2017–2019 COMMUNITY HEALTH IMPLEMENTATION PLAN

CHRISTUS® ST. VINCENT

EXECUTIVE SUMMARY

What would it mean for a community and its hospital to be true partners, working seamlessly toward the long-term wellness of their population? How could cross-community collaboration be orchestrated between everyone with a role to play in improving health and well-being to turn the curve in crucial areas where change is needed? What if the public and private resources dedicated to health and social services were perfectly coordinated to leverage all a community's assets on behalf of its people? What would life in Santa Fe look like then?

This 2017-2019 Community Health Implementation Plan (CHIP) lays out strategies and a framework for beginning to address these important questions and the critical health priorities identified in CHRISTUS St. Vincent's (CSV) 2017-2019 Community Health Needs Assessment (CHNA). It provides a pathway for continuing and building upon partnerships, which are working to resolve the most pressing population health goals and issues we face. It also shows a way forward by proposing both community-based and CSV-based strategies. This dual approach to community health means that CSV will be working diligently on the areas of greatest need identified in its 2017-2019 Community Health Needs Assessment (CHNA) and further refined to three Super Priority areas in this CHIP, from both an internal and external or system of care perspective.

The three Super Priority areas to be addressed are: adults with behavioral health conditions (i.e., addictions or mental illness), care for senior citizens and victims of violence in the home. These priorities were selected through the process of listening to our community and examining critical needs through the CHNA. Through community forums, expert panels and stakeholder interviews, we learned which health needs continually rose to the top of people's concern. We honed in on those needs that were supported by health data, pointed to issues of health equity and seemed to have insufficient community support to make the progress necessary to mitigate them over time. CSV, as a reflection of our mission and core values, has chosen to "run toward the fire" in selecting priorities that matter most and are robbing our community of its bright future.

Our strategies to address the three Super Priorities have been created in collaboration with the City of Santa Fe, Santa Fe County, Santa Fe Community Foundation, the CSV Board Community Health and Wellness Committee, local experts in community health and CSV leaders.

In addition to the super priorities, CSV will also maintain continued effort for initiatives begun through the first CHNA and CHIP in 2013. These priorities include: Maternal Health and Early Childhood, School Age Children & Adolescents, Adult Physical Health and Women's Health.

We know that it will take dedication and focus to make our ambitious goals a reality, and we are prepared for the challenge! We also know that it will take extensive cross-community collaboration and pulling together to cross this finish line. Unfortunately, not all of Santa Fe's health issues can be addressed simultaneously by CSV, and we will look to others to provide support and direction in these areas. Together we can protect and foster a spectacularly bright, future for Santa Fe and its people that lives up to our guiding community health vision, "Transforming Health: Strengthening Our Community."

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2017-2019 CHIP INTRODUCTION

CHRISTUS St. Vincent (CSV) embraces its role in contributing toward improving the health and wellbeing of our community. This 2017-2019 Community Health Improvement Plan (CHIP) is a reflection of both the community's and the hospital's best thinking and research on how we can partner to improve population health in Santa Fe. It outlines strategies that address the most crucial threats to the health and well-being of this community.

In addition, this CHIP meets the IRS 990 reporting requirement for non-profit hospitals to conduct a Community Health Needs Assessment (CHNA) and Community Health Implementation Plan. The CHNA is conducted every three years (beginning in 2013) and demonstrates that CSV has studied and understands the health needs of the community. The CHIP is an opportunity to further prioritize the needs in the CHNA and show how we plan to address them. In 2017, the IRS added an additional requirement of examining health disparities and social determinants of health.

This CHIP also outlines how CHRISTUS St. Vincent plans to work with and support the community to improve the health of our residents, using our lifespan model, over the next three years. We know that improving the health status of our community will take partnerships; not one organization or entity alone can address the complexity of health and social conditions we find in Santa Fe.

Within this document we set forth the two prong approach which includes internal strategies we will employ to optimize care at CSV as well as plans to partner in the community to strengthen the system of care. By implementing these internal and community-based strategies, we aim to create a healthier Santa Fe where every person can enjoy the best possible health and happiness. To that effect our guiding Community Health Vision is:

Transforming Health: Strengthening Our Community

Our CHIP Priorities are based on the 18 health indicators highlighted in the 2017—2019 CHNA. When analyzing these indicators, three population groups rose to the top in priority based on pre-selected criteria. Titled "Super Priorities," these chosen priority groups are: Adult Behavioral Health, Senior Care and Violence in the Home. Within each of the Super Priorities, three health indicators, from the original 18 in the CHNA, were selected to guide progress and provide data points and a baseline.

ADULT BEHAVIORAL HEALTH	SENIOR CARE	VIOLENCE IN THE HOME
Alcohol Related Deaths	Fall Related Injuries	Child Abuse & Neglect
Adult Suicide	Immunizations	Domestic Violence
Drug Related Deaths	Elder Abuse	Elder Abuse

CHRISTUS St. Vincent Mission:

Our healing ministry is to improve the health and well-being of the communities we serve.

Core Values:

*Compassion * Dignity * Integrity * Excellence * Stewardship*

CHRISTUS ST. VINCENT COMMUNITY HEALTH

In the midst of Santa Fe's story and long history lies CHRISTUS St. Vincent (CSV), the sole community provider hospital. It is a product of Santa Fe's collective wish for the very best health and wellness for its residents. CSV is where our neighbors work, our babies are born, a loved one passes away and others come for quality health care. Flu shots, primary care visits, cancer treatment, physical therapy and even drug or alcohol detox happen every day within CSV's walls. CSV acts on the community to shape health, and is in turn molded by the community to be what it is today. CSV is truly of the community and for the community, and together, we will strive always to bring comfort and healing to the sick.

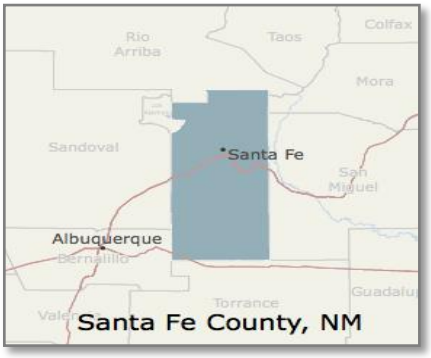
The mandate, to uncover and treat the root causes of sickness, occurs not only in response to our place in this community, but is also a legacy of the Sisters of Charity of Cincinnati, which began St. Vincent's Hospital 151 years ago in 1865. These brave religious women, who dedicated and often gave their lives to serve the sick and poor, knew their community and did not turn away from the most challenging health problems. They embraced a commitment to the sick and were undeterred regardless of the difficulties or disasters encountered. In 1977 St. Vincent's moved to the current location at St. Michael's Drive. Between 1977 and 2008, St. Vincent's was a non-profit community hospital. In 2008, St. Vincent's entered a partnership agreement with CHRISTUS Health, a non-profit Catholic health care system sponsored by the Sisters of Charity of the Incarnate Word, once again becoming sponsored by Catholic Sisters. Today CHRISTUS St. Vincent is a 50/50 partnership between CHRISTUS Health and SVHSupport.

The heritage of CHRISTUS St. Vincent is founded upon principles of compassionate care, the dignity of all persons, responding to needs that no one else attends to, priority for the most vulnerable, and serving all people regardless of ability to pay. CSV Community Health is based upon the principles of concern for the common good and social justice. The health care priorities and implementation strategies adopted reflect our commitment to these principles. Our mission and core values today reflect this legacy and continued devotion to our community:

The CSV Department of Community Health is the living demonstration of our commitment to improving the health and well-being of some of the most vulnerable in our community. The CSV Department of Community Health coordinates and manages the Community Health Needs Assessment (CHNA) and Community Health Implementation Plan (CHIP), manages over $1 million in annual funding to local non-profits that serve the needs of our community, and operates a 15 bed Sobering Center. The department also operates the HUGS Program – High Utilizer Group Services, a program that annually serves the most frequent utilizers of the Emergency Department with an addiction or mental illness and partners with the SKY Center to offer similar services for adolescents. We are actively engaged in working with our local partners including Santa Fe County, the City of Santa Fe, Santa Fe Community Foundation, other local foundations, non-profits, and stakeholders who are equally committed to responding to the health and social service needs of our community.

COMMUNITY PROFILE

The Community is defined as Santa Fe County, which is the primary service area for CHRISTUS St. Vincent. CSV is the only Level 3 Trauma Center in North Central New Mexico, an area covering seven counties, including Santa Fe, Rio Arriba, Los Alamos, Taos, Colfax, Mora and San Miguel. Santa Fe County is the third most populous county in New Mexico.



	Santa Fe	New Mexico
Population (July 1, 2014)	147,515	2,098,380
% New Mexico population	7.03%	100%
Households	71,554	907,233

Source: *United States Census Bureau – www.census.gov/quickfacts/table*

Santa Fe County, similarly to New Mexico, is a minority-majority race/ethnic population. Hispanics make up just over 50 percent of the total residents. A quarter of Santa Fe County's population is under the age of eighteen years old. However, statistics shows that by the year 2030, New Mexico will be the 10th largest state in terms of our senior population. Out of the total population of Santa Fe County, a reported 16.7% of our residents live in poverty. A vast majority of the people living in poverty are Hispanics and Native Americans. Furthermore, 18.7% of Santa Fe County residents are uninsured. The above table and information, as well as further data on the demographics of Santa Fe County, are available in our 2017—2019 CHNA.

HEALTH EQUITY

CHRISTUS St. Vincent strives to address health disparities and barriers to care in our community. Health inequities exist and negatively impact the health of particular populations and geographic areas of our community. Health disparities are largely the result of poverty, discrimination, power imbalances, and social determinants of health, such as access to housing, employment, transportation and education.

Health Equity is not about providing the same amount of services, resources and care to people regardless of who they are and their circumstances. Health equity is about serving and recognizing that people are multifaceted, exist within a complex socio-cultural context and have a whole host of individual strengths and challenges. By seeing and responding to a fuller picture of the human condition, CSV hopes to offer everyone opportunity and access to the kind of healthcare and life that they deserve. In this way, health

equity is a principle that overlays everything we do as an organization and is not relegated to being just a concern of our community health focused efforts.

CHRISTUS HEALTH and SVH Support comprise the 50/50 partnership in the ownership of CHRISTUS St. Vincent. CHRISTUS Health, an international non-profit, Catholic health system, has established Health Equity as one of its top organizational goals in its strategic plan. CHRISTUS St. Vincent is aligned in achieving the goal established by CHRISTUS Health to "Improve access to appropriate care for the economically disadvantaged by reducing, inappropriate visits to the emergency room by 10%." CHRISTUS St. Vincent's strategies for achieving this goal are identified in the section "HUGS: A Strategy That Works" below.

Underserved Populations in Santa Fe County

Underserved populations in Santa Fe County include residents of the Southside (including Agua Fria Village, and portions of the Airport Road area), Native Americans, LGBTQ groups and high utilizers of healthcare. Please consult the 2017—2019 CHNA for further detail on underserved groups and unmet community needs.

HUGS: A STRATEGY THAT WORKS

Through the HUGS (High Utilizer Group Services) program, Adolescent HUGS, and Sobering Center detox programs, CSV has implemented strategies to make highly specialized, wrap-around case management a reality for high-utilizers and individuals who often have co-occurring issues of drug and/or alcohol addiction and mental illness. These have become our preferred strategies due to their efficacy in working with disenfranchised populations who face huge obstacles in getting the care they need.

All too often, high utilizers of the hospital are individuals who fall through Santa Fe's net of social services and suffer in isolation. Barriers, easily overlooked, prevent people from receiving proper care. Routine tasks, like the ability to call for an appointment and remember what date to show up, having transportation or knowing how to use a bus to get to an appointment, having the ability to complete the necessary paperwork, speaking the language of the provider, having childcare during the necessary hours, or maintaining the cognitive ability and financial resources necessary to abide by a provider's follow up instructions, are significantly harder for those who are disenfranchised. Many struggle to complete these tasks and therefore, do not get care. For them, the inflexibility of the system repeatedly sets unachievable expectations and then casts blame for their plight.

Using the following approaches, CSV has demonstrated outcomes in reducing costly and unnecessary hospital utilization and more importantly witnessed people overcoming significant challenges and making consistent strides toward wellness. On average, adult HUGS clients reduce their use of the emergency department, due to health improvements, by 30-60% within the first six months of receiving services from a HUGS Navigator. Given that these are individuals who often times have struggled with addiction or mental health issues for decades, the results speak to not only what is possible, but what becomes statistically probable when care is responsive to what the individual needs. The five key elements for working with individuals with multiple, complex social determinant challenges are:

1. **Relationships first.** Asking people what they need to improve their health, understanding their challenges and building upon their strengths supports compassionate and effective service provision. Breaking down barriers and setting reasonable expectations given their life circumstances is also key. We

have found that by getting to know our clients as individuals and even seeing them as our guides and teachers, the pathway to their healing becomes clearer.

2. **Mobile services** that come to the individual instead of expecting them to show up at our offices makes the difference. Going to people breaks down barriers to access, including lack of transportation, difficulty setting and keeping appointments and the stigma these patients may face in a more traditional clinic or office setting. Whether it be moms without sufficient childcare, people who are wary of service providers due to past treatment, or even home-bound seniors, going to the person is essentially the only way to deliver care for many populations.

3. **Flexible spending money** is unrestricted money designated for unique needs. These needs may include a pair of shoes, a sleeping bag, or a bus ticket. These funds acknowledge the full spectrum of social determinant based needs an individual may be facing and creates the needed flexibility in responding to these obstacles to wellness. It furthers equity of care by acknowledging the participant's unique reality and creates a more participant-driven and centered program. Most funding sources do not allow for flexibility in spending.

4. **Address organizational barriers.** Programs with rigid boundaries that offer the same services for everyone regardless of life circumstance are limited in their ability to respond to complex needs. Even seemingly insignificant program components, like the length of intake paperwork can be enough to deter people from getting the help they need. CSV will strive to address issues that may create barriers and will work with community partners to do the same.

5. **Creating connection heals.** In working with our clients, we aim to build a team of interested persons around them and bring multiple entities to the table to share information, build support and coordinate helpful strategies within the bounds of confidentiality. CSV knows that the answers to population, community and individual health concerns do not lie with one agency or entity but will only be realized through concerted effort to create systems that make sense.

These innovative approaches are being utilized whenever possible within CSV to decrease barriers of care, and increase participants' control over their healing process. These approaches are widely applicable to other settings. CSV gives preference to these practices in our community health strategies because their effectiveness has been consistently demonstrated.

BUILDING ON OUR COMMUNITY'S STRENGTHS

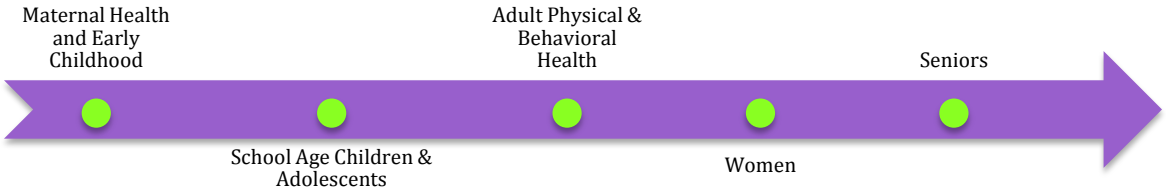
While there are areas of health where Santa Fe struggles to keep pace with New Mexico and the U.S., we also have health advantages that are the envy of other cities and states. The 2017-2019 CHNA and CHIP places focus on identifying and responding to the areas of greatest need, yet it is important to also recognize our strengths and resources. These strengths and resources, or protective factors, can be built on and leveraged to optimize our response to those areas where Santa Fe is challenged. For example, Santa Fe is located in a beautiful natural environment which offers recreational opportunities including walking, running, biking, hiking, camping, and other healthy forms of stress relief, exercise and fun. Another protective factor is the close ties and deep bonds to culture, faith and family present in Santa Fe. These assets give Santa Feans a health and wellness boost that should be recognized and built upon to improve population health.

EVALUATION OF 2013—2016 CHIP

The first Community Health Needs Assessment (CHNA) was conducted in 2013 in partnership with Santa Fe County. The report titled, "Santa Fe Community Health Profile" covered a broad range of health indicators. That CSV and Santa Fe County coordinated efforts and resources to conduct the assessment together was the first of many positive impacts of the 2013 CHNA.

Health needs can change as we age. In our CHNA and CHIP, CSV has taken the approach of looking at issues of wellbeing and need throughout the lifespan when addressing community health.

Lifespan Approach to Health Care



The lifespan approach helps to organize health care needs along a continuum so that appropriate focus can be placed on each time in people's lives. From the 2013 CHNA, CSV implemented 13 initiatives impacting our resident's wellbeing all along the life span and in keeping with our lifespan model. Some of these actions taken were conducted entirely by CSV and others came about as a result of strong partnerships with other non-profits where CSV at times provided technical, financial and other support. The table below shows these 13 initiatives.

POPULATION		CSV 2014 - 2016 COMMUNITY HEALTH INITIATIVE
Health Care System's Improvements		Patient Navigation
		Medicaid & HIX new eligibles
Maternal Health & Early Childhood		Healthy Babies – Prenatal Care for all
		Opiate Addicted Pregnant Women
		Home visitation for new births
School Age Children & Adolescents		Adolescent High Utilizer Group Services (HUGS)
		Healthy Habits
Adults	Chronic Diseases	MyCD Program (Manage My Chronic Disease) & Healthy Habits
	Behavioral Health	High Utilizer Group Services (HUGS)
Women's Health		Safety Net: Hospital based DV program
		Bridge to Safety Program: Practitioner Tool Kit
Seniors		Senior Care Continuum – Patient Navigation
		Senior Care Dashboard

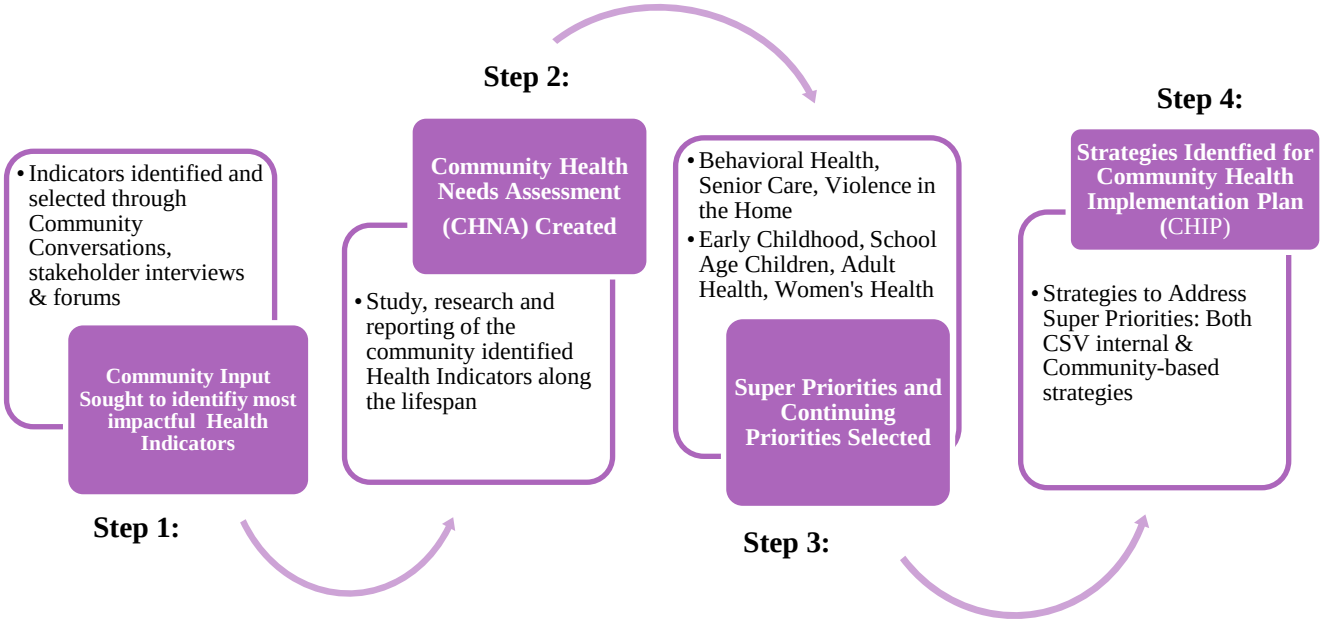
While there are numerous accomplishments from the 2014-2016 CHNA, a couple of initiatives were not as successful or could not be maintained for all three years. Healthy Habits, which was a collaborative initiative with the New Mexico Department of Health to address obesity and diabetes in youth and adults, did not move forward because of the changes in staffing at CSV and discontinuing of the grant at the Department of Health. As a result, a new program was developed with a local non-profit. This new program is a summer program to reduce youth obesity and is being offered in a CSV pediatric clinic. The Senior Care Continuum, a group of local experts and stakeholders, was convened by CSV on multiple occasions and worked well together to establish proper transitions of care for seniors. Unfortunately, due to staffing changes this work was put on hold.

In addition to the efforts described above, CSV annually awarded over one million dollars in Community Benefit funds to local non-profit organizations that strategically focused on addressing the social determinants of health and gaps in Santa Fe's system of care. Community benefit funding is dedicated by CSV to supporting the efforts of local non-profits. For each age group along the life span, specific services were funded. For example, one of our 2013 priority population groups was individuals with addictions and mental illness. We saw that for CSV patients with an addiction and behavioral health diagnosis, who were also homeless, when discharged from the hospital, were at heightened risk for poor health outcomes. Many times these individuals were not sick enough for hospitalization, but definitely needed a place to recover where they could be indoors all day and have someone looking out for them. Community Benefit funding is now being provided to two local homeless shelters to fund respite beds. These respite beds allow our patients to have a warm, safe, caring place in which to be out of the elements and to heal. Under the direction of the CSV Board Community Health and Wellness Committee, implementation strategies and funded programs, like our respite bed partnership, are reviewed annually for their effectiveness.

2017—2019 CHIP DEVELOPMENT

The development of CSV's CHNA and CHIP is shown in the following diagram depicting how CSV has moved through the process of choosing health indicators, conducting the CHNA, selecting priorities, and finally creating internal and community-based strategies for addressing the super priorities through the CHIP.

2017 – 2019 CHNA & CHIP Process



COMMUNITY INPUT for INDICATOR SELECTION

The 2017 - 2019 CHNA began in the Fall of 2015 with Community Conversations designed to identify top community health needs, referred to as "indicators" of the population's health status. The indicators selected were chosen through Community Conversations held in the Winter of 2015. The Community Conversations involved professionals from local non-profits that are funded through the CSV Community Benefit funding, officials from local government Health and Human Services Departs of Santa Fe, Santa Fe Community Foundation, the CSV Board of Community Health and Wellness Committee, members of the CHNA data team, and other key stakeholders. Attendees were asked to participate based upon their direct knowledge and experience serving at-risk populations or working to address health and social conditions within the community.

Data Collection

Quantitative and qualitative data were collected on the indicators and are documented in the 2017 – 2019 CHNA. Quantitative data on the priority indicators were gathered from the New Mexico Department of Health, Centers for Disease Control, Census, Santa Fe Public Schools, Healthy People 2020, Kids Count, County Comparisons and a range of other studies and key data sources. A team of University of New Mexico Master of Health Administration students was instrumental in collecting and organizing the quantitative data. The Community Health Epidemiologist, with the New Mexico Department of Health, was instrumental in assisting us to obtain and refine data specific to Santa Fe County. In addition, hospitalization, emergency room and outpatient utilization data were retrieved internally and reviewed to further understand the prevalence of health care conditions on utilization at CSV and the larger healthcare delivery system.

The table on page 13 shows Santa Fe County comparisons to New Mexico and the U.S. Red means we rated worse, yellow means the rates were similar and green means that Santa Fe is doing better. This table was helpful in assessing where the areas of greatest need existed.

Qualitative data, gathered from a number of sources, helped flesh out why residents believe the selected health indicators are significant problems in Santa Fe, and how these issues impact real lives. The qualitative data gathered enriches and brings meaning to the quantitative data. The "Voice of the Community" section (which can be found in the 2017—2019 CHNA) includes resident's input gathered through key informant interviews, focus groups and community forums. Key informant interviews were conducted with medical practitioners and individuals who had direct experience either professionally or personally and a high level of expertise in a given health concern.

Through the focus groups a broad range and large number of individuals provided input and gave feedback on the data pertaining to each indicator. There was wide agreement that the indicators chosen were of high priority and have a significant impact on the lives of people in our community. The following five focus groups were held: Santa Fe County Health Policy & Planning Commission, City of Santa Fe Health Study Group, San Isidro Catholic Parish, Santa Fe Prevention Alliance, and a Santa Fe Community College Sociology Class.

CHIP 2017 – 2019 PRIORITIES

In the 2017 – 2019 CHNA, and by the means described above, three indicators were chosen for each of the six lifespan categories (Maternal Health and Early Childhood, School Age Children and Adolescents, Adult Physical Health, Adult Behavioral Health, Women, and Seniors). This resulted in 18 total indicators as follows. These indicators range from our community's elevated rates of low birth weight babies to the high incidence of fall related deaths for seniors.

MATERNAL HEALTH

- Prenatal Care
- Low Birth Weight Babies
- Child Abuse and Neglect

SCHOOL-AGE CHILDREN & ADOLESCENTS

- Childhood Obesity
- Youth Depression
- Youth Resilience

ADULT BEHAVIORAL HEALTH

- Drug Related Deaths
- Adult Suicide
- Alcohol Dependence

WOMEN

- Domestic Violence
- Obesity
- Homelessness

ADULT PHYSICAL HEALTH

- Chronic Diseases
- Obesity
- Healthy Food Consumption

SENIORS

- Fall Related Unintended Deaths
- Immunizations
- Elder Abuse

The following table shows each indicator and compares Santa Fe's rates to those in New Mexico and nationally. Green depicts areas where Santa Fe is doing better than New Mexico or the nation, yellow depicts rates similar to comparison groups, and red depicts rates where Santa Fe fares worse than the comparison groups. This table was instrumental in helping CSV assess the areas of greatest need.

POPULATION		INDICATOR	HOW ARE WE DOING COMPARED TO: NM	US
Maternal Health & Early Childhood	1	Prenatal Care in the First Trimester	🔴	🟡
	2	Low Birth-Weight Babies	🔴	🔴
	3	Substantiated Child Abuse	🟡	🔴
School-Age Children & Adolescents	1	Childhood Obesity	🟢	🟢
	2	Youth Depression	🔴	🔴
	3	Youth Resilience	🟡	Data not available
Adult Behavioral Health	1	Drug Related Deaths	🔴	🔴
	2	Adult Suicide	🔴	🔴
	3	Alcohol Abuse	🟡	🔴
Adult Physical Health	1	Chronic Diseases	🟡	🟢
	2	Obesity	🟢	🟢
	3	Healthy Food Consumption	🟢	🟢
Women's Health	1	Domestic Violence	🔴	🔴
	2	Obesity	🟢	🟢
	3	Homelessness Among Women	🔴	Data not available
Seniors	1	Unintended Fall Injury Deaths	🔴	🔴
	2	Immunizations	🔴	🔴
	3	Elder Abuse	Data not available	Data not available

Prioritizing Criteria, Super Priorities and Continuing Priorities

A priority-setting session was held in late July 2016 to determine the 2017-2019 CSV CHIP priorities. Participants were key stakeholders and experts including CSV and community leaders. Three "Super Priorities" were selected from the18 health indicators examined through the CHNA by applying the following criteria established by CSV:

- Help those who are most in need, have been impacted the most and are the most marginalized
- An area where CSV has some expertise and know-how
- Address and issue that helps reduce health disparities and barriers to care
- Have a significant impact on:
    - Population and patient health
    - Human suffering and quality of life
    - Strengthens community's system of care
    - Is quantifiable through data
- Measure and consider the level of current focus in the community in terms of:
    - Funding from other community stakeholders
    - Expressed desires of community and leadership
    - Current collaboration and strength between our potential partners

CONTINUING PRIORITIES

A level of effort and focus will continue with the current and past population priorities as shown in the previous diagram titled "2014 – 2016 Community Health Implementation Strategies" in this CHIP. Progress was made between 2014 and 2016 and do not want to lose ground in the gains acheived. CSV will continue to focus on areas where patient care both inside and beyond the walls of the hospital or outpatient clinics is needed such as promoting healthy births and prenatal care. As CSV resources are allocated, including Community Benefit funding to local non-profits, decisions for extending funding will be made based upon our community health priorities. Outcomes of funded programs will be assessed and

will help to further inform decision-making. CSV is committed to continue involvement in community partnerships in areas where effort is underway and where they have traditionally played a role.

Continued Population Priorities:

Maternal Health and Early Childhood

School-Age Children

Adult Physical Health

Women's Health

SUPER PRIORITIES

CHRISTUS St. Vincent is shifting toward a community impact agenda, therefore, we have narrowed the number of community health priorities to three "Super Priorities." Through multiple levels of input and applying the CSV Community Health Prioritizing Criteria to the 18 indicators from the 2017- 2019 Community Health Needs Assessment, three Super Priorities emerged as those of greatest need.

The three "**Super Priorities**" are:

Adult Behavioral Health

Seniors

Victims of Violence in the Home

The established criteria, and nominated super priorities were presented to a panel of experts from the community including representatives from Santa Fe County, Santa Fe Community Foundation, SVH Support, the CSV Board Community Health and Wellness Committee and CSV leaders from Mission, Community Health, Care Connection, Behavioral Health, and Case Management. Participants validated the CHNA findings and solidified the choice of the three super priorities. CSV leaders expressed that the predominant health issues of patients at the hospital and the hospital's struggle to meet these needs is mirrored in the larger community's health issues identified in the CHNA and particularly in the three super priorities.

Finally, with the super priorities established, CSV leadership convened to discuss strategies to address the super priorities. Participants were encouraged to think about where they see patients falling through the cracks and what it will take to address the gaps. Strategies were developed both to improve our community's response, leverage community resources and also to further refine CSV's internal focus and processes. The following sections outline the strategies.

COMMUNITY HEALTH IMPLEMENTATION PLAN (CHIP) OVERVIEW

The following sections lay out the CSV 2017-2019 Community Health Implementation Plan (CHIP). A vision for health and the Internal CSV and community-based System of Care strategies are outlined for each of the super priorities: adult behavioral health, seniors and violence in the home. Next existing CSV initiatives and community partnerships are summarized for each priority. Following the super priorities section, implementation strategies for the continuing priorities from the 2014-2016 CHNA and CHIP are presented.

CSV will investigate all possible avenues for bringing these strategies into existence. Resourcing ourselves and utilizing low cost/ no cost strategies will be an important consideration in making these efforts a reality. Creating efficiencies in existing processes and other areas for building in sustainability possibly through outside funding sources will also be sought.

Collaboration with partners is an essential part of the CSV CHIP. Improving the health status of our population takes partnerships particularly with those entities that play a large role in improving the health and wellness of the community including Santa Fe County, the City of Santa Fe, the Santa Fe Community Foundation, and other organizations and leaders. CSV participates with these entities to promote health across our population including convening the Collaborative Health Funders Group.

- *Collaborative Health Funders Group* – In 2015, Santa Fe County, City of Santa Fe, Santa Fe Community Foundation, Con Alma Foundation, Thornburg Foundation, Brindle Foundation and SVH Support convened to discuss opportunities for coordinating funding to local non-profits. Each of these entities funds health and social services in Santa Fe. Together we believe funding decisions and processes can be better coordinated and funding can be jointly leveraged to have greater community impact.

- *Santa Fe County, Community Services Department* - the Santa Fe County Community Services Department is responsible for administering the Santa Fe County Health Plan under the direction of the Santa Fe County Health Planning and Policy Commission. The Department also oversees County operated health and human service programs to seniors, adults with addictions, maternal and child health, etc. The Department also oversees administration of County Indigent Funding to address the needs of County residents without access to care. The Santa Fe County Health Plan is focused on key priorities that CSV has a role in helping to address.

- *City of Santa Fe, Youth and Family Service Division- Oversees* the Children and Youth Commission, Youth and Teen After School Program and Summer Youth Programs. It also administers Human Services Section funding through two councils, one for youth and the other for adult social service needs. Santa Fe City has its own list of indicators and community health and service priorities which it is work toward to improve the "safety net" of services in our community.

SUPER PRIORTY AREA: ADULT BEHAVIORAL HEALTH

Our Vision for a Healthy Community:

All people with an addiction or mental illness are shown kindness and are served in ways that are empowering and sensitive to each individual's struggles.

2017—2019 Implementation Strategies			
Indicators	**Performance Measures**	**Internal (CSV) Strategies**	**System of Care Strategies**
Our goal is to reduce: **Alcohol Related Deaths**	Increase the number of adults correctly identified with a behavioral health issue Increase the number of most vulnerable receiving specialized care through organized responsive system of care Increase the number of adults receiving intervention referrals and follow up care	**All Facilities:** • Integrate Super Priority work into CSV Strategic Plan • Screening, care and follow up for patients • List of community resources • Tightly linked referral network based on patient needs • Training for staff on patient issues • Hardwire cross-department coordination for patients with complex care issues • Community Benefit Council • Data collection to collect baseline data and track progress • Coordinator for each of the Super Priorities • Identify necessary resources and identify low cost/no cost strategies • Make better use of technology and innovative services **Inpatient:** • Behavioral Health patient flow • Address ED flow for patients with BH issues **Outpatient:** • Enhance Outpatient Behavioral Health care • Provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) • High Utilizer Group Services (HUGS): • Professional development for staff - overdose prevention and distribute naloxone to prevent opioid overdose	• Evolve Community Benefit funding process • Use collaborative Funders Group to support Super Priorities • Continue to build responsive system of care • Cross-community collaboration on complex individual cases • Identify other funding sources to support priorities • Continue collaboration on community needs from stakeholders

CHIP PARTNERSHIPS AND CSV INITIATIVES

CSV Initiatives – CSV operated programs or initiatives serving people with mental illness.

- *High Utilizer Group Services (HUGS)* – an initiative serving annually the top 75 highest utilizers of the CSV Emergency Room. Services include intensive wrap-around care.
- *Sobering Center* – fifteen bed social detox 24 hour, 7 day/week facility. Services are free, voluntary and include detox, therapeutic groups as well as case management.
- *Behavioral Health Unit* – nine bed inpatient psychiatric hospital unit.
- *Chemical Dependency Consults* – assessment for chemical dependency available inpatient

Community Benefit – CSV dedicates funding to local non-profit service providers that make up the system of care. Services funded are strategically selected to respond to gaps in the delivery system and/or respond to specific needs of CSV patients. Behavioral health service providers may include:

- Presbyterian Medical Services: Santa Fe Community Guidance Center
- Solace Trauma Treatment Center
- National Alliance for Mentally Ill
- Life Link
- Santa Fe Recovery
- Friendship Club

Community Partnerships – The following community-wide partnerships are collaborative efforts focused on addressing health and human service issues impacting the population.

City of Santa Fe:

- *Project LEAD (*Law *Enforcement Assisted Diversion)* - an initiative to create alternative approaches to incarceration for offenders with mental illness.
- *MIHO (Mobile Integrated Health Office)* - Santa Fe Fire Department –a proactive approach to addressing high utilizers of the 911 system, solve root-cause social determinant and health issues and prevent unnecessary use of 911, ambulance and hospital services. MIHO collaborates closely with CSV high-utilizer team.

Santa Fe County

- *Project LEAD (*Law *Enforcement Assisted Diversion)* – funded by SF County and administered through Life Link, it is an initiative to create alternative approaches to incarceration for offenders with behavioral health conditions.
- *Santa Fe Crisis Response Team* - Funded by Santa Fe County, and administered through Santa Fe Community Guidance Center (SFCGC). SFCGC operates a mobile crisis response team to respond to behavioral health crises and prevent escalation.
- *Santa Fe County Health Plan* – Includes suicide reduction and reduction of drug and alcohol abuse as top priorities.

Santa Fe Behavioral Health Alliance

- *Santa Fe Behavioral Health Alliance* – A collaboration of justice and behavioral health providers. Its purpose is to reduce the number of people with mental illness in the criminal justice system. It meets quarterly to review progress and share agency plans.

Santa Fe Public Schools

- *Santa Fe Prevention Alliance* – Collaboration of public schools, law enforcement, youth providers, and providers focused on reducing substance abuse and its harms.

SUPER PRIORITY AREA: SENIOR CARE

Our Vision for a Healthy Community:
All seniors have strong bonds to family and/or social support systems
and
Feel a meaningful purpose in life

2017—2019 Implementation Strategies			
Indicators	**Performance Measures**	**Internal CSV Strategies**	**System of Care Strategies**

Our goal is to reduce:
Fall Related Injuries and Deaths
	Increase the number of identified disconnected seniors
	
	Increase the number of most vulnerable receiving specialized care through organized responsive system of care
	
	Increase the number of adults receiving intervention referrals and follow up care
		All Facilities
		• Integrate Super Priority work into CSV Strategic Plan
		• Screening, care and follow up for patients
		• List of community resources
		• Tightly linked referral network based on patient needs
		• Training for staff on patient issues
		• Hardwire cross-department coordination for patients with complex care issues
		• Community Benefit Council
		• Data collection to collect baseline data and track progress
		• Coordinator for each of the Super Priorities
		• Identify necessary resources and identify low cost/no cost strategies
		• Make better use of technology and innovative services to serve population needs
		  ○ Including Telehealth
		
		Inpatient:
		• Document immunization refusals to know who has been offered and assess if the problem is outreach or if the patients do not want vaccines
		
		Outpatient:
		• Facilitate family/caregiver education for proper care
		• Provide and advertise accessible immunizations
		• Provide public education on immunizations
			• Evolve Community Benefit funding process
			
			• Use collaborative Funders Group to support Super Priorities
			
			• Continue to build responsive system of care
			
			• Cross-community collaboration on complex individual cases
			
			• Identify other funding sources to support priorities
			
			• Continue collaboration on community needs from stakeholders
			
			• Recruit Home Help and modifications services
			  ○ Identify appropriate community partners

CHIP PARTNERSHIPS AND CSV INITIATIVES

CSV Initiatives – CSV operated programs or initiatives serving Seniors.

- Patient Navigation – Patient navigators who assist patients with navigating the health care system to receiving the best care possible.
- CSV Geriatric Care-A CHRISTUS ST. Vincent medical care focused specifically on the health needs of seniors in our community

"Caring for our seniors is perhaps the greatest responsibilities we have. Those who walked before us have given us so much and made possible the life we all enjoy."

-Senator John Hoeve

Community Benefit – CSV dedicates funding to local non-profit service providers that make up the system of care. Services funded are strategically selected to respond to gaps in the delivery system and/or respond to specific needs of CSV patients. Senior Care service providers may include:

- Kitchen Angels
- Coming Home Connections

Community Partnerships – The following community-wide partnerships are collaborative efforts focused on addressing health and human service issues impacting the population.

- City of Santa Fe and Santa Fe County have strategies to address the need of seniors including Santa Fe County's Senior Centers and immunization and flu shot outreach.
- Santa Fe Fire Department hopes to grow its Mobile Integrated Health Program (MIHO) into a service which can visit and respond to seniors, who may be at risk for bad health outcomes, or who may have fall hazards or other safety issues in their homes.

SUPER PRIORITY AREA: VIOLENCE IN THE HOME

Our Vision for a Healthy Community:

All survivors of abuse are offered compassion, connection and a safe and supportive environment in order to heal

<table>
<tr><th colspan="4">2017-2019 Implementation Strategies</th></tr>
<tr><th>Indicators</th><th>Performance Measures</th><th>Internal CSV Strategies</th><th>System of Care Strategies</th></tr>
<tr>
<td>Our goal is to reduce:
Child Abuse and Neglect</td>
<td rowspan="2">Increase the number of identified children and adults who are victims of abuse at CSV

Increase the number of most vulnerable receiving specialized care through organized responsive system of care

Increase the number of adults receiving intervention referrals and follow up care</td>
<td rowspan="2">All Facilities
Integrate Super Priority work into CSV Strategic Plan
Screening, specialized care and follow up for patients
List of community resources
Tightly linked referral network based on patient needs
Training for staff on patient issues
Hardwire cross-department coordination for patients with complex care issues
Community Benefit Council
Data collection to collect baseline data and track progress
Coordinator for each of the Super Priorities
Identify necessary resources and identify low cost/no cost strategies
Make better use of technology and innovative services
Inpatient:
Establish Domestic Violence Coordinator for consults for survivors, community coordination and safety planning</td>
<td rowspan="2">Evolve Community Benefit funding process
Use collaborative Funders Group to support Super Priorities
Continue to build responsive system of care
Cross-community collaboration on complex individual cases
Identify other funding sources to support priorities
Continue collaboration on community needs from stakeholders
Safety Net model for domestic violence response rolled out to clinics and community</td>
</tr>
<tr>
<td>Our goal is to reduce:
Domestic Violence</td>
</tr>
</table>

CHIP PARTNERSHIPS AND CSV INITIATIVES

CSV Initiatives – CSV operated programs or initiatives serving victims of violence in the home.

- *Bridge to Safety*- A program that began in 2011and includes consults for abuse survivors, training for all new staff on the signs and symptoms of domestic violence and a response model for intervention. CSV is hopeful to fill the role of Domestic Violence Coordinator in the near future through the assistance and partnership of Solace Trauma Treatment Center.

Community Benefit – CSV dedicates funding to local non-profit service providers that make up the system of care. Services funded are strategically selected to respond to gaps in the delivery system and/or respond to specific needs of CSV patients. Providers who serve abuse victims may include:

- Pete's Place
- St. Elizabeth's Shelter
- Solace Trauma Treatment Center

Community Partnerships – The following community-wide partnerships are collaborative efforts focused on addressing health and human service issues impacting the population.

- *Santa Fe Safe*- Quarterly meetings, coordination and training around preventing and addressing domestic violence in Santa Fe. Is attended by domestic violence and other therapeutic, or violence prevention oriented non-profits and providers as well as law enforcement, Children Youth and Families Department,
- *Esperanza Shelter*
- *Santa Fe Children Youth and Families Department, Child Protective Services*

> *"It is also well established that individuals adopt violent behaviors through the unconscious modeling of observed behaviors. The additional physiological effects from both witnessing violence and from trauma accelerate the contagion. In short, violence is transmissible. It behaves like all epidemics. It has the exact characteristics of a contagious disease. Violence as a public health problem is not merely a metaphor, it is a scientific fact."*
>
> *—Gary Slutkin*

CONTINUED PRIORITIES

The first CHIP developed by CSV was in 2013 for 2014-2016. The following table identifies the programs and/or initiatives implemented by CSV. The following will be continued due to positive outcomes that have been achieved.

Population		Initiative	2017-2019 continue	Current Status
Health Care System's Improvements		Patient Navigation	Yes	Patient navigation system established within CSV
		Medicaid & HIX new eligibles	Yes	HIX enrollment taking place with each new enrollment period. Medicaid enrollment on-going.
Maternal Health & Early Childhood		Healthy Babies – Prenatal Care for all	Yes	Prenatal care available to all persons
		Opiate Addicted Pregnant Women	No	Initiative completed in partnership with SF County, SF Community Foundation & La Familia
		Home visitation for new births	Yes	Home visitation for new families assists with early childhood development, breast feeding, etc.
School Age Children & Adolescents		Adolescent High Utilizer Group Services (HUGS	Yes	Youth at high risk have been diverted from the ER
		Healthy Habits	No	Initiative not successful. Initiative to be replaced
Adults	Chronic Diseases	MyCD Program (Manage My Chronic Disease) & Healthy Habits	Yes	Numerous classes run. Plan to expand into CSV clinics
	Behavioral Health	High Utilizer Group Services (HUGS)	Yes	CSV will continue to operate HUGS
Women's Health		Safety Net: Hospital based DV program	Yes	CSV to continue to implement
		Bridge to Safety Program: Practitioner Tool Kit	Yes	CSV to continue to implement
Seniors		Senior Care Continuum – Patient Navigation	Yes	Patient navigation services have been implemented
		Senior Care Dashboard	Yes	Initiative put on hold.

CHIP PARTNERSHIPS AND CSV INITIATIVES

CSV Initiatives – CSV operated programs or initiatives supporting current initiatives.

Maternal Health & Early Childhood:

- Ob/Gyn services in Las Vegas, NM. After Ob/Gyn services were discontinued in Las Vegas, NM, CSV began providing women's health services outpatient. CSV practitioners travel to Las Vegas weekly.
- Adolescent High Utilizer Group Service Program – funded through CSV and administered by our community partner, the SKY Center. Offers wrap-around services to youth, and their families. This program is for youth who present frequently to the Emergency Department or Youth Detention Center and appear to be at-risk due to family conflict, behavioral health issues or drug and alcohol use.
- My Chronic Disease Program (My CD)- Coordinated by CSV following a Stanford evidence-based model. Provides peer led groups for individuals with chronic disease who wish to gain support and information about how best to address and cope with their chronic disease.

Community Benefit- CSV dedicates funding to local non-profit service providers that make up the system of care. Services funded are strategically selected to respond to gaps in the delivery system and/or respond to specific needs of CSV patients. Providers who serve the needs of individual specified in our continuing priorities may include:

- New Vistas
- Las Cumbres
- Presbyterian Medical Services
- SKY Center
- Gerard's House
- IMPACT Personal Safety
- Youth Shelters
- La Familia Medical Center

Community Partnerships – The following community-wide partnerships are collaborative efforts focused on addressing health and human service issues impacting the population.

- *Santa Fe Birth to Career Collaboration (SF B2*C) - a collective impact effort among committed leaders and stakeholders to achieve birth to career success for all Santa Fe children, families, and communities by aligning our strategies, actions, and resources to improve outcomes.
- *The Early Childhood Steering Committee (ECSC)* - one of the SF B2C Collaborative Working Groups and has been meeting for over two years to align efforts to improve early childhood outcomes and increase public awareness about the need and effectiveness of quality early childhood care and education.
- *Santa Fe Mayor's Children, Youth and Families Community Cabinet*- its mission is to create a cross-sector collaborative governance structure of cross-sector leaders to improve coordination, efficiency, and alignment of resources across local levels of government, private sector and community agencies. The Cabinet's four priority focus areas include Early Childhood; Mentorship, Leadership and Education; Re-engagement of Disconnected Youth; and Workforce Development and Career Pathways.

NEEDS NOT ADDRESSED AND RATIONALE

The 18 indicators identified and studied in the CHNA are all areas of concern in our community. We are challenged to select amongst these priorities because the health needs and issues faced by our population are all of significance. Unfortunately, we cannot address all 18 indicators and hope to make progress. A diffuse approach where there is little focus and much to be accomplished is a recipe for poor achievement. This year we were challenged to narrow our focus in an effort to really change the system of care around the three biggest areas of need or Super Priorities. The indicators not chosen as super priorities are those for which there is already significant effort occurring in the community either through public or other private funding, and/or for which there is work going on through community collaboration, or that did not meet our Community Health Prioritizing Criteria. Though we must be disciplined in our efforts, we will continue our commitment to our Continuing Priorities selected in the 2013 CHNA and will also leverage our community benefit funding and have as much involvement as possible in the full spectrum of health issues this community faces.

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