Lourdes understands the importance of all the health needs of the community and is committed to playing an active role in improving the health of the people in the communities it serves. For the purposes of this implementation strategy, Lourdes has chosen to focus its efforts on the priorities listed above.

Needs That Will Not Be Addressed

Based on the prioritization criteria, the health needs identified through the CHNA that Lourdes does not plan to address at this time include:

- Transportation was cited as a predominant barrier (regardless of living setting) to receiving healthcare services in the area. This need was not selected because the decision was made to incorporate this need as an action step in one of the other needs to address this concern.
- Participants spoke of the need to provide further community-wide education to build awareness of current available services. This need was not selected because a marketing campaign to highlight available services at Lourdes is already underway.
- More coordination and integration has positively impacted care delivery within the area. Participants acknowledged that providers and healthcare systems are working more collaboratively. This need was not selected because it is already occurring. The decision was made to continue collaborating wherever possible throughout the Lourdes system.
- Chronic conditions such as obesity and diabetes were raised by several participants as problems within the community. These are considered big challenges to improving the community's overall health long term. This need was not selected because there is already a focused effort within the hospital system and the community to address obesity and diabetes in the community.
- Several participants recognized the considerable effort that Lourdes has made to address community healthcare needs, particularly given the COVID-19 pandemic stress. This need was not selected because it is already occurring.

While these needs are not the focus of this implementation strategy, Lourdes may consider investing resources in these areas as appropriate, depending on opportunities to leverage organizational assets in partnership with local communities and organizations. Also, this report does not encompass a complete inventory of everything Lourdes does to support health within the community.

To find a list of resources for each need not being addressed, please refer to the Lourdes 2022-2025 CHNA: www.Guthrie.org

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Acute Community Concern Acknowledgement

A CHNA and Implementation Strategies (IS) offer a construct for identifying and addressing needs within the community(s) it serves. However, unforeseen events or situations, which may be severe and sudden, may affect a community. At Ascension, this is referred to as an acute community concern. This could describe anything from a health crisis (e.g., COVID-19), water poisoning, environmental events (e.g., hurricane, flood) or other event that suddenly impacts a community. In which case, if adjustments to an IS are necessary, the hospital will develop documentation, in the form of a SBAR (Situation-Background-Assessment-Response) evaluation summary, to notify key internal and external stakeholders of those possible adjustments.

Written Comments

This IS has been made available to the public and is open for public comment. Questions or comments about this implementation strategy can be submitted via the website:
www.Guthrie.org.

Approval and Adoption by Lourdes Board of Directors

To ensure Lourdes' efforts meet the needs of the community and have a lasting and meaningful impact, the 2022-2025 implementation strategy was presented and adopted by the Lourdes Board of Directors on October 21, 2022. Although an authorized body of the hospital must adopt the IS to be compliant with the provisions in the Affordable Care Act, adoption of the IS also demonstrates that the board is aware of the IS, endorses the priorities identified, and supports the action plans that have been developed to address prioritized needs.

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Action Plans

The IS below is based on prioritized needs from the hospital's most recent CHNA. These strategies and action plans represent where the hospital will focus its community efforts over the next three years. While these remain a priority, the hospital will continue to offer additional programs and services to meet the needs of the community, with special attention to those who are poor and vulnerable.

PRIORITIZED NEED # 1: *Improve Access to Specialty Care Providers, w/ Specific Attention to Those Specialists Providing Care to Patients Age 60 and Older.*

GOAL 1*: Improve community members' ability to schedule a specialty appointment, with a special focus on people 60+ years of age.*

ACTION PLAN

STRATEGY 1.1: Leverage the work of the Lourdes Medical Group Access Committee to improve specialty access for new patients.

BACKGROUND INFORMATION:

- *Target Population:* Population in the primary service area (PSA) with special focus on seniors age 60+
- *General Info:*
- *SDOHs Addressed:* Any/All

RESOURCES:

- Baseline productivity Data and tracking available slots per day; % of filled slots per day
- Human resources (Medical Group Leadership, analysts, support staff, etc.)
- Data regarding appointment slot availability for both Lourdes & UHS

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Active management by Medical Group leadership of provider productivity.	Laura Pascucci	Dr. Rai, Eric Skorupa, Kristin Evans	Standardard-ized Productivity	Individual Baselines	50th percentile	Premier
2	Implement the 5 Prioritized Access Initiatives: to increase on-line appointments, daily provider care team huddles, same day access for acute needs, non-urgent calls returned within 1 day, and increase non-traditional hours.	Laura Pascucci	Medical Group Leadership	All 5 initiatives completed- Access Scorecard	TBD- Access Scorecard		Access Scorecard

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ANTICIPATED IMPACT – OUTCOMES												
SMART OBJECTIVES: **I.** *By December 2023, increase the number of providers meeting daily appointment slots to the AMG standard (Year 1).* **II.** *By December 2024 increase in % of appointment slots filled.*												
ACTIONS	**SHORT-TERM OUTCOMES**				**MEDIUM-TERM OUTCOMES**				**LONG-TERM OUTCOMES**			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

PRIORITIZED NEED # 1: *Improve Access to Specialty Care Providers, w/ Specific Attention to Those Specialists Providing Care to Patients Age 60 and Older.*

GOAL 1*: Improve community members' ability to schedule a specialty appointment, with a special focus on people 60+ years of age.*

ACTION PLAN								
STRATEGY 1.2: Create and implement a plan to partner with others to address community-wide specialty shortage areas that could be addressed through alignment with other providers.								
BACKGROUND INFORMATION: ● *Target Population:* Community members needing specialty appointments with special focus on 65+ ● *General Info:* ● *SDOHs Addressed:* Any/All								
RESOURCES: ● Medical Staff development plan data on community provider need; Senior leadership and Lourdes Recruitment Plan ● Referral data for tier 2 and tier 3 referrals out of network								
ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**				
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Review and evaluate the Lourdes Medical Staff Development Plan to identify specialty shortages for the community.	Clinical Ecosystem Team		Completed planning document			Lourdes Medical Staff

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							Develop ment Plan
2	Meet with K. Connerton to review recommendations	Lourdes Leadership					
3	Implement as directed	Lourdes Leadership					

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *By December 31, 2023 complete the plan review and recommendations.*

II. *By December 31, 2024 implement the finalized recommendations.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

PRIORITIZED NEED # 1: *Improve Access to Specialty Care Providers, w/ Specific Attention to Those Specialists Providing Care to Patients Age 60 and Older.*

GOAL 2: *Improve the ability for scheduled patients to get to a specialty office appointment–reduce No-Shows.*

ACTION PLAN

STRATEGY 2.1: Adopt a standardized approach to appointment scheduling that includes asking patients about their plans to get to the appointment. If plans are unstable, resources should be offered at the time of scheduling to support the patient in getting to the appointment.

BACKGROUND INFORMATION:

- *Target Population:* Patients that have multiple no-shows in rolling 12 months (Out of No-Show reports in Athena); data organized by geography
- *General Info:* The CHNA that was conducted revealed that the general community is reporting difficulty in accessing specialists, not just Lourdes specialists.
- *SDOHs Addressed:* All that are identified as barriers.

RESOURCES:

- Show/No show data/Next Available Appointment Report - Data Analytics Support
- Front Desk Staff

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- Team for Social Determinants of Health assistance - Pop Health/Community Health Worker Support
- Access Committee
- Home Health Team (Home Health Aides)

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				KPI	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Complete any initial data capture/explorative data needed	Kristin Evans	Mat Stein	Comprehensive Dataset	N/A	1 Dataset	Athena
2	Develop protocols to enhance and support patients getting to appointments– - Organize who can help with getting patients to appointments - Link between individuals doing scheduling and those that can help with patient engagement. - Collaboration with front desk staff to redesign the scheduling interview to capture information on the patients' plans to get to the appointments. - Develop script and supporting workflow - Explore opportunities to convert from in-person to virtual visit where clinically applicable.	Kristin Evans, Debbie Blakeney	Operations Managers, CHW Team, Relevant CBOs	No-show Rate and Next Available Appts, Volume of transport-ation this work is supporting (by location), Virtual Visits Count	(Revisit for data entry)	Attain 6% no-show rate.	Athena
3	Convene with key providers to engage and attain feedback–for appropriate referrals to specialty care.	Dr. Rai	Laura Pascucci, Dr. Sanjiv Patel	# of Providers engaged, # of referrals providers make.		One (1) represent -ative engaged from each specialty	N/A
4	Development of Access Improvement plan - Should be aligned with Access Scorecard	Kristin Evans	Dr. Rai, Laura Pascucci, Dr. Patel, Mat Stein, Ops Managers	Completed Plan	N/A	One completed plan	N/A
5	Based on findings, select diverse sites to pilot	Kristin Evans	Operations Managers	# sites identified for pilot	N/A	N/A	N/A

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6	Optimize and Scale	Kristin Evans	Operations Managers	Rollout to additional Sites	N/A	N/A	N/A

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. By December 31, 2023, increase the # of referrals for SDOH assistance by 5%.

II. By December 31, 2024, decrease appointment no shows by 5%.

III. By December 31, 2024, improve the rate of next available appointments to Ascension standard.

IV. By December 31, 2024, increase the number of virtual visits for specialty offices by 3%.

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

PRIORITIZED NEED # 1: ***Improve Access to Specialty Care Providers, w/ Specific Attention to Those Specialists Providing Care to Patients Age 60 and Older.***

GOAL 3: ***Decrease the number of individuals who do not access care or medication due to their inability to pay for that care or medication.***

ACTION PLAN

STRATEGY 3.1: Assist people with an inability to pay for medications and medical care.

BACKGROUND INFORMATION:

- *Target Population:* Medically indigent population in the PSA with special focus on Seniors age 60+
- *General Info:*
- *SDOHs Addressed:* Any/All

RESOURCES:

- Identified CBO Partners (M&B Perinatal Network, BU)
- Finance Department
- Pharmacy
- Community Health Workers (CHWs)
- Embedded Social Workers (SWs)
- Care Managers/Navigators (Inpatient and primary care)

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ACTIONS:		LEAD ORG / STAFF	COLLAB ORG / STAFF	PROCESS MEASURES – OUTPUTS			
				Indicator	*Base-line Value / Date*	*Target Value / Date*	*Data Source*
1	Convene brainstorming team around improvements in financial assistance for medication and services. Develop proposal / implementation plan and if approved implement.	Tom Forrest, Mat Stein	Andy Stein	Number of lives supported and amount of charges that are written off	TBD	TBD	Financial and billing systems for Lourdes patients
2	Education on and utilization of the Neighborhood Resource tool and United Way 2-1-1	Deb Blakeney /Karen Riewerts	Amber Moore and Neighbor-hood Resource Team	Referral tracking reports	TBD	TBD	Neighbor-hood Resource
3	Establish, if feasible, an Access Specialist (possibly in coordination with the Binghamton University pharmacy school or residency program) to work directly with patients, providers, insurance companies and manufacturers to review all opportunities for financial assistance for specialty medications.	Tom Forrest	Pharmacy Team	Completion of feasibility study and recommend-ations			People Soft
4	For individuals not eligible for insurance coverage or PFAP, develop a fee schedule that is based on net service revenue rather than charges.	Joe Ingold		New fee schedule developed if feasible			Financial Reports
5	Analyze Point of Service Enrollment opportunities (Walk-in locations, Emergency Department, Specialty sites, etc) that can be optimized by adjusting location and hours. Identify partners (Community Based Organizations) who can assist with efforts around enrollment and help offset financial risk/burden.	Andy Stein	AMG, Service-line, and Captive PC Leadership	Enrollment tracking rate			Enrollment Product-ivity reports
6	Facilitate a connection to the Hope Dispensary, PFAP, and other financial assistance programs	Deb Blakeney/ Tom Forrest	Financial Counselors, Care Managers	Number of people served by		Increase the number served	Volume Reports

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	(e.g., access to benefits, copay cards, patient assistance programs or foundations).			these programs			

ANTICIPATED IMPACT – OUTCOMES												
SMART OBJECTIVES: **I.** *Decrease the percentage of Self Pay patients by 06/30/25.* **II.** *Increased numbers of patients who are enrolled in available insurance programs by 06/30/25.* **III.** *Decrease in writing off bad debt (dollars) for self pay patients by 06/30/25.*												
ACTIONS	**SHORT-TERM OUTCOMES**				**MEDIUM-TERM OUTCOMES**				**LONG-TERM OUTCOMES**			
	Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
TBD during action plan implementation												

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PRIORITIZED NEED #2: Improve Availability and Access of Mental/Behavioral Health Services, including Substance Use Services, w/ Focus on Community Collaboration.

GOAL 1*: Educate and raise awareness regarding stigma in seeking mental/behavioral health services.*

ACTION PLAN

STRATEGY 1.1: Review and evaluate, through the lens of stigmatization, policies that impact how individuals with mental/behavioral issues are cared for at Lourdes.

BACKGROUND INFORMATION:

- *Target Population:* Individuals with mental/behavioral health issues
- *General Info:* As Lourdes continues to broaden mental health services offerings, patients may be reluctant to seek services due to community stigma. Lourdes seeks to break this cycle through reviewing and revising (as necessary) policies and procedures and educating associates to policy changes that address the reduction of stigma. In addition, new policies will be created, if the need is identified during the policy review to support the reduction of stigma for patients seeking mental/behavioral health services.
- *SDOHs Addressed:* Reducing stigma for patients seeking behavioral health services

RESOURCES:

- Applicable policies across the organization
- PolicyStat system

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Create a taskforce to determine which policies need review.	Sue Bretscher	Representation from ED, inpatient, primary care, Security, specialty practices, LCMH/Social Work, ACBC, Erin Belensky	Taskforce created and meetings scheduled		Taskforce created and first meeting held by January 31, 2023	Lourdes Policies and Proced-ures
2	Identify policies to address perception of stigmatization of patients with mental/behavioral health issues.	Taskforce Lead	Taskforce	Policies identified and reviewed		Identification and review completed by December 31, 2023.	

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3	Complete review and revision (if needed) of identified policies to address perception of stigmatization of patients with mental/behavioral health issues.	Taskforce Lead	Taskforce	Policies reviewed and revised (if appropriate)		Policies rewritten and submitted for approval by December 31, 2024.	
4	Consider and identify additional policies; create policies as needed.	Taskforce Lead	Taskforce; subject matter experts	Gaps in policies identified; new policies written and implemented		Additional policies considered, identified and created as needed by June 30, 2025	Lourdes Policies and Proced-ures

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *Completion of policy assessment that includes a summary of gaps and/or missing language from policies, revision of policies and creation of any additional new policies needed by June 30, 2025.*

II. *Review and revise policies so that language reflects non-stigmatizing context–ongoing updates as necessary by June 30, 2025.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

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PRIORITIZED NEED #2: Improve Availability and Access of Mental/Behavioral Health Services, including Substance Use Services, w/ Focus on Community Collaboration.

GOAL 1*: Educate and raise awareness regarding stigma in seeking mental/behavioral health services.*

ACTION PLAN

STRATEGY 1.2: Create a marketing campaign regarding building trust to increase access to mental/behavioral health services, with a focus on reducing stigma.

BACKGROUND INFORMATION:

- *Target Population:* Individuals with mental/behavioral health issues
- *General Info:* As Lourdes continues to broaden mental health services offerings, patients may be reluctant to seek services due to community stigma. Lourdes seeks to break this cycle through raising awareness in the community regarding the importance of building trust to ensure patients feel comfortable and safe in seeking treatment; thereby reducing stigma.
- *SDOHs Addressed:* Reducing stigma for patients seeking behavioral health services

RESOURCES:

- Marketing and Communications Department
- Community-based organizations (CBOs)

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Base-line Value / Date***	***Target Value / Date***	***Data Source***
1	Identify existing messaging/communication methods Lourdes is using to destigmatize mental/behavioral health care.	Lisa Donovan	Lisa Donovan, Julie Weisberg	Use available analytics to determine media for campaign		Review and selection of media completed by 6/30/23	Media
2	Identify or create mental/behavioral health messaging to be delivered via selected media.	Lisa Donovan, Bill Perry, Sidney Graham	National Alliance on Mental Illness (NAMI); NYS Office of	Messages identified and created. Use of A/B testing to determine		Messages identified and created by 6/30/24	Media

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			Addiction Services and Support (OASAS)	the effective-ness of multiple messages.			
3	Prepare a timeline and deliver messages accordingly.	Lisa Donovan	Lisa Donovan; Julie Weisberg	Timeline created and messages delivered; level of engagement (reactions and comments) on social media number of “click throughs” on digital ads		Messages delivered according to timeline (by 6/30/25).	Media

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *Marketing plan developed and implemented to build trust to increase access to mental/behavioral health services, with a focus on reducing stigma by June 30, 2025.*

II. *Use social media analytics and A/B testing to determine the engagement and responses to messaging at 06/30/2024 and 06/30/2025.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

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PRIORITIZED NEED #2: Improve Availability and Access of Mental/Behavioral Health Services, including Substance Use Services, w/ Focus on Community Collaboration.

GOAL 2: *Create a referral pathway for Lourdes patients seeking mental/behavioral health care.*

ACTION PLAN

STRATEGY 2.1: Normalize assessment of patients to include mental/behavioral health concerns across Lourdes ministry.

BACKGROUND INFORMATION:

- *Target Population:* Individuals with mental/behavioral health issues
- *General Info:* As Lourdes continues to broaden mental health services offerings, the consistent use of mental or behavioral health screening tools at all points of entry is needed. Lourdes' goal is to increase the use of and normalize these assessments at all entry points to the Lourdes system.
- *SDOHs Addressed:* Destigmatizing mental or behavioral health needs to normalize assessment (as with any other medical condition).

RESOURCES:

- AMG and Hospital sites of care
- Ascension Technologies (AT)

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Work to make Phreesia tablets accessible in specialty care areas for assessment of mental or behavioral health concerns.	Erin Lacey/ Erin McAndrew	Leadership Group (TBD), AT	# Specialty Areas Using Phreesia Tablets.	N/A	Screening tools available on Phreesia tablets in >60% of specialty areas by 12/31/23.	Cerner/ AT request
2	Work to make Phreesia tablets (or similar technology) accessible in the hospital/walk-ins for assessment of mental or behavioral health concerns.	Erin Lacey/ Erin McAndrew	Leadership Group (TBD), AT	# Walk-ins and hospital locations using Phreesia Tablets (or similar technology).	N/A	Screening tools available on Phreesia tablets in at least 2 hospital-based and	Cerner/ AT request

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						all walk-in areas by 12/31/23.	
3	Define a process to follow-up with primary care providers (PCP) for patient scores needing follow-up and returning patients to PCP care upon discharge from Lourdes Center for Mental Health (LCMH).	Erin Lacey/ Erin McAndrew	Leadership Group (TBD), AT	# Patients with scores indicating follow-up need to see their PCP. Process for transfer of care to PCP upon discharge from LCMH created.	N/A	At least 80% of patients whose screening score indicates a need for follow-up are seen by their PCP by 12/31/24. Patients completing treatment at LCMH are transitioned back to their PCP by 12/31/24.	Meeting Minutes; Statistics on follow-up for patients with scores indicating need for follow-up; Statistics on patients transition ed to PCP after LCMH discharge.
4	Define a process for affirmative answers to PHQ-9 question 9 complete the Columbia Suicide Risk Assessment (CSRA) and associates are educated on use of CSRA and resources to address patients needs based on their answers.	Erin Lacey/ Erin McAndrew	Leadership Group (TBD), AT	Completed process & education of staff	N/A	Training completed for affirmative answers by 12/31/23 by all impacted associates.	Attend-ance for training; statistics on patient referrals based on answer to Q9 and # of CSRA's complet-ed based on answers.

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *All appropriate facilities have Phreesia pads (or similar technology) and all patients are screened for mental/behavioral health concerns at these locations by 12/31/23.*

II. *At least 90% of appropriate associates complete education by 12/31/23.*

III. *All patients with a high score or an affirmative to question 9 complete a Columbia Suicide Risk Assessment and have a follow-up conversation with the provider they are seeing at the time of the affirmative response to question 9 by 6/30/25.*

ACTIONS	**SHORT-TERM OUTCOMES**				**MEDIUM-TERM OUTCOMES**				**LONG-TERM OUTCOMES**			
	Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicato r***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
TBD during action plan implementation												

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Lourdes

PRIORITIZED NEED #2: Improve Availability and Access of Mental/Behavioral Health Services, including Substance Use Services, w/ Focus on Community Collaboration.

GOAL 2: *Create a referral pathway for Lourdes patients seeking mental/behavioral health care.*

ACTION PLAN

STRATEGY 2.2: Review Lourdes Center for Mental Health (LCMH) self referral process to accept referral from other Lourdes departments/providers

BACKGROUND INFORMATION:

- *Target Population:* Individuals with mental/behavioral health issues
- *General Info:* As Lourdes continues to broaden mental health services offerings, a pathway to allow referral from Lourdes providers to Lourdes Center for Mental Health is needed to ensure appropriate care of patients and access to mental health services.
- *SDOHs Addressed:*

RESOURCES:

- LCMH SW and Med Team
- AMG Leadership
- Focus groups or current patients to review intake packet
- Student Assistance Program
- Data Analytics Department

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Review and revise LCMH intake packet to simplify process for patient entry	Bill Perry; LCMH SW/AMG and Lourdes Leadership	Erin Belensky and Forms Team; Nikki Shipos	Updated intake packet	N/A	Intake packet revised and simplified by 9/30/23.	Article 31
2	Make referrals for youth as needed to prevention programs (SAP, etc.) based on parent score/information	Sidney Graham, Lourdes Leadership	SAP,, LCMH Staff	# of youth referrals made	N/A	Provide referrals to SAP based on positive response on LCMH Substance Use / Addictive Behaviors	LCMH Substance Use / Addictive Behaviors form

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						form and with appropriate ROI by 12/31/24.	
3	Develop a process for providers to refer patients to LCMH and identify pilot departments based on the number of shared patients.	Bill Perry; LCMH SW/AMG and Lourdes Leadership	Nikki Shipos, Katie Loveland, Erin Lacey, Ramsie Stephens	Process is developed and # of depart-ments identified to implement process	N/A	3 depart-ments identified and date for pilot set by 9/30/2023	Cerner, Celerity
4	Trial process in the identified departments and develop and implement an evaluation of the process and results.	Bill Perry; LCMH SW/AMG and Lourdes Leadership	AMG Providers	Pilot implement-ed and evaluated.	N/A	Pilot fully implement-ed in 3 locations and initial evaluation completed by 6/30/2024	Number of patients referred; evalua-tion

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *LCMH intake packet revised and in use by September 30, 2023.*

II. *Process for providers to refer patients to LCMH created and implemented in 3 pilot locations by* June 30, 2024.

III. *Increase the number of referrals to SAP received from previous year by 40 from hospital and other Lourdes sites by 12/31/24.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

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Lourdes

PRIORITIZED NEED #2: Improve Availability and Access of Mental/Behavioral Health Services, including Substance Use Services, w/ Focus on Community Collaboration.

GOAL 3: *Explore needs of Lourdes ministry in serving persons with substance use disorders.*

ACTION PLAN

STRATEGY 3.1: Lourdes will participate in implementing strategies identified through the NIDA HEALing Communities Study to address gaps in services, based on available capabilities and resources.

BACKGROUND INFORMATION:

- *Target Population:* Individuals with mental/behavioral health issues
- *General Info:* Lourdes will partner with community-based organizations (CBOs) to determine behavioral health needs for Lourdes patients and community members. Lourdes will assess resources and abilities to assist the CBOs in implementing strategies identified by the NIDA HEALing Communities Study.
- *SDOHs Addressed:* Reducing barriers for accessing services through collaboration with community partners

RESOURCES:

- Staffing
- Requirements for different licenses (e.g., medication-assisted treatment)
- Identified Location/Facility
- CBO Support (BCHD, UHS, ACBC, OMH, OASAS, Drug Court, AA, REACH, STAP, RHN, Truth Pharm)

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Use the HEALing Communities Study (HCS) gap analysis to determine next steps	JoAnn Moore/Sidney Graham	LCMH Staff, HCS	Completion of gap analysis	N/A	As per HCS timeline	HCS gap analysis
2	Align with HCS regarding next steps regarding dual licensing.	Bill Perry, LCMH Staff	Data Analytics, Lourdes Leader-ship	HCS recommend-ations	N/A	As per HCS timeline	HCS Recommend-ations
3	Look at requirements of licensing to determine feasibility of a dual outpatient license (Article 32 or Article 99)	Bill Perry	Bill Perry, Wayne Miteer, Robin Kinslow-Evans, Data Analytics, OMH	N/A	N/A	Determine feasibility of dual license [alignment with HCS recommend ations] by 12/31/23.	OMH/ OASAS State MHPD

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4	Move forward with at least 3 recommendations of the HCS (prioritize application for dual license if recommended and feasible).	Bill Perry, JoAnn Moore, Sidney Graham	Lourdes Leader-ship, Wayne Miteer, Robin Kinslow-Evans, Data Analytics, OMH	3 HCS recommendations implemented	N/A	Recommendations implemented in alignment with HCS timeline by 6/30/25.	Meeting Minutes from HCS

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *Implement at least 3 recommendations of the NIDA HEALing Communities Study by 06/30/25.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

PRIORITIZED NEED #2: Improve Availability and Access of Mental/Behavioral Health Services, including Substance Use Services, w/ Focus on Community Collaboration.

GOAL 3: *Explore needs of Lourdes ministry in serving persons with substance use disorders.*

ACTION PLAN

STRATEGY 3.2: Explore creation of a seamless entry into treatment for opioid addiction and problematic use patients.

BACKGROUND INFORMATION:

- *Target Population:* Individuals with mental/behavioral health issues
- *General Info:* NYS provides guidance and procedures for hospitals and emergency departments to initiate medication assisted treatment (MAT) for substance use. A process to implement MAT and consistent seamless entry into treatment from multiple Lourdes service sites needs to be created and implemented to support substance use disorder patients.
- *SDOHs Addressed:* MAT services lacking in the community

RESOURCES:

- Peer Advocates

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- NIDA HEALing Communities Study
- CBO Support (BCHD, UHS, ACBC, OMH, OASAS, Drug Court, AA, REACH, STAP, RHN, Truth Pharm)

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Build process flows for seamless entry into treatment for patients with substance use disorder at all points of entry to Lourdes services.	Lourdes Leadership/ JoAnn Moore	CBOs listed above ; UHS	Finished process flows	N/A	Process Flows completed by 12/31/23	Pro-cess Flows
2	Identify providers licensed and willing to offer MAT and current number of patients served, and build a contingent of additional providers.	AMG Leadership/ JoAnn Moore	Medical Staff Office	Providers and panels identified and additional providers licensed		Identification and licensure completed by 12/31/23	Spread sheet of providers and panels
3	Implement process flows for at least 2 Lourdes service sites.	Lourdes Leadership	CBOs listed above	Process flows implement-ed at 2 service sites		Implement-ation completed by 12/31/24.	New pa-tients served

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *Patients that choose to enroll into substance use treatment services will use Lourdes process flows by 12/31/24.*

ACTIONS	**SHORT-TERM OUTCOMES**				**MEDIUM-TERM OUTCOMES**				**LONG-TERM OUTCOMES**			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

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PRIORITIZED NEED #2: Improve Availability and Access of Mental/Behavioral Health Services, including Substance Use Services, w/ Focus on Community Collaboration.

GOAL 3: *Explore needs of Lourdes ministry in serving persons with substance use disorders.*

ACTION PLAN

STRATEGY 3.3: Partner with CBOs to reduce overdose occurrences and increase safe medication disposal to improve harm reduction efforts.

BACKGROUND INFORMATION:

- *Target Population:* Individuals with mental/behavioral health issues
- *General Info:* The community currently lacks access to overdose reversal medication (Narcan) and to easily dispose of controlled substances.
- *SDOHs Addressed:* Provide the community with safer and more effective ways to dispose of unused medications; reduce overdoses through access to Narcan.

RESOURCES:

- CBO Support (BCHD, UHS, ACBC, OMH, OASAS, Drug Court, AA, REACH, STAP, RHN, Truth Pharm)
- Deterra Bags
- Medication Lock Boxes
- Needle Disposal Boxes

ACTIONS:		LEAD ORG / STAFF	COLLAB ORG / STAFF	PROCESS MEASURES – OUTPUTS			
				Indicator	*Base-line Value / Date*	*Target Value / Date*	*Data Source*
1	Partner with CBOs to distribute safe medication disposal bags (Deterra bags) to improve harm reduction efforts. Explore needle disposal capabilities with the Broome County Health Department (BCHD).	Ralphalla Richardson	BCHD, Learning Services, Lourdes Pharmacy	# of Deterra Bags available at Lourdes sites of care and # of sites with installed needle disposal capability	N/A	Deterra bags available at >10 Lourdes sites of care by 6/30/24. Needle disposal capability at >3 Lourdes sites of	Meeting Minutes

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						care by 6/30/24	
2	Raise awareness and educate staff and patients regarding safe medication disposal to increase harm reduction efforts.	Ralphalla Richardson, Sidney Graham	ACBC, Truth Pharm, Learning Services, Marketing	Curriculum developed and trainer identified for associate training; awareness-raising activity designed and implement-ed	N/A	At least 1 educational offering completed for associates and at least 1 awareness-raising activity completed for patients by 12/31/24.	Google Calendar
3	Distribute medication lock boxes to keep medication safe from children and pets.	Sidney Graham/Bill Perry	BCHD, BOAC, Drug Free Communi ties, STAP	# of distributed lock boxes	N/A	50 boxes distribut-ed by 12/31/23.	Records of total number of boxes distrib-uted for each event
4	SAP and trained Lourdes Associates to partner with local school districts and community events to offer Narcan training and SUD education.	Sidney Graham, SAP Associates	ACBC, Truth Pharm, Learning Services, Marketing, STAP, CBOs	# schools w/ Narcan training and # of events attended	N/A	By 12/31/23 schools /community events identified and sessions booked	attend-ance sheets from events
5	Explore having Narcan available to distribute to patients as needed through appropriate Lourdes Departments [e.g., emergency department, pharmacy, pain and wellness]	Pharmacy Staff, Tom Forrest	Lourdes Leadership	# departments with Narcan	N/A	Determine # of departments by 12/31/23.	Cerner

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *Distribute 50 Deterra bags for safe medication disposal by 12/31/2024.*

II. *Identify 3 Lourdes sites where needle disposal units can be added by 12/31/2024.*

III. *Distribute 50 lock boxes to safely store medications by 12/31/23.*

IV. *Increase Narcan-trained associates by 40 by 6/30/24.*

V. *At least 2 departments will have Narcan available to distribute to patients/family members by 12/31/24.*

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ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

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PRIORITIZED NEED #3: Improve Access and Infrastructures for Health Services in Rural Communities.

GOAL 1: *Educate and raise awareness in associates regarding rural populations and their health care needs and preferences to increase patient trust and willingness to access services (trust in rural communities), in collaboration with Rural Health Network*

ACTION PLAN

STRATEGY 1.1: Assess needs, preferences, and beliefs of the population served, as well as the associates providing services, through primary and secondary research (focus groups, in depth Interviews, Social Vulnerability Index)--community-based participatory research.

BACKGROUND INFORMATION:

- *Target Population:* Associates, identified rural community's populations
- *General Info:* Each rural community has unique health care needs and preferences. Learning about those needs and preferences and using that information to educate and raise awareness in associates will help to build trust between rural communities and healthcare professionals. Building trust to create or improve these relationships and better understanding services desired and needed will, in turn, improve access to healthcare for rural communities. In addition, this information can be used to determine which rural communities are most ready to engage with Lourdes in addressing healthcare needs.
- *SDOHs Addressed:* Identification of SDOH to be determined through this strategy.

RESOURCES:

- Needs assessment template, preferences, and beliefs of the population served, as well as the associates providing services, through primary and secondary research
- Research tools (i.e., focus groups question guide, in depth interviews guide, Social Vulnerability Index tool)
- (Potentially) consultant to conduct primary research

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Develop or identify assessment tools for focus groups and stakeholder interviews.	Sue Bretscher; Karen Riewerts; RHN	CCN Potentially: Consultant	Assessment tool developed.	No assessment tool presently available August 2022.	Completion of assessment tools February 28, 2023.	Meeting Notes and Assess-ment tools
2	Schedule and hold focus groups and stakeholder groups.	Sue Bretscher; Karen Riewerts; RHN	CCN Potentially: Consultant	Focus and Stakeholde r groups completed	Schedule Focus and Stakeholder Groups March 1, 2023.	Complete Focus groups April 30, 2023.	Focus and Stake-holder Groups

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							tran-scripts
3	Identification of secondary data sources.	Lourdes Data Analytics	RHN CCN Potentially: Consultant	Secondary data sources identified.	# secondary sources identified.		Data Sources
4	Data pulling from secondary sources.	Lourdes Data Analytics		N/A	Data from Secondary Sources by June 30, 2023.		Data sources
5	Primary and secondary data analysis.	Lourdes Data Analytics		N/A	Completed Analysis by June 30, 2023.		Data Sources
6	Development of Comprehensive white paper/report delineating findings.	Lourdes Data Analytics	RHN CCN Potentially: Consultant	Completion of White Paper report.	White Paper Report Completed by September 30, 2023.		White Paper
7	Identify and prioritize the population to serve (community based). Set criteria for identification of pilot communities (e.g., other Lourdes services offered, such as PACT, school-based dental, etc.).	Sue Bretscher; Karen Riewerts	AMG Leadership RHN, CCN	At least 3 comm-unities identified and prioritized.	Identify and prioritize 1 community to serve by December 31, 2023.	Identify and serve additional 1-2 comm-unities by June 30, 2025.	Meeting Minutes

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *Complete the needs assessment of the prioritized population by September 30, 2023.*

II. *Identify and prioritize the target population by December 31, 2023.*

ACTIONS	**SHORT-TERM OUTCOMES**				**MEDIUM-TERM OUTCOMES**				**LONG-TERM OUTCOMES**			
	Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
TBD during action plan implementation												

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PRIORITIZED NEED #3: Improve Access and Infrastructures for Health Services in Rural Communities.

GOAL 1*: Educate and raise awareness in associates regarding rural populations and their health care needs and preferences to increase patient trust and willingness to access services (trust in rural communities), in collaboration with Rural Health Network*

ACTION PLAN

STRATEGY 1.2: Use results of research to create and implement a learning plan to educate and raise awareness in associates.

BACKGROUND INFORMATION:

- *Target Population:* Associates, identified rural community's populations
- *General Info:* Each rural community has unique health care needs and preferences. Learning about those needs and preferences and using that information to educate and raise awareness in associates will help to build trust between rural communities and healthcare professionals. Building trust to create or improve these relationships and better understanding services desired and needed will, in turn, improve access to healthcare for rural communities.
- *SDOHs Addressed:* Identification of SDOH to be determined through this strategy

RESOURCES:

- Learning Services
- Identified CBOs (RHN, CCN)
- Community Leaders (TBD)
- Lourdes Rural Primary Care Operation Leaders
- Youth Services

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Base-line Value / Date***	***Target Value / Date***	***Data Source***
1	Create a taskforce to develop a learning plan, based on needs assessment.	Sue Bretscher/ Karen Riewerts	RHN; CCN; BCHD; Lourdes Leadership; Learning Services	Learning plan completed.		Learning Plan completed by June 30, 2024.	Learning plan
2	Implement a learning plan according to the timeline.	Learning Services; The Taskforce		Learning plan implement -ed: at least 3 education-al programs		At least 1 education-al program offered and completed by	myLearning

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				completed by target audience.		December 31, 2024.	
3	Evaluate learning plan and refine as needed.	The taskforce	RHN; CCN; BCHD; Lourdes Leadership; Learning Services	Revise learning plan as per the findings of the evaluation.		Revision of learning plan as needed by June 30, 2025.	myLearning

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *The taskforce and the learning plan are created based on the needs assessment by June 30, 2024.*

II. *Implement the learning plan according to the timeline by December 31, 2024.*

III. *Evaluate and refine the learning plan as per the evaluation by June 30, 2025.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

PRIORITIZED NEED #3: Improve Access and Infrastructures for Health Services in Rural Communities.

GOAL 2: *Increase access to Lourdes specialty and pharmacy services in rural communities using available resources and technology hubs (ex schools, libraries, community halls).*

ACTION PLAN

STRATEGY 2.1: Identify specialty care providers and community leaders to design and pilot care models.

BACKGROUND INFORMATION:

- *Target Population:* Associates, identified rural community's populations
- *General Info:* Due to several factors there is an inequity in the speciality services that rural communities are able to access. Bringing specialty services to people is key to increasing access and improving health outcomes in rural communities; however, this can not be a one size fits all approach. Trust must be built between the health service

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provider and the community members. As a result the specialty provider must understand this and be willing to work with community partners to form a successful partnership with a commitment to serve that community.

- *SDOHs Addressed:* Identification of SDOH to be determined through this strategy; transportation

RESOURCES:

- Completed Needs Assessment
- Data Analytics
- AMG Leadership
- Community Participation
- CBO Support (CCN, RHN)

	ACTIONS:	**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Identify criteria for specialty participation (e.g., required training; expectations of providers, etc.).	Rural Health Taskforce (strategy, data, learning services, AMG leadership representation, interested clinicians)	AMG Leadership	Identified Criteria approved by Lourdes Leadership.	1-2 specialty service lines identified by March 31, 2024.	Increase the number of participat-ing specialty service lines by an additional 1-2 by June 30, 2025.	Meet-ing minutes and identi-fied criteria
2	Select/ identify/engage with community leaders.	Rural Health Taskforce Lead	Operation Managers Local town leaders, BCHD, RHN, CCN	Community leaders identified and engaged.	1-2 communities selected/ identified by September 30, 2024.	Increase the number of participating commun-ities by an additional 1-2 by June 30, 2025.	Meeting minutes
3	Select specialties and specific providers for pilots.	Rural Health Taskforce Lead	AMG Leadership	Specialties and providers identified and engaged.	1-2 specialty service lines identified by September 30, 2024.	Increase the number of participating specialty service lines by an additional 1-2 by June 30, 2025.	Meeting minutes Health data

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ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *Identify criteria for specialty participation (e.g., required training; expectations of providers, etc.) by March 31, 2024.*

II. *Select, identify and engage with community leaders by September 30, 2024.*

III. *Select specialties and specific providers for pilot by September 30, 2024.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

PRIORITIZED NEED #3: Improve Access and Infrastructures for Health Services in Rural Communities.

GOAL 2: *Increase access to Lourdes specialty and pharmacy services in rural communities using available resources and technology hubs (ex schools, libraries, community halls).*

ACTION PLAN

STRATEGY 2.2: Work with specialty care providers and community leaders to design care models for rural communities.

BACKGROUND INFORMATION:

- *Target Population:* Associates, identified rural community's populations
- *General Info:* Due to several factors there is an inequity in the speciality services that rural communities are able to access. Bringing specialty services to people is key to increasing access and improving health outcomes in rural communities; however, this can not be a one size fits all approach. Trust must be built between the health service provider and the community members. As a result the specialty provider must understand this and be willing to work with community partners to form a successful partnership with a commitment to serve that community.
- *SDOHs Addressed:* Identification of SDOH to be determined through this strategy; transportation

RESOURCES:

- Completed Needs Assessment
- Data Analytics
- AMG Leadership
- Community Participation
- CBO Support (CCN, RHN)

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ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Review best practice care models and select/build models to implement in identified rural communities.	Rural Health Taskforce (strategy, data, learning services, AMG leadership representation, interested clinicians)	Decker School of Nursing (Dr. Ncole Rouhana) - NP Program RHN, CCN	Care models selected or built.		Rural health care model determined by September 30, 2023.	Meeting minutes
2	Collaborate to build technology capabilities in identified communities, if needed, including identification of funding source (broadband, equipment, etc) .	Rural Health Taskforce (strategy, data, learning services, AMG leadership representation, interested clinicians)	Ascension technologies, Southern Tier 8, County Government, Office for the Aging, Community leadership	Technology needs identified in each of the target communities.	Ensure access at identified community locations where care will be delivered by December 31, 2023.	Broadband access in identified communities by June 30, 2025.	Meeting minutes
3	Implement chosen model in pilot rural communities.	Rural Health Taskforce (strategy, data, learning services, AMG leadership representation, interested clinicians)	AMG leadership, Ops Managers, Community leaders	Implementation of care model.	Care model implemented in pilot community by December 31, 2023.	Care model implemented in 1-2 additional communities by June 30, 2025.	Meeting minutes
4	Develop and implement marketing and education plans for staff and the community regarding the care model.	Rural Health Taskforce (strategy, data, learning services, AMG leadership representation, interested clinicians)	Learning services, Lourdes Marketing	Marketing and training plan developed and implemented.	Marketing of care model in pilot community by December 31,2023; Training of staff involved in delivery of care completed by December 31, 2023.	Marketing of care models in additional 1-2 communities by June 30, 2025.	mylearn-ing

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ANTICIPATED IMPACT – OUTCOMES
SMART OBJECTIVES: **I.** *Review best practice care models and select/build models to implement in identified rural communities by September 30, 2023.* **II.** *Collaborate to build technology capabilities in identified communities, if needed, including identification of funding source (broadband, equipment, etc) by December 31, 2023.* **III.** *Implement the model chosen in pilot rural community by December 31, 2023.* **IV.** *Develop and implement marketing and education plans for staff and the pilot community regarding the care model by December 31, 2023.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

PRIORITIZED NEED #3: Improve Access and Infrastructures for Health Services in Rural Communities.

GOAL 2: *Increase access to Lourdes specialty and pharmacy services in rural communities using available resources and technology hubs (ex schools, libraries, community halls).*

ACTION PLAN
STRATEGY 2.3: Increase access to and use of Lourdes retail pharmacies for prescriptions written for patients in rural communities.
BACKGROUND INFORMATION: ● *Target Population:* identified rural community's populations ● *General Info:* Timely access to prescription medications can be challenging in rural communities. Delivering medications via mail order can remove the barrier of travel and improve health through ensuring consistent access to prescribed medications. ● *SDOHs Addressed:* Identification of SDOH to be determined through this strategy; transportation
RESOURCES: ● Mail order pharmacy (MCHF Grant) ● Community Participation ● CBO Support (CCN, RHN)

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ACTIONS:		LEAD ORG / STAFF	COLLAB ORG / STAFF	PROCESS MEASURES – OUTPUTS			
				Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
1	Develop mail order pharmacy (including credentialing).	Lourdes Retail Pharmacy/ Lourdes Leadership		Mail order pharmacy developed	Implement mail order pharmacy in 1 community by June 30, 2024.	Mail order pharmacy in 1-2 additional commun-ities by June 30, 2025.	Meeting minutes
2	Develop marketing plans for communities and providers.	Lourdes Retail Pharmacy/ Lourdes Leadership	Lourdes Marketing	Marketing plan developed	Marketing plan for pilot community completed by June 30, 2024.	Marketing plan for additional 1-2 commun-ities completed by June 30, 2025.	Meeting minutes, Market-ing Plan

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

- ***I.*** *Develop mail order pharmacy (including credentialing) by June 30, 2024.*
- ***II.*** *Develop a marketing plan for communities and providers by June 30, 2024.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

PRIORITIZED NEED #3: Improve Access and Infrastructures for Health Services in Rural Communities.

GOAL 3*: Improve quality metrics for patients living in targeted rural communities.*

ACTION PLAN

STRATEGY 3.1: Design, implement, and evaluate interventions to improve selected quality metrics in rural communities.

BACKGROUND INFORMATION:

- *Target Population:* Associates, identified rural community's populations

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- *General Info:* In an effort to improve overall health outcomes in rural communities and recognizing that each rural community is unique in its SDOH, conducting a study of quality measures within targeted communities would pinpoint challenges and help focus resources. In addition, conducting a study will provide metrics to measure levels of success to continue refining the process.
- *SDOHs Addressed:* Identification of SDOH to be determined through this strategy

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RESOURCES:

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<tr><td colspan="2" rowspan="2"><u>ACTIONS:</u></td><td rowspan="2">LEAD ORG / STAFF</td><td rowspan="2">COLLAB ORG / STAFF</td><td colspan="4">PROCESS MEASURES – OUTPUTS</td></tr>
<tr><td>Indicator</td><td>Baseline Value / Date</td><td>Target Value / Date</td><td>Data Source</td></tr>
<tr><td>1.</td><td>Examine payer data and medical records to determine low performance quality metrics.</td><td>Data Analytics; Revenue Cycle</td><td>AMG Leadership; Ops Managers; Population Health</td><td>Identify low perform-ance quality metrics.</td><td>Identify low perform-ance quality metrics in 1 rural community by December 31, 2023.</td><td>Identify low perform-ance quality metrics in 1-2 additional rural commun-ities by June 30, 2024.</td><td>Cerner, Payer data for quality metrics; Payer data for selected communities</td></tr>
<tr><td>2.</td><td>Identify SDOH factors using available tools (e.g., Social Vulnerability Index) and/or other drivers of care gaps in pilot communities.</td><td>Data Analytics; Strategy; RHN</td><td>Ops Managers; Population Health Dept; Commun- ity leadership; CCN</td><td>SDOH factors and/or other drivers of care gaps identified in pilot commun-ities</td><td>Identify at least 2 SDOH factors and/or other drivers of care gaps in 1 pilot commun-ity by December 31, 2023.</td><td>Identify at least 2 SDOH factors and/or other drivers of care gaps in at least 1 additional pilot commun-ity by June 30, 2024.</td><td>Cerner, Payer data for quality metrics; Payer data for selected communities</td></tr>
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3	Identify best practices for closing care gaps based on identified variables.	AMG Leadership ; Population Health	Lourdes Data Analytics; Ops Managers; Commun- ity leadership	Best practices for closing care gaps identified	Best practices for closing care gaps in 1 pilot commun- ity determin- ed by June 30, 2024.	Best practices for closing care gaps in 1-2 additional pilot commun- ities determined by December 31, 2024	Meeting minutes
4	Design interventions based on best practices to close care gaps.	Lourdes Leadership	Lourdes Data Analytics; AMG Leadership; Ops Managers; Population Health Dept; Community leadership	Interventio ns designed based on best practices to close care gaps.	Implement chosen interven- tions for closing care gaps in 1 pilot community by Sept 30, 2024.	Implement chosen interven- tions for closing care gaps in 1-2 additional pilot commun- ities by June 30, 2025.	Meeting minutes
5	Develop and implement marketing/education plans for communities if needed.	Lourdes Marketing and communi- cations	Lourdes Data Analytics; AMG Leadership; Ops Managers; Population Health Dept; Community leadership	Marketing/ education plan developed and implement ed if needed.	Marketing/ education plan developed and implement- ed if needed in 1 pilot community by September 1, 2024.	Marketing/ education plan developed and implement- ed if needed in 1-2 additional communitie s by June 30, 2025.	Marketing Plan
6	Determine measures of success in closing care gaps.	Lourdes Data Analytics	AMG Leadership; Ops Managers; Population Health Dept; Community leadership	Success measures for closing care gaps identified.	Implement measure of success for closing care gaps in 1 pilot community by June 30, 2024.	Implement measures of success for closing care gaps in 1-2 additional commun- ities by June 30, 2025.	EMR; payer data

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *Examine payer data and medical records to determine low performance quality metrics in 1 pilot rural community by December 31, 2023.*

II. *Identify at least 2 SDOH factors and/or other drivers of care gaps in 1 pilot community by December 31, 2023.*

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III. *Identify best practices for closing care gaps based on identified variables by June 30, 2024.*

IV. *Design and implement interventions based on best practices to close care gaps in 1 pilot community by September 30, 2024.*

V. *Develop a marketing/education plan for communities if needed by September 1, 2024.*

VI. *Improvement in identified quality metrics in pilot rural community by June 30, 2025.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

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PRIORITIZED NEED #4: Improve Health Outcomes by Focusing on Prevention and Wellness.

GOAL 1*: Expand the health coach program by piloting in key outpatient services with a focus on lifestyle choices.*

ACTION PLAN

STRATEGY 1.1: Fully staff health coaches in Cardiometabolic Health and begin health coach pilot at Vestal Internal Medicine.

BACKGROUND INFORMATION:

- *Target Population:* Patients referred by their doctors with lifestyle and/or health challenges
- *General Info:* In an effort to improve the health of our community, we plan to expand our outpatient services to include health coaches to address behaviors and lifestyle interventions as an effective means to treat and prevent chronic disease.
- *SDOHs Addressed:* Health literacy (nutrition information, exercise, sleep etc.), access to healthy food, transportation

RESOURCES:

- 1 approved FTE for Health coach for CMH to backfill open position
- Community Health Worker resource
- 1 approved FTE for Vestal Internal Med (net new FTE).
- Primary Care and Specialty care Providers
- Patients referred from VIM providers
- Community Health Workers and Nurse Navigators
- Identified CBOs
- Medical Mission at Home team

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Identify best certifications for new staff to attain.	Dr. Einav	Matt Stein	Certification attainment within 6 months of hire as applicable		Identify certifications for staff by 3/31/23.	Uploaded Copies of Certificates
2	Development of workflow and referral system (including identification of KPIs to track patient progress in program)	Josh Pascucci, Matt Moore	Dr. Rai, Katie Molter, Dr. Einav	Completion of the workflow and referral system		Completion of the workflow and referral system by 3/31/23	Work-flow

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3	Upon approval of Health Coach for VIM, submit position management request for 1 Health Coach FTE	Laura Pascucci	Katie Molter	Filled Position		Position posted and filled by 1/31/23	People-soft
4	Identify additional health outcome/SDOH mitigation/metrics for select referred patient populations with VIM health coach.	Matt Moore	Data Analysts, Physician leads	Identified metrics/SDOH mitigation/ outcomes		Metrics identified 3/31/23	Health Coach Pro-forma
5	Impact analysis completed (e.g,. 6 month pre/post hospitalization, A1C levels pre/post program, BMI levels pre/post program, ACQA Claims, Continuity of care of Podiatry and Orthopedics comparing those who are in health coaching versus those who are not)	Josh Pascucci	Physician Leads/Population Health	Impact analysis completed		Impact analysis complet-ed by 6/30/23	Health Coach Pro-forma

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *By 12/31/23, increase revenue at VIM by $67,000.*

II. *By 6/30/23, VIM Health Coach is fully established and improved health outcomes/metrics for select referred patient populations are measured and realized.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

PRIORITIZED NEED #4: Improve Health Outcomes by Focusing on Prevention and Wellness.

GOAL 1: *Expand the health coach program by piloting in key outpatient services with a focus on lifestyle choices.*

ACTION PLAN

STRATEGY 1.2: Once Health Coach is fully established within the workflow of VIM (3-6 months), expand pilot to additional facilities (e.g., Owego Primary Care, Pain and Wellness, Endocrinology, or Cardiology).

BACKGROUND INFORMATION:

- *Target Population:* Patients referred by their doctors with lifestyle and/or health challenges

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- *General Info:* In an effort to improve the health of our community, we plan to expand our outpatient services to include health coaches to address behaviors and lifestyle interventions as an effective means to treat and prevent chronic disease.
- *SDOHs Addressed:* Health literacy (nutrition information, exercise, sleep etc.), access to healthy food, transportation

RESOURCES:

- 1 approved FTE for piloting Health Coach to backfill open position
- Community Health Worker resource
- 1 approved FTE for each new site (e.g., Owego Primary Care, Pain and Wellness, Endocrinology, or Cardiology)
- Completed pro forma for health coach program (Financial Analyst time)

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Upon approval of Health Coach for VIM, Submit position management request for 1 Health Coach FTE (backfill for VIM HC)	Laura Pascuccii	Practice Ops Manager	Filled position		Posted and filled by 6/30/23	People Soft
2	Establish a program rollout timeline and determine organizational structure (reporting structure)	Josh Pascucci	Dr. Rai, Laura Pascucci	Timeline created and organization-al structure determined		Establish timeline and fit within the organizati on by 6/30/23	People Soft
3	Alignment of workflow of health coach with other ancillary services/resources available to patients.	Matt Moore	Josh Pascucci, Dr. Rai, Practice Ops Managers	Alignment of Workflow		Establish workflow alignment by 6/30/23	Cerner-referral manage-ment

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *By 6/30/23, outline for expansion of Health Coaches to additional sites completed.*

II. *By 6/30/23, workflow fully integrated into the practice.*

ACTIONS	**SHORT-TERM OUTCOMES**				**MEDIUM-TERM OUTCOMES**				**LONG-TERM OUTCOMES**			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

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PRIORITIZED NEED #4: Improve Health Outcomes by Focusing on Prevention and Wellness.

GOAL 2: *Develop and disseminate educational materials regarding healthy lifestyle behaviors through a didactic curriculum and/or social media.*

ACTION PLAN

STRATEGY 2.1: Utilize Health Coaches reach and non-clinical rapport with patients to implement casual weekly social media videos with hints/tips/advice/motivation for healthy lifestyle choices (i.e., physical activity, healthy eating tips, recognizing signs of disease, etc.).

BACKGROUND INFORMATION:

- *Target Population:* Social media followers & viewers
- *General Info:* As social media grows as a ubiquitous source of information and communication, we can use this resource to expand our reach, improve health literacy and grow attribution with the use of consistent informal videos from our staff.
  SDOHs Addressed: health literacy, access to care

RESOURCES:

- Marketing Support - access to Our Lady of Lourdes social media platforms and Website
- Listing of approved topics (or curriculum) for social media campaigns.
- Media Release forms
- Health observance calendar for Calendar Year
- Health coaches
- Clinical Staff for content review/approval
- Patients for testimonials

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Integration of educational content creation into HC job responsibilities.	Josh Pascucci	HR Talent Acquisition	Job posting updated		Job posted by 6/30/23	Job posting
2	Development of guidelines for content creation (e.g., video length, content selection process, etc.)	Matt Moore	Marketing and Communi-cations, Health Coaches	Guide-lines created		Guide-lines created by 1/31/23	Meet-ing minutes

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3	Draft of video script/concept for approval	Matt Moore	Marketing and Communi-cations, Health Coaches	Script outline created		Script out-lined by 2/28/23	Meet-ing minutes, Video script
4	Produce/edit video content	Matt Moore	Marketing and Communi-cations, Health Coaches	Video created		Video pro-duced by 3/31/23	Meeting minutes, Videos
5	Review produced content with the marketing team for final approval for posting.	Julie Weisberg Marketing and Communi-cations, Health Coaches	Matt Moore	Content approved		Content approv-ed by 4/30/23	Meeting minutes
6	Development of deployment and marketing plan	Julie Weisberg Marketing and Communi-cations, Health Coaches	Matt Moore	Content posted		Videos deployed and marketing plan implement-ed by 5/31/23	Marketing plan, social media sites

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *By 12/31/23 Improve engagement through social media (i.e. clicks, views, likes, interactions, comments, shares, # followers, etc.) by 5%.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

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PRIORITIZED NEED #4: Improve Health Outcomes by Focusing on Prevention and Wellness.

GOAL 2: *Develop and disseminate educational materials regarding healthy lifestyle behaviors through a didactic curriculum and/or social media.*

ACTION PLAN

STRATEGY 2.2: Use platform and access to the population at Lourdes Health & Fitness facility to begin classes/workshops to build health literacy (weight loss, nutrition, fitness development, etc.) while creating access and education to Lourdes outpatient services.

BACKGROUND INFORMATION:

- *Target Population:* Lourdes Health & Fitness members, community members
- *General Info:* With the addition of the Lourdes Health & Fitness facility and growing membership, we can use this resource to expand our reach, improve health literacy and grow attribution by facilitating educational classes/workshops to facility members and the community.
- *SDOHs Addressed:* health literacy, access to care

RESOURCES:

- Marketing Support - access to Our Lady of Lourdes social media platforms and Website
- Listing of approved topics (or curriculum) for social media campaigns.
- Media Release forms
- Health observance calendar for Calendar Year
- Health and Wellness professionals (Health Coaches, Trainers, Nutritionists, Dieticians etc.)
- Clinical Staff for content review/approval
- Patients for testimonials

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Have health/wellness information on screens at Health & Fitness Center	Health & Fitness Center Representative, Lourdes Leadership	Marketing-PR Health & Fitness Center Professionals, Needs Theme Group 4	Health/ Wellness information is displayed at the Health & Fitness Center	Information displayed by 3 health and wellness professionals by 12/31/23	Information displayed by an additional 6-10 health and wellness professionals by 6/30/25	Confirmation of information displayed
2	Health and wellness information to take/receive available at a variety of locations	Marketing-PR	Health & Fitness Center Professionals, Needs Theme Group 4	Health/ wellness information (e.g., rack card, pamphlets) created	Information displayed by 3 health and wellness professionals by 12/31/23	Information displayed by an additional 6-10 health and wellness professionals by 6/30/25	Confirm-ation of informa-tion displayed
3	Hold a series of wellness classes in a variety of locations (e.g., Lourdes Health & Fitness Center, community centers, etc.).	Health Coaches	Health and Wellness professionals, Needs Theme Group 4	Hold wellness classes	3 wellness classes held by 12/31/23	6-10 additional wellness classes held by 6/30/25	Attend—-ance at classes

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ANTICIPATED IMPACT – OUTCOMES												
SMART OBJECTIVES: **I.** *Health and Fitness professionals videos created and aired by 12/31/23.* **II.** *Promotional materials created by 12/31/23.* **III.** *Series of wellness classes/workshops scheduled to begin by 12/31/23.*												
ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

PRIORITIZED NEED #4: Improve Health Outcomes by Focusing on Prevention and Wellness.

GOAL 2*: Develop and disseminate educational materials regarding healthy lifestyle behaviors through a didactic curriculum and/or social media.*

ACTION PLAN

STRATEGY 2.3: Physical media widely accessible at all Primary Care, Walk-In locations, and for all recently approved PFAP applicants; with the potential for expansion.

BACKGROUND INFORMATION:

- *Target Population:* Community Members
- *General Info:* Physical media provides direct resources to patients allowing them to be more directly involved in their care plan and supports the continuum of care. Improved access to physical media at all outpatient facilities and to PFAP applicants, encourages health literacy and access to care.
- *SDOHs Addressed:* Financial, Access to care, Health literacy

RESOURCES:

- Physical media widely accessible at all sites
- PFAP staff
- Marketing & Communications
- Primary Care Operation Managers
- Print Shop staff
- Specialty Sites (e.g., trainers, dieticians, ortho, podiatry, pain and wellness)

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ACTIONS:		LEAD ORG / STAFF	COLLAB ORG / STAFF	PROCESS MEASURES – OUTPUTS			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Review and assemble existing media (e.g., tips,flyers, diabetes newsletter, pamphlets) available to educate patients (create as needed).	Andy Stein	Marketing & Communications, Practice Operations Managers	Review of existing media completed		Complete the review of the existing media by 12/31/23	Meeting minutes
2	Provide approved material/media to newly enrolled PFAP patients.	Andy Stein	Eric Skorupa	Materials included in outgoing PFAP packets		Material provided to newly enrolled PFAP patients by 12/31/23	Email confirm-ation by Andy Stein or other PFAP rep
3	Distribute/promote media with providers and staff (e.g., ED and walk-ins, Associate Health, practices etc.).	Marketing & Communications	Practice Operations Managers, AMG Team	Media distributed and promoted.		Media distribut-ed and promoted by 12/31/24	Meeting minutes and/or emails

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *By 12/31/23, provide approved educational materials to 800-1000 newly approved PFAP patients.*

II. *Distribute/promote media with providers and staff (e.g., ED and walk-ins, Associate Health, practices etc.) by 12/31/24.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

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PRIORITIZED NEED #4: Improve Health Outcomes by Focusing on Prevention and Wellness.

GOAL 3: *Target the prevention of childhood obesity through the expansion of the FitKid Program framework.*

ACTION PLAN

STRATEGY 3.1: Expand access to the FitKids program at the Lourdes Health and Fitness Center.

BACKGROUND INFORMATION:

- *Target Population:* Community members struggling to afford membership dues and/or consistent transportation to Lourdes Health & Fitness center
- *General Info:* The FitKid program operated at the Lourdes Health and Fitness Center provides a framework to reach additional pediatric patients to improve health and fitness and decrease childhood obesity rates.
- *SDOHs Addressed:* Transportation, Financial

RESOURCES:

- Lourdes Health and Fitness Representative
- Identified CBOs for Partnering
- Lourdes Marketing & Communications support
- Southern Tier Tuesdays

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	*Coordinate transportation options as needed.*	Ben Robinson	GetThere Program Rural Health Network, CCN, BC Bus Company representative	Transportation arranged as needed.			Emails, meeting minutes, If applicable-bus receipts
2	Explore financial assistance/ scholarship opportunities/sliding scale options for children to participate	Andrew Stein	Mark Powell, Lourdes Leadership	Financial Assistance/ sliding scale/ scholarship opportunities explored.		Financial assistance/ scholarship opportunities or sliding scale explored by 6/30/2023.	Financial reports, meeting minutes
3	Once the pathway to financial support for participants is explored, if approved, begin the process for setting up financial assistance/scholarship fund/sliding scale (determining	Andrew Stein	Mark Powell, Lourdes Leadership, Finance	If approved, the scholarship process/ sliding scale is created.		Scholarship process/ sliding scale created by 12/31/23	Meeting minutes, emails, financial reports

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	eligibility, and securing an ongoing funding source).						
4	If financial support for participants is approved, develop the selection criteria/committee for picking scholarship recipients and disseminate scholarship applications.	Andrew Stein	Mark Powell, Lourdes Leadership, Finance	If approved, the committee is created, scholarship criteria developed and applications disseminated.		Selection committee established and scholarship applications disseminated by 12/31/24	Meeting minutes, emails, financial reports

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *Explore financial assistance/scholarship/sliding scale fee opportunities by 6/30/23.*
II. *Transportation options coordinated for increased access to the Health and Fitness Center for Fit Kid participants as needed by 6/30/25.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

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PRIORITIZED NEED #5: Address Services Needed for Vulnerable Populations, Including the Medically Indigent and Homeless Populations, Integrating Social Care w/ Prevention and Medical Care for a More Person-Centered Approach to Care Through Community Collaboration.

GOAL 1: *Integrate the delivery of social care with the delivery of medical care throughout our healthcare system by 2025 (for those engaged with us).*

ACTION PLAN

STRATEGY 1.1: Standardize the assessment of social care needs throughout our system through the use of the Social determinants of Health (SDOH) screen in Cerner to improve identification of the social care needs of the population we serve.

BACKGROUND INFORMATION:

- *Target Population:* At risk patients, such as the poor, vulnerable or homeless
- *General Info:* Screening is step one. Developing trust with patients to allow for SDOH intervention will be step two and more challenging.
- *SDOHs Addressed:* Transportation, food insecurity, insurance, medication coverage, housing

-

RESOURCES:

- Lourdes Associates
- Data Analytics (DA) Team
- Standardized SDOH Screen within Lourdes
- Data from Community Health Workers (CHW) Screening

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Develop a plan to perform SDOH Screening with patients in the outpatient (OP) setting (i.e., Primary Care, Specialty Care)	Lourdes Practice Operations Managers	RHN, Gerioulds, CCN, OP Nursing, SW, CMs, GPS	Volume of SDOH screens completed quarterly	SDOH Screen Value by 12/31/22	TBD after baseline review	Cerner Report
2	Develop a plan to perform SDOH Screening with patients in inpatient (IP) setting (i.e., ED, IP Units)	Lourdes IP Nurse Managers	IP Nursing, SW, Navigators and CMs	Volume of SDOH screens completed quarterly	SDOH Screen	TBD after	Cerner Report

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					Value by 12/31/23	baseline review	
3	Evaluate the possibility through Cerner or other workflows to allow a positive SDOH screen to trigger a referral to SW, CM, CHW, etc.	MIS Cerner Team	Lourdes Associates, GPS, Deb Blakeney, Cindy Felice	Referral Process established	TBD	TBD	Cerner/ Work-flow
4	Organize a committee to evaluate the progress and workflow for consistent SDOH screening and referrals and address areas of low performance	Deb Blakeney	Needs Theme 5 Group	Committee Organized	Committee meetings quarterly by January 31, 2023		Comm-ittee Meeting Minutes
5	Identify resource to manage data requirements to monitor progress with this strategy	Chad Miller	DA Team	Quarterly Data available for review	Data available by January 31, 2023		Data reports

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *Increase the volume of SDOH screens completed in the OP settings by 12/31/23.*

II. *Increase the volume of SDOH screens completed in the IP settings by 12/31/24.*

	SHORT-TERM OUTCOMES				**MEDIUM-TERM OUTCOMES**				**LONG-TERM OUTCOMES**			
	Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***	***Indicator***	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
TBD during action plan implementation												

PRIORITIZED NEED #5: Address Services Needed for Vulnerable Populations, Including the Medically Indigent and Homeless Populations, Integrating Social Care w/ Prevention and Medical Care for a More Person-Centered Approach to Care Through Community Collaboration.

GOAL 1*: Integrate the delivery of social care with the delivery of medical care throughout our healthcare system by 2025 (for those engaged with us).*

ACTION PLAN

STRATEGY 1.2: Identify resources and workflows to intervene on the social care needs of the population we serve to support improvement in their health outcomes.

BACKGROUND INFORMATION:

- *Target Population:* those with SDOH needs identified with a focus on the ACQA Medicaid population

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- *General Info:* Workflows that support development of trust with patients to allow for SDOH intervention is step two. Continuity of care through engagement with Social Workers, Care Managers, Community Health Workers (CHWs) and CBO's will support this.
- *SDOHs Addressed:* Transportation, food insecurity, insurance, medication coverage, housing, care gaps

RESOURCES:

- Contract with CBOs for CHWs and social care services
- Identification of need by care team in the practices
- CHW flyers- explain services to Lourdes associates and patients
- Google sheet to track work/outcomes
- External emails (if applicable) for external partners to access various google-based resource documents
- Neighborhood Resource (AH platform to support SDOH referrals)

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Identify SDOH needs via Cerner ad hoc form and Lourdes staff/provider referrals, and evaluate opportunities to utilize additional assessments specific to SDOH needs identified	Debbie Blakeney	Primary Care - Care teams, Pam P., CBO's	SDOH's for interven-tion	Volume by 12/31/ 22	Volume by 12/31/23	Cerner report CBO data
2	Identify workflows to engage CHWs with patients, preferably during an office visit, to provide assistance with social care needs	Debbie Blakeney	CHW's, Primary Care - Care Team	Volume of patients engaged with chw's	Volume by 12/31/22	Volume by 12/31/23	Lourdes CHW tracker, CCN data
3	CHW establishes trusting relationship with patient, provides solutions for social care needs and promotes closure of care gaps	Debbie Blakeney	CHWs, Primary Care - Care Team	Volume of social needs managed and care gaps closed	Volume by 12/31/22	Volume by 12/31/23	Lourdes CHW tracker, CCN data
4	Data collection through Lourdes Google sheet and data from CBOs	Debbie Blakeney	CHWs, CBOs	Data management resources in place	Volume by 12/31/22	Volume by 12/31/23	Lourdes CHW tracker, CCN data
5	Track and monitor quality measure performance for excellus ACQA Medicaid population	Debbie Blakeney	Joann Moore	volume of care gaps closed	Volume by 12/31/22	Volume by 12/31/23	Lourdes CHW tracker, Arcadia
6	Participate in the "localization" of the Neighborhood Resource platform and roll-out to associates as a tool to assist with social care needs (scheduled to be live Oct/Nov 2022).	Debbie Blakeney	Primary Care - Care Managers, Health Home Care Managers, CHWs, CBOs	volume of referrals placed in the Neighborhood Resource platform	Monthly volume 12/31/22	Monthly and annual volume by 12/31/23	Neighbor-hood Resource platform

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ANTICIPATED IMPACT – OUTCOMES
SMART OBJECTIVES: **I.** *Identify social interventions that lead to improved health outcomes- care gap closure by 12/31/23.* **II.** *Decrease the inequity in quality measure outcomes (w/ focus on Excellus ACQA patients) by 12/31/24.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

PRIORITIZED NEED #5: Address Services Needed for Vulnerable Populations, Including the Medically Indigent and Homeless Populations, Integrating Social Care w/ Prevention and Medical Care for a More Person-Centered Approach to Care Through Community Collaboration.

GOAL 1*: Integrate the delivery of social care with the delivery of medical care throughout our healthcare system by 2025 (for those engaged with us).*

ACTION PLAN

STRATEGY 1.3: Advocate for pilot programs for payer coverage of social care needs that were identified as having a positive impact on the health outcomes of a population through partnerships with local networks and/or Ascension Health advocacy.

BACKGROUND INFORMATION:

- *Target Population:* Medicaid population and the payer that insures them
- *General Info:* SDOH interventions are currently uncovered services by payers.
- *SDOHs Addressed:* transportation, food

RESOURCES:

- SDOH data- needs and results through data analytics or CBO data
- CCN and their social care network
- Local SDOH advisory board
- Ascension advocacy
- Payer willing to collaborate

ACTIONS:	LEAD ORG / STAFF	COLLAB ORG / STAFF	PROCESS MEASURES – OUTPUTS

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				Indicator	Baseline Value / Date	Target Value / Date	Data Source
1	Collect data obtained through the CHW pilot in Primary/Specialty care to identify interventions that deliver successful outcomes	Debbie Blakeney	Data Analytics	Volume of social care interventions and care gap closures	12/31/22	12/31/24	Cerner/ CHW tracker, CCN data
2	Understand CCN's work in the development of their social care network and identify opportunities that may exist to pursue a payer pilot for coverage of social care.	Lourdes	CCN, Managed Care Team	CCN meetings, payer options		12/31/24	
3	Participate on local SDOH advisory board and identify opportunities to pursue a payer partnership for coverage of social care needs	Debbie Blakeney	SDOH Advisory Board, Managed Care Team	SDOH meetings, payer options		12/31/24	
4	Remain informed of Ascension advocacy and/or national payer contracting opportunities to pursue a payer pilot for coverage of social care needs.	Lourdes	Managed Care Team			3/30/25	
5	Meet with payers to share data on SDOH intervention successes	Lourdes	Managed Care Team, VP-Strategy, CMO	Payer options		6/30/25	
6	Contract with payer in pilot for reimbursement for social care that has proven success to improve health outcomes.	Lourdes	Managed Care Team, Finance, Admin	Completed contract		6/30/25	

ANTICIPATED IMPACT – OUTCOMES												
SMART OBJECTIVES:I. *By 6/30/25 contract with a payer for a pilot for reimbursement for social care needs of their population that have been proven to improve health outcomes.*												
ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

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PRIORITIZED NEED #5: Address Services Needed for Vulnerable Populations, Including the Medically Indigent and Homeless Populations, Integrating Social Care w/ Prevention and Medical Care for a More Person-Centered Approach to Care Through Community Collaboration.

GOAL 2: *Create access to medical care outside of our "brick and mortar" locations through telehealth and nontraditional care models by 2025.*

ACTION PLAN

STRATEGY 2.1: Identify entities/ areas that serve vulnerable populations, and expand telehealth cart availability to a total of 8 locations.

BACKGROUND INFORMATION:

- *Target Population:* At risk populations with limited access to medical care
- *General Info:* Patients are unable to access our traditional "brick and mortar" locations. This initiative will take services to "where patients are".
- *SDOHs Addressed:* access to medical care

RESOURCES:

- community based organizations to identify locations for placement of telehealth carts
- additional telehealth carts
- providers to support additional telehealth services
- support for people to utilize telehealth services (e.g., educator, written instructions, help line, etc.)

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Meet with CBOs in the area to identify the populations that may benefit from telehealth services	Mat Stein	CBOs	Meetings with CBOs		12/31/22	Meeting minutes
2	Evaluate locations In Binghamton: North side,East side, West side, South side	Mat Stein	CBO's, DA team	Meetings with CBOs		12/31/23	Meeting minutes
3	Evaluate locations In Johnson City: A location near the arch	Mat Stein	CBO's, DA team	Meetings with CBOs		6/30/24	Meeting minutes
4	Evaluate locations In Endicott: Near Washington Ave or near Price chopper plaza	Mat Stein	CBO's, DA team	Meetings with CBOs		12/31/24	Meeting minutes

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5	Obtain additional telehealth carts - identify funding source	Mat Stein	Grants, AH funding	Dollars available for cart purchase	TBD	TBD	Funding
6	Establish carts within identified buildings- secure and private location within the building, support for utilization of the cart	Mat Stein	AT	# of tele-health carts	2 carts - 9/26/22	8 carts- 12/31/24	Teleh–ealth cart inventory
7	Monitor cart utilization at all locations to ensure the service is meeting the need and to monitor downstream opportunities from the telehealth visit	Mat Stein	Mat, DA team	# of telehealth visits and down-stream services	Initial 2 carts- 10/31/22	TBD	Tele-health cart utilization data

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *Telehealth carts throughout the community will increase access to medical services for vulnerable populations by 6/30/25.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

PRIORITIZED NEED #5: Address Services Needed for Vulnerable Populations, Including the Medically Indigent and Homeless Populations, Integrating Social Care w/ Prevention and Medical Care for a More Person-Centered Approach to Care Through Community Collaboration.

GOAL 2*: Create access to medical care outside of our "brick and mortar" locations through telehealth and nontraditional care models by 2025.*

ACTION PLAN

STRATEGY 2.2: Develop a care team to support patients connected through telehealth services to assist in coordination of their medical and social care needs to improve their health outcomes.

BACKGROUND INFORMATION:

- *Target Population:* At risk populations with limited access to medical care
- *General Info:* Target population has increased healthcare disparities leading to poor health outcomes and high healthcare costs which may be preventable through additional support. Care Team will offer patient engagement tools

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to promote measurable outcomes; such as medication management program, safe link phone, or routine appointments for chronic disease management

- *SDOHs Addressed:* medication, income, insurance, housing, transportation, gaps in healthcare screenings and chronic disease follow up care

RESOURCES:

- Lourdes Care Management
- Primary Care Nurse Navigator
- Social Workers
- Lourdes Medication Management Program
- Lourdes Patient Financial Assistance Program
- Data Analytics Team
- Providers
- Lourdes Center for Mental Health
- Community Resources e.g., DSS, Food Banks

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Sourc e***
1	Identify a process to SDOH screen the population using the telehealth cart.	Mat Stein, Tom Ellerson	DA Team	SDOH completed	12/31/23	TBD	TBD
2.	Identify the needs of patients using the telehealth cart	Needs theme 5 team	DA Team	Identified patient needs	12/31/23	TBD	Meeting Minutes
3	Develop a Care Team to support patients that engage using telehealth to assist in coordination of their medical and social needs	Needs theme 5 team	LCM, PFAP, LMMP Providers, RN Patient Navigator, SW, Mental Health, CR	Care Team Organized	12/31/24	6/30/25	Meeting Minutes

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4	Streamline a referral process to appropriate Care Team resources to meet the needs of the patient using the telehealth cart	Needs theme 5 team	LCM, PFAP, LMMP, Providers, RN, Patient Navigator SW, Mental Health, CR	Referral process established	Quarterly Care Team collab-oration meetings 12/31/23	Process in place 3/31/24	Meeting Minutes Cerner
5	Develop report to show Care Team's response to patients needs	Needs theme 5 team	DA Team	Quarterly Data available for review	Data available 12/31/24	6/30/25	Meeting Minutes

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *Patients using telehealth carts will have medical needs met and social needs identified by 6/30/25.*

II. *A Care Team to support telehealth cart services will improve healthcare outcomes for the population served- improved quality care with reduced healthcare costs by 6/30/25.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

PRIORITIZED NEED #5: Address Services Needed for Vulnerable Populations, Including the Medically Indigent and Homeless Populations, Integrating Social Care w/ Prevention and Medical Care for a More Person-Centered Approach to Care Through Community Collaboration.

GOAL 3: ***Develop an understanding of how, and a plan to provide medical care to the homeless population through community collaborations by 2025.***

ACTION PLAN

STRATEGY 3.1: Expand the reach and frequency of Lourdes Medical Mission at Home (Med Mission) events with the development of a staffing pool, and coordination of the delivery of additional services identified as needs by the population served.

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BACKGROUND INFORMATION:

- *Target Population:* Med Mission attendees / Community members
- *General Info:* The Med Mission events have been able to expand the reach of Lourdes' Mission to serve the poor and vulnerable. By expanding the frequency, attending staff, and locations of these events there will be improved access to care, health literacy among our community and improved overall attribution.
- *SDOHs Addressed:* Access to care, health literacy

RESOURCES:

- CBOs (e.g., Lee Barta Center, NoMa)
- Med Mission Resource Team
- Mobile vans
- Lourdes service providers- dependent on identified needs

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Coordinate a team of resources (i.e., residents, nurses, health coaches, MOA's, admin staff, security, etc.) to serve at med missions providing social and medical care at additional sites in the community.	Sue Bretscher /Karen Riewerts	CBOs, Med Mission Steering Comm-ittee	Creation of a Med Mission resource team to provide care at community sites.	Med Mission resource team established by 12/31/23	Med Mission resource team rotates at the identified sites by 12/31/24	Meeting minutes, Feed-back from CBO's, Attend-ance at MMH Events
2	Identify additional service locations, dates, services needed and begin providing services	Sue Bretscher /Karen Riewerts	CBOs, Med Mission Steering Comm-ittee	Expansion of Med Missions to additional community sites.	Expand Med Missions to 1 additional community site by 12/31/23	Expand Med Missions to additional 1-2 sites by 6/30/2025	Attend-ance at Med Missions

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *Begin providing additional medical mission services utilizing the Med Mission resource team at additional locations by 6/30/25.*

ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

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PRIORITIZED NEED #5: Address Services Needed for Vulnerable Populations, Including the Medically Indigent and Homeless Populations, Integrating Social Care w/ Prevention and Medical Care for a More Person-Centered Approach to Care Through Community Collaboration.

GOAL 3: ***Develop an understanding of how, and a plan to provide medical care to the homeless population through community collaborations by 2025.***

ACTION PLAN

STRATEGY 3.2: Develop a partnership with the "street team" or other entities connected with the homeless population to clarify the need and "how to" deliver medical and social care to this vulnerable population.

BACKGROUND INFORMATION:

- *Target Population:* homeless population (i.e,. homeless served by the street team, formerly incarcerated individuals, etc.)
- *General Info:* The homeless population in our area continues to grow as housing options have become increasingly limited. This population lacks access to medical care, as well as many of the daily necessities of life. Establishing trust with this population has been identified as a necessary initial step in this work.
- *SDOHs Addressed:* access to medical care, social care

RESOURCES:

- CBOs with connections to the homeless (e.g.,. Lee Barta Center, NoMa, Homeless Coalition, Street Team, Br Co jail)
- Med Mission Resource Team (new teams to develop at Lourdes)
- Mobile vans
- CBOs to provide social care

ACTIONS:		**LEAD ORG / STAFF**	**COLLAB ORG / STAFF**	**PROCESS MEASURES – OUTPUTS**			
				Indicator	***Baseline Value / Date***	***Target Value / Date***	***Data Source***
1	Invite coordinators from the Street Team and other CBOs connected with the homeless to participate in discussions to identify the population(s) that will best be served by our services and steps to be taken to offer this support.	Debbie Blakeney	Rebecca Rathmall-Homeless Coalition Representative, Needs theme 5 group	Task force created with meetings scheduled to develop plan	Kick off meeting by 1/1/2023	Plan by 12/31/23	Meeting minutes with finalized plan
2	Create a flier to distribute during street outreach or other encounters with the homeless population with info on current Lourdes Medical Mission dates, times and	Needs theme 5 group, Lourdes	CBOs. police, DSS	Flier distribution	50 flyers distribut-ed by 1/31/23	Addition-al 1-200 flyers distribut-	Flier count by

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	locations for people to access. Possibly partner with police dept and DSS to distribute this information.	Marketing & Communi-cations				ed by 12/31/23	print shop
3	Locate Lourdes Medical Mission in a location "safe" for the homeless to attend	Needs theme 5 team, Med Mission Steering Committee	Lourdes staff, CBOs	Additional Medical Mission locations	1 additional location by 12/31/23	1-2 addition -al loca-tions by 6/30/25	Log of Med Miss-ions
4	Through discussions with those connected with the homeless and area CBOs identify solutions that will be utilized by the population. Services to be considered include: - Partner with local churches/ community organizations to open hours of showers more than once a week for longer hours - Partner with CBOs to offer a voucher program for clothing - Partner with a local laundromat to provide free washing and drying to people in need - Provide assistance for people in obtaining IDs through transportation to sheriffs dept or other entities that may be able to assist - Partner with a local hotel to be able to provide shelter	Needs theme 5 group, CBOs	Lourdes associates, CBOs	Additional services available / provided	TBD	TBD	
5	Evaluate a proposal for a Lourdes social care van to provide showers, clothing, and food directly or through collaboration with CBOs	Needs theme 5 group, Lourdes sr. leaders	Lourdes Finance	Social care van approved (if funding available) and in service	Van approval by 6/30/24 (if funding available)	Van providing service to the populatio n 3/1/2025	Mobile social van

ANTICIPATED IMPACT – OUTCOMES

SMART OBJECTIVES:

I. *By 6/30/24 will collaborate with the Street Team and CBOs working with the homeless population to develop an understanding of how to provide medical care to the homeless population.*

II. *By 6/30/25 offer 2 Medical Mission at Home opportunities for the homeless.*

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ACTIONS	SHORT-TERM OUTCOMES				MEDIUM-TERM OUTCOMES				LONG-TERM OUTCOMES			
	Indicator	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*	*Indicator*	*Baseline Value / Date*	*Target Value / Date*	*Data Source*
TBD during action plan implementation												

Evaluation

Lourdes will develop a comprehensive measurement and evaluation process for the implementation strategy. The Ministry will monitor and evaluate the action plans outlined in this plan for the purpose of reporting and documenting the impact these action plans have on the community. Lourdes uses a tracking system to capture community benefit activities and implementation. To ensure accountability, data will be aggregated into an annual Community Benefit report that will be made available to the community.

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