

Mat-Su 2016 Community Health Needs Assessment (CHNA)
Implementation Strategy
Written Plan

I. General Information

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Date Written Plan Was Adopted by Organization's Authorized Governing Body:
Mat-Su Regional Medical Center (MSRMC): February 20, 2017
Mat-Su Health Foundation (MSHF): February 21, 2017

Date Written Plan Was Required to Be Adopted: May 15, 2017

Authorizing Governing Body that Adopted the Written Plan: Mat-Su Health Foundation Board of Directors and Mat-Su Regional Medical Center Board of Directors

Was Written Plan Adopted by Authorized Governing Body by End of Tax Year in Which CHNA was completed? Yes

Available to the Public? Will be posted on website for MSRMC and MSHF

Address of Hospital Organization(s):

Mat-Su Regional Medical Center, 2500 S Woodworth Loop, Palmer, AK 99645
Mat-Su Health Foundation, 950 E. Bogard Rd. Ste 218, Wasilla, AK 99654

Estimated 2017 Implementation Plan Budget Total For Each Facility:

Mat-Su Regional Medical Center: at least \$1,453,001
Mat-Su Health Foundation: at least \$2,117,000

II. List of Community Health Needs Identified in Written Report

List of Community Health Needs Identified in CHNA Written Report, Ranked by CHNA's Priority:

The Mat-Su Community Health Needs Assessment (CHNA) has 34 different topic sections containing both quantitative and qualitative data that includes traditional health status indicators, as well as indicators of health and social equity, service utilization and community sustainability. Quantitative data was gathered from multiple sources including the Alaska Behavioral Risk Factor Surveillance System (BRFSS) and a household survey of 700 Mat-Su households conducted by The McDowell Group, designed to yield results representative of the Mat-Su population. Health indicators are reported as individual data points, included in trend analyses, and compared to available state, national and Healthy People 2020 goals when available. Also included in the analysis is utilization data from Mat-Su Regional Medical Center and several other collaborative partners including Alaska Family Services, CCS Early Learning, Mat-Su Health Services, and Sunshine Community Health Center.

Qualitative data was gathered through a total of 25 focus groups with 433 participants that were conducted by the Strategy Solutions consulting team and the staff of the Mat-Su Health Foundation. Focus group participants were also asked to complete a short survey that included several questions regarding the health

status and goals for the community. Eight stakeholder interviews with 21 participants were also conducted by members of the consulting team with professionals who represent perspectives that were not able to participate in the focus groups. Fourteen in-depth interviews were also conducted with Mat-Su Regional Medical Center patients who have visited the Emergency Department five or more times within the past year.

Priority areas for the CHNA were identified by tabulating the number of times specific topics were identified/discussed as priority need areas by more than 450 individuals that participated in focus groups and interviews. The top priority need areas were affirmed by the CHNA Steering Committee at its September 20, 2016 meeting. The highest priority needs areas included:

Top Factors Affecting Health	Top Issues and Services Needed
<ul style="list-style-type: none"> • Transportation 	<ul style="list-style-type: none"> • Substance Abuse
<ul style="list-style-type: none"> • Family and Social Connection/Support 	<ul style="list-style-type: none"> • Access to Behavioral Health Services
<ul style="list-style-type: none"> • Education and Information 	<ul style="list-style-type: none"> • Access to Health Care
<ul style="list-style-type: none"> • Income 	<ul style="list-style-type: none"> • Preventative Services
<ul style="list-style-type: none"> • Housing 	<ul style="list-style-type: none"> • Safe Parks and Recreation

List of Collaborating Organizations

In order to conduct the 2016 Mat-Su CHNA, the Mat-Su Health Foundation (MSHF) and Mat-Su Regional Medical Center (MSRMC) collaborated with a number of organizations that agreed to share data and guide the data gathering and analysis process. Collaborating organizations included: Alaska Family Services, Alaska Mental Health Trust Authority, CCS Early Learning, Identity Inc. (Advancing Alaska’s LGBT Community), Knik Tribal Council, Sunshine Community Health Center (a Federally Qualified Health Center (FQHC)), Chickaloon Village Traditional Council, and Mat-Su Health Services, Inc. (also a FQHC). In addition, a Steering Committee comprised of representatives of 28 community agencies, organizations and local municipalities, including the collaborative partners, was assembled to guide the process and affirm top priorities.

III. Health Needs Planned to Be Addressed By Facility

List of Health Needs the Facility Plans to Address

MSHF, through their mission to improve the health and wellness of Alaskans living in Mat-Su, and, MSRMC, through their mission to provide progressive, competent and quality health care for our growing community through the teamwork of families, doctors, employees and volunteers, have developed strategies to address a number of the top priority health-related needs and issues in the CHNA. These issues including: family and social connection/support, education and information, substance abuse, access to behavioral health services, access to health care, preventative services, and safe parks and recreation (including physical activity).

Transportation

Mentioned more often than any other factor that impacts health in the focus groups and stakeholder interviews, the lack of public transportation is a barrier to accessing both primary care and specialty services, many of which are located in Anchorage. Transportation also impacts the ability to enjoy many of the

existing indoor and outdoor recreational activities that help individuals lead a healthy lifestyle. Lack of transportation also creates social isolation and limits continuity of care, making it difficult to appropriately manage chronic conditions when they do occur. While the existing human services transportation system has a broader service area than the public transit system, which serves primarily Wasilla and Palmer, it is often limited to those who qualify for Medicaid, have disabilities, or specific clients of an organization. Many are unaware of the transportation resources that do exist. Some cannot afford to use them, even where they are offered. Limited hours of operation also make it difficult to schedule trips, especially when needing multiple health care or other appointments in the same day (CHNA page 25). Palmer and Wasilla have both transit dependence and health needs (CHNA page 72). Lack of reliable transportation was a barrier to receiving health care in the past year for 7 percent of the household survey respondents (CHNA page 153).

The most common means of travel to work in Mat-Su is driving alone (70 percent), followed by carpooling (14.2 percent). Use of public transportation (1.2 percent) is very limited (CHNA page 71). The Center for Neighborhood Technology, Housing and Transportation Affordability Index measures Neighborhood Characteristics on a scale from 0-10. The lower the access number, the more likely the community is car-dependent with very little or no access to public transportation. Mat-Su and Palmer have limited transit access with a transit score less than 1, indicating these communities rely on cars for transportation as public transportation is extremely limited. Palmer has slightly fewer public transportation trips available than Mat-Su overall, although both are limited in available trips per week (SDR page 100).

Family and Social Connection/Support

The 2016 Mat-Su Household Survey measured social connectedness in terms of access to support and giving support. As far as giving support, Mat-Su residents were likely to do favors or help people within their community, including those outside their family and relatives. They were likely to intervene with a child skipping school in their neighborhood. However, less than half of residents reported volunteering in their community. About 7 out of 10 Mat-Su residents report attending a community event in the last 12 months. Based on the data, between 10-13 percent of Mat-Su residents appear to have limited social support available to them (CHNA page 140). In terms of receiving support, only 45 percent of household survey respondents indicated that they would be very comfortable seeking help in their neighborhood if they had an emergency (CHNA page 141).

According to the Alaska Youth Behavior Risk Factor Survey results reported on page 56 of the CHNA report, only 48.5 percent of youth attending traditional high schools and 45.8 percent of students attending alternative high schools indicated that their community feels like they matter. Only 42.3 percent of those attending traditional high schools and 28.1 percent of those attending alternative high schools reported that they had at least one parent who talks to them about school every day. Page 57 highlights input from teens and professionals who say that teens and young adults need access to peer support, support to finish high school and move onto a career, foster care, and housing for teens experiencing abuse and homelessness, as well as transportation to recreational and social opportunities. Page 136 of the CHNA highlights that only 50 percent of students participate in extra-curricular activities one or more times per week.

As noted on page 63 of the CHNA, LGBTQ teens spoke passionately about how gender identity impacts health, including discrimination in schools as well as health professionals who are ill-equipped to provide support and information to address health questions and concerns. Page 72 of the CHNA notes that the lack of transportation creates social isolation and limits continuity of care, making it difficult to manage

chronic conditions where and when they do occur. Those who live in the core area have better access to services and are more likely to have options for social connection and assistance than those living in more isolated rural areas (CHNA page 80).

Page 99 of the CHNA highlights that, while more isolated, rural residents have slightly better social cohesion than the urban residents on some indicators, although low numbers indicate opportunities for improvement. About a third (34 percent) of rural residents reported on the household survey that they reach outside of their circle of friends to give or receive help very often or often, versus only 28 percent of urban residents. Almost half (46 percent) of rural respondents indicated that they have helped a community member (outside of their family or relatives) in the last year often or very often, versus 42 percent for urban residents.

Mat-Su seniors indicated that having supportive family or friends can help them in time of need is a key factor in maintaining health. Other factors mentioned included age and whether they experience social acceptance or discrimination, along with having a good sense of humor, and a sense of belonging (CHNA page 61).

Education and Information

Page 26 of the CHNA notes that many professionals participating in the focus groups told stories of how their clients struggle financially if they lack the education that gives them the ability to get a job that pays a living wage. While slightly better than the Alaska overall rate, only 77.6 percent of Mat-Su students graduate from high school in four years (CHNA page 116). The more rural areas of the borough have lower graduation rates (CHNA page 117).

Education also includes awareness and understanding of various topics related to risky behavior and its impact on health. Numerous people talked about how the lack of information on various topics is harmful to the community, including the need for immunizations for young children, parenting skills, dangers associated with synthetic drugs, and risky sexual behavior. Noted in the CHNA Supplemental Data Resource (SDR), 6 percent of urban respondents to the household survey and 11 percent of the rural respondents to the survey indicated that they were not able to get information because they didn't have access to a computer (SDR page 175). Mat-Su seniors noted that whether they have access to information and resources to help guide them is a key factor that impacts health (CHNA page 61).

Those with less than a high school education (CHNA page 36) were less likely to state that cost is not a barrier to accessing care (73.3 percent) compared to college graduates (89.9 percent). They are also less likely to report no limitations due to physical, mental or emotional problems (63.1 percent versus 78.2 percent for college graduates) or no poor mental health days (page 38; 56.2 percent versus 67 percent for college graduates).

Focus group and stakeholder interview participants noted that without early care and education, children struggle to meet developmental and educational milestones, lowering high school graduation rates and literacy (page 53). As noted on page 113 of the CHNA, residents with lower education levels are less likely to have health insurance (74.4 percent), a primary care provider (59.5 percent), report they are healthy (63.4 percent) or physically healthy (44.3 percent), and are more likely to have thoughts of suicide or harming self (9.7 percent), asthma (11.3 percent), diabetes (13 percent), high blood pressure, (39.5 percent) and arthritis (33.9 percent). They are also less likely to be non-smokers (48.3 percent).

Income

Overall, 8.5 percent of Mat-Su households have incomes less than \$15,000, with the Upper Susitna Valley having the highest percentage of very low-income households (14.3 percent), and Palmer (5.7 percent) having the lowest percentage among the sub-regions in the valley. An additional 7.4 percent of Mat-Su households have incomes between \$15,000 and \$24,999 (SDR page 240). Residents in Knik-Goosebay Road area have the highest average household income (\$99,607), while those living in Upper Susitna Valley have the lowest (\$65,978), a difference of \$33,629. The average annual household income for Mat-Su Borough is \$88,647, which is lower than Anchorage (\$103,580) and Alaska (\$94,042) (SDR page 247). The median household income for Mat-Su is \$73,217 (CHNA page 95).

Overall, 11.2 percent of the Mat-Su population lives in poverty (SDR page 249). While 17.8 percent of families with male heads of households with children under 18 years live in poverty in Mat-Su, more than twice as many (36.6 percent) families with female heads of households live in poverty (CHNA page 47). In Mat-Su in 2014, there were an estimated 7,478 children under the age of 5 years and approximately 12.9 percent lived below the poverty level (965 children) (CHNA page 52). A substantial percentage of Mat-Su seniors (14.6 percent of those 75 to 84 years and 20.6 percent of those 85 and older) live in poverty.

When struggling financially, people will delay or avoid seeking care because they cannot pay high out-of-pocket expenses, resulting in more serious diagnoses down the road (CHNA page 133). Income affects the ability to get and/or afford insurance, as well as the financial means to afford accessing care and/or the other resources (i.e. healthy foods, sports/recreation opportunities for children) that support living a healthy lifestyle. One major medical issue for someone without insurance can cause homelessness (CHNA page 26).

Housing

Housing was mentioned in many focus groups/interviews as both a factor that impacts health, as well as an area that is impacted when people have major medical problems without the financial resources to pay for medical care (CHNA page 26). Persons who are homeless either do not seek the medical attention they need, or if they do, have nowhere to go to recuperate once discharged to recuperate. Conversely, poor health is a major cause of homelessness (CHNA page 76).

Mat-Su lacks diversified housing. The majority (84.96 percent) of residential parcels are single-family units. There are limited options for younger residents just starting out in the workforce looking for apartments (CHNA page 77). One in five residents (20 percent) in Mat-Su have experienced severe housing problems in 2016. The percentage of residents experiencing a severe housing problem has been fairly consistent over the past three years (CHNA page 78).

According to professionals in the Mat-Su region, the lack of diversified housing stock is a problem, because not everyone can afford a single-family home on an acre of land, which is the predominant type of housing available. This adversely affects both seniors on fixed incomes and young people who are just getting started in their careers and cannot yet afford to purchase a single-family home. There is a sizable number of homeless youth in the region who struggle to finish high school due to lack of stability. Many of these young people will be destined to live in poverty due to lack of education and adequate income. The lack of utility infrastructure especially in the rural/ remote areas of the borough results in housing that lacks running

water and electricity, making sanitation a factor in some homes and places. In some cases, the quality and safety of the house itself is an issue, because some people choose to come to Alaska to live off the land and attempt to build their own houses out of pocket, and without appropriate carpentry and other skills required (CHNA page 79).

A total of 5 percent (3 percent urban and 2 percent rural) of respondents to the household survey reported that they have gone without housing in the past 12 months and the same percentages indicated that they have gone without utilities such as heat or electricity in the past 12 months (CHNA page 99). Mat-Su residents spend almost half (49 percent) of their income on housing and transportation. The combined cost of housing and transportation are considered a burden for a family when they account for 45 percent or more of the household expenses (CHNA page 127).

Substance Abuse

Reported on page 153 of the CHNA, 5.0 percent of household survey respondents indicated that they did not know where to go to get help with a substance abuse problem in the past year. Page 166 of the SDR notes that the highest percentage of homeless individuals in 2009 were those with chronic substance abuse (13.9 percent). Page 175 of the SDR states that 6 percent of urban and 5 percent of rural respondents indicated that they experienced problems with drug or alcohol abuse in the past year.

Page 179 of the SDR includes utilization of services for patients diagnosed with various conditions and shows that data was comparable between the two reporting FQHCs (Sunshine Community Health Center and Mat-Su Health Services), with the exception of "other substance abuse disorders" (Sunshine had 10.4 average visits for that condition versus 3.2 for Mat-Su), although Mat-Su Health Services has a higher percentage of patients diagnosed with anxiety disorder or PTSD (24.0 percent versus 5.2 percent) and "other mental disorders" (18.2 percent versus 3.0 percent).

Page 217 of the SDR outlines the various conditions that were treated most frequently at MSRMC over the past three years and includes both primary and secondary diagnosis. Tobacco use disorder was by far the most frequent substance abuse diagnosis, followed by alcohol withdrawal. Opioid dependence has become one of the top diagnoses in the past two years. Many of the professionals participating in the focus groups discussed the role that adverse childhood experiences and trauma play in contributing to mental health, substance abuse, and chronic disease issues well into adulthood. Children who grow up in unsafe and/or unstable environments have trouble in school and contribute to drop out rates before high school graduation (SDR page 197).

Focus group participants provided input using an automated audience response polling system. A little over half of the voting participants rated the health status of the community as Fair or Poor. Reasons for the lower ratings most often included broken families, unhealthy family life and trauma, drugs and substance abuse, homelessness, mental health/depression, and domestic violence. (SDR page 320). Access to mental health and substance abuse services were noted as a top community need in 17 of the focus groups (SDR page 341) with participants noting that there are long waiting lists for detox centers, substance abuse/rehab, and mental health services.

Access to Behavioral Health Services

According to the Mat-Su Household Survey, 8 percent of rural and 8 percent of urban residents had a mental health concern in the past year (SDR page 175). Ten percent (10 percent) of urban and 7 percent of rural respondents didn't know where to go for mental health care. Personal, family, and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of LGBTQ individuals (CHNA page 62).

The Mat-Su Borough includes a number of designated Health Professional Shortage Areas. As outlined on page 195 of the SDR. The borough needs mental health professionals. The Alaska Family Services data on page 205 of the SDR reports that 40.1 percent of clients made progress on two or more goal areas, while 28.2 percent relapsed in two or more areas and 31.6 percent did not make any progress. Case managers also noted that client outcomes percentages would be higher if more resources were available in the community for clients. For example, lack of affordable housing, transportation, access to specialty medical care, and mental health services often prevent clients from following through on referrals.

Access to mental health and substance abuse services were noted as a top community need in 17 of the focus groups (SDR page 401) with participants noting that there are long waiting lists for detox centers, substance abuse/rehab, mental health services. Page 369 of the SDR reports that access to mental health services and the ACEs scores were identified in most of the focus groups as a significant community need. Page 409 of the SDR also notes that 10 of the focus groups identified access to mental health services as a top community goal.

Access to Health Care Services

Mat-Su residents' ability to access care based on cost during 2010-14, was influenced by gender, community of residence, age, education level, and income level. Females were more likely to forgo medical care due to cost than males. Older residents were more likely to receive needed care, with residents age 35-44 more likely to forgo medical care compared to other age groups. Rural residents were more likely to forgo medical care due to cost than residents in Palmer or Wasilla (CHNA page 32). Only 62.6 percent of males and 73.8 percent of females reported (2010-2014) that they have a primary health care provider (CHNA page 46). Residents who live in the rural areas (73.9 percent) are less likely than those who live in Palmer (84.4 percent) and Wasilla (79.2 percent) to have health insurance (CHNA page 80). Only about two thirds (67.9 percent) of Mat-Su residents have a primary care physician (CHNA page 151).

According to the 2016 Mat-Su Household Survey, between 7-10 percent of seniors report the following barriers to seeking health care: not knowing where to go for care, inability to get information because they had no computer, not being able to afford care, inability to get an appointment time that works, and not having transportation (CHNA page 61). Alaska Legal Service Corporation reported that their Mat-Su office sees a large number of elderly and disabled individuals being denied or terminated from their health care benefits for erroneous or invalid reasons. Access to these benefits can often times mean the difference between life and death, e.g. getting cancer treatment or receiving the necessary help to take life-saving medication. The Director of the Mat-Su office of Alaska Legal Service Corporation stated, "We are only able to serve about 50.0 percent of the residents who request our services." (CHNA page 150).

Page 203 of the SDR reported that 10.0 percent of urban and 7 percent of rural household survey respondents didn't know where to go for medical care. Six percent (6 percent) of urban and 7 percent of rural respondents indicated that they did not have transportation to get to a medical appointment in the

past year. The percentage of respondents to the Mat-Su Household Survey that indicated they have not sought health care because they could not afford it in the past year increased slightly from 2013 from 17 percent to 19 percent (SDR page 203).

Mentioned more often than any other factor that impacts health in the focus groups and stakeholder interviews, the lack of public transportation is the biggest barrier to accessing both primary care and specialty services, many of which are located in Anchorage (CHNA page 25). Income affects the ability to get and/or afford insurance, as well as the financial means to afford accessing care and/or the other resources (i.e. healthy foods, sports/recreation opportunities for children) that support living a healthy lifestyle. Additionally, while there are many types of resources and services that support healthy lifestyles in the Valley, many people are not aware of these and how to access them (CHNA page 26). Participants also indicated that those who live in the core area have better access to health care services than those who are more isolated in the rural areas (CHNA page 80). As mentioned above, Mat-Su includes a number of designated Health Professional Shortage Areas which can inhibit access to health care.

Challenges to accessing needed care include long waits to access care and high insurance co-pays and deductibles. Waiting lists for many of the critically needed services, including drug detoxification, drug and alcohol rehabilitation, transitional housing and other housing support services, as well as specialty medical care, currently exist in the borough. Although the Valley has some urgent care centers that recently opened to improve access, they are not open on Sundays and do not provide continuity of care with other providers. Fear of being found or being found out is a factor that impacts access to care and ultimately health in the Mat-Su region as well. Some residents do not want the authorities to know what was happening to them or their children for fear that their children would be taken away. Those hiding after fleeing other states just do not want to be found. Some people do not want to find out that something is wrong with them, so they avoid going to the doctor all together (CHNA page 155).

Preventative Services

There were health conditions and other issues that were brought up repeatedly by the community. These included the impact of substance abuse and lack of access to treatment services in Mat-Su; lack of access for some residents to medical and behavioral health care; not enough focus on prevention and preventative services for health conditions and social issues; and the importance of having accessible and safe parks and recreational activities (CHNA page 26).

The FQHC Centers in the Mat-Su region offer the opportunity to extend care to many residents who would not otherwise be able to access primary care and preventative services. Based on the UDS (Universal Data System) data provided by Sunshine Community Health Center, in 2015, 87.2 percent of Sunshine's 3,352 patients (2,923) lived in zip codes categorized as Mat-Su. The majority of these patients live in Talkeetna (36 percent) and Willow (34.7 percent). About a third (33.7 percent) of patients served had no health insurance, which is an approximately 10.0 percent decline over the three-year period 2013-2015 (CHNA page 87).

The need for preventative services was the third most frequently mentioned need by focus group participants, mentioned in 12 of the groups (SDR page 301). Preventative services was also mentioned as a key component of a healthy community by participants in nine of the focus groups (SDR page 407), and as a top community goal by participants of 13 focus groups (SDR page 403).

Safe Parks and Recreation (Physical Activity)

Only 30.6 percent of Mat-Su residents are at a healthy weight (CHNA page 136). Income affects the ability to get and/or afford insurance, as well as the financial means to afford accessing care and/or the other resources (i.e. healthy foods, sports/recreation opportunities for children) that support living a healthy lifestyle. The importance of having accessible and safe parks and recreational activities was brought up repeatedly by the community as a top need (CHNA page 26).

Transportation also impacts the ability to enjoy many of the existing indoor and outdoor recreational activities that help individuals lead a healthy lifestyle (CHNA page 72). Long commutes impact the ability to get physical activity and spend adequate time with family, which also impact the health status of Mat-Su residents (CHNA page 133).

According to data available from Mat-Su Borough, page 265 of the SDR illustrates the current number of parks in the Mat-Su Borough. The borough has more undeveloped parks (17) than other types of recreational spaces. There are also 10 undeveloped parks with lake access and 10 parks. There are very few campgrounds offering amenities such as trails and athletic fields.

According to focus group and interview participants, those who live in the core area have better access to indoor recreation than those who are more isolated in the rural areas (CHNA page 80). While the Mat-Su region has much natural beauty and opportunities for outdoor recreation and access to nature, participants indicated that transportation is often required to take advantage of trails and other natural resources in the area. Participants noted, however, that individuals who are able to enjoy those resources have healthier lives. Safe routes to school and safe playgrounds for kids were also identified as needs in the region. Many schools are not in locations that are "walkable" even from nearby homes. There is also a perception that many of the community parks are not safe today, because of the needles and other debris (CHNA page 139).

Children who do not have access to adequate physical activity tend to be overweight, and this leads to increased health problems later in life (CHNA page 139). Obesity impacts children in families where opportunities for recreation, physical activity, and safe places to play are either unavailable or unaffordable in the local area (SDR page 90). The explosion of video games and other technology-related entertainment has impacted the amount of physical activity for some people, contributing to the rate of obesity (SDR page 160).

Recreational activities including a pool was the third most frequently mentioned need by focus group and interview participants (SDR page 301). Safe parks and recreation spaces were also the second most frequently mentioned feature of a healthy community (SDR page 407). Indoor recreation was one of the top 10 most frequently noted community goals by focus group and interview participants (SDR page 409).

Identification and Description of How Facilities Plan to Address Each Health Need

In response to the identified priority community needs, MSHF and MSRMC have developed four overarching goals and identified specific implementation strategies and programs to address the needs in each of the identified priority areas. The goals and implementation strategies are as follows:

Goal 1: All Mat-Su Residents Have Access to an Effective and Complete Behavioral Health Continuum of care

Objectives include:

- A. Build out the Emergency Department (ED) as part of the behavioral health Crisis System
- B. Support the development of needed behavioral health Crisis Services
- C. Increase Emergency Department behavioral health staffing
- D. Improve the environment for behavioral health patients in the Emergency Department
- E. Support a complete behavioral health system of care by creating behavioral health inpatient beds and other services
- F. Connect MSRMC behavioral health patients to appropriate outpatient services
- G. Encourage appropriate use of the ED and improve the coordination of care for patients within and between Alaskan emergency departments
- H. Encourage the connection of community services to the MSRMC ED electronic information system
- I. Improve the quality of behavioral health services delivered at MSRMC
- J. Improve the quality of behavioral health services delivered in the community
- K. Maintain specific crisis care teams and participate in crisis care data collection
- L. Ensure use of crisis care data to improve the system of care
- M. Improve the quality of behavioral health services and care coordination in the Mat-Su medical and behavioral health community

The indicators that will be tracked to evaluate the outcomes and impact of these strategies include:

- Percent of Substance Abuse and Mental Health Services Administration (SAMHSA) behavioral health model of care present in Mat-Su
- Percent of MSRMC ED behavioral health patients who are high utilizers (>5 visits per year)
- Percent of MSRMC ED staff trained in Crisis Intervention
- Percent of first responders trained in Crisis Intervention
- Date Psychiatric Practitioner for the ED hired
- Date Social Work coverage available in ED seven days per week
- # of ED and inpatient behavioral health beds at MSRMC
- # of options for immediate access to detox services for Mat-Su residents
- # of residents using "Bridge" detox option
- # of types of behavioral health services that have greater than one week waiting time
- Percent of residents who know where to go for behavioral health services
- Percent of behavioral health patient "Bounce Backs" to ED within specified time frame
- Percent of behavioral health patients who receive a successful follow-up phone call after ED discharge
- Percent of unnecessary ED visits per year
- System initiated for ED patient exchange among hospitals

- # of primary care appointments made within 72-96 hours after discharge
- # of patients who kept appointment made after discharge
- # of ED prescribers enrolled in prescription drug monitoring database
- # of community healthcare providers connected to the MSRMC ED electronic information system
- # of ED staff educated on behavioral health assessment and Pride training
- # of Mat-Su organizations trained and supported on BH quality care practices
- # of Mat-Su organizations trained and supported serving LGBTQ residents
- # of Sexual Assault Response Team (SART) visits to MSRMC
- # of Suspected Child Abuse and Neglect Team (SCAN) visits to MSRMC
- # of physicians receiving CME in behavioral health
- # of settings in Mat-Su offering integrated behavioral and physical health care
- # of Mat-Su health care settings conducting routine Screening, and Brief, Intervention, and Referral to Treatment (SBIRT) screening
- # of Mat-Su health care settings conducting routine trauma screening
- # of MSRMC staff trained on social stigma
- Percent of residents who report no stigma in seeking behavioral health care

Goal 2: All Mat-Su Children and Families are Safe, Healthy and Thriving through an Engaged and Coordinated Community

- A. Promote a complete array of initiatives and programs focused on prevention of child maltreatment and promotion of resilient families and children
- B. Promote quality care provision to Mat-Su children and families
- C. Promote family-friendly work environments for Mat-Su parents
- D. Promote support for the “whole” parent and child in medical settings
- E. Provide birth-related care that promotes family resilience
- F. Increase social connectedness to support families and children
- G. Promote social and emotional competence in children
- H. Promote knowledge of parenting and child development

The indicators that will be tracked to evaluate the outcomes and impact of these strategies include:

- # of gaps that exist in array of initiatives and programs for families and children identified in Behavioral Health Environmental Health Report 3
- Percent of staff receiving counselling when needed
- Percent of staff completing trauma-informed education
- Percent of child welfare, behavioral health and first responder organizations that offer secondary trauma care for employees.
- # of staff and organizations completing trauma-informed training
- Existence of family-friendly human resource policies at MSRMC and MSHF
- # of health care setting in Mat-Su that offer integrated care
- # of health care settings in Mat-Su that conduct universal screening for trauma
- # of health care settings in Mat-Su that screen for basic need assistance and other social service needs

- Date MSRMC received Baby Friendly hospital status
- Date Kangaroo Care began
- Existence of collaboration initiative(s) among birth facilities
- Existence of central Mat-Su volunteer organizing entity
- # of Project Search participants
- Percent of children younger than 5 years old participating in early learning
- # of parent support initiatives in Mat-Su
- The existence of policy to ensure the provision of parent education and information and referral to resources for families served at MSRMC care delivery sites.

Goal 3: All Mat-Su Residents Have Adequate Income, Housing, Transportation, Education Levels, Social Connections and Information on Resources and Health to Support Good Health and Access to Physical and Behavioral Health Care.

- A. Increase access to Mat-Su physical and behavioral health services and programs
- B. Increase access to affordable transportation that allows residents to get to work, health care appointments, school/community activities, and other opportunities that affect the quality of their lives.
- C. Increase economic opportunities that allow residents to have a level of income that supports a healthy lifestyle and provides for safe and affordable housing.

The implementation strategies and programs were developed collaboratively between MSHF, MSRMC and other community partners. Significant resources and effort will be placed on education and community connections and support services through the Resource Center which will be housed with the Mat-Su Health Foundation.

Over the long run, these programs are expected to positively impact overall health status, lifestyle, risk behaviors, and decrease the number of emergency department visits for ambulatory care sensitive conditions. Indicators that will be tracked to evaluate the outcomes and impact of the individual programs will include:

- Date Community Resource Center is open
- # of people utilizing the Community Resource Center
- # of patients participating in Coordinated Care Project initiative who have improved health status
- # of eligibility screenings for MSRMC patients
- # of identified resources for MSRMC patients
- # of internal medicine providers recruited
- Date Medicare Clinic opened
- Percent of seniors accessing primary care physician network
- # of patients using extended hours
- Percent increase of same-day appointments at MSRMC Urgent Care
- # of specialists added to clinically integrated network
- Date calendared screening and health awareness initiative established
- # of glucose screenings per year
- # of cholesterol screenings per year
- # of blood pressure screenings per year

- # of fall prevention education participants
- # of referrals due to number of transportation vouchers given out
- # of transportation vouchers used
- Percent of adults who reported they didn't have transportation to a medical appointment
- # of people placed in housing
- # of homeless youth placed in housing
- # of seniors placed in housing
- # of residents placed in residential hospice
- # of residents placed in skilled nursing
- Percent of locals hired to fill positions
- # of scholarships provided

Goal 4: All Mat-Su Residents are a Healthy Weight

- A. Ensure Mat-Su area and school environment promote healthy weights through opportunities for physical activity and healthy nutrition

The indicators that will be tracked to evaluate the outcomes and impact of these strategies include:

- Number of trail and playground construction and improvements
- Number of community initiatives related to physical activity and health nutrition sponsored by the hospital

IV. Health Needs Facilities Do Not Intend to Address Comprehensively

During the Mat-Su CHNA process, the data revealed more than of 150 health, social and health equity and community sustainability indicators, issues and needs that were considered in the prioritization process. After the data was tabulated, and the prioritization process was completed, 10 top priority need areas were identified and affirmed by the CHNA Steering Committee.

MSHF and MSRMC have developed implementation strategies to address these 10 priorities, to some degree. Seven of the 10 priority areas have more comprehensive implementation strategies. There are three individual high-priority need areas identified by the CHNA for which MSHF and MSRMC do not have comprehensive implementation strategies. These include transportation, housing and income. Comprehensively addressing the financial needs of Mat-Su residents who live in poverty, as well as those facing transportation and housing needs, are outside of the mission of MSHF and MSRMC. These high-priority needs are also being addressed by other organizations in the community. Additionally, MSHF may indirectly impact these indicators through its grant-making and the development of the Community Resource Center.

Appendix:

Overall implementation strategies and action plan includes the following:

GOAL 1: Residents Have Access to an Effective and Complete Behavioral Health Continuum of Care			
MSRMC Action Steps (Timeline)	MSHF Action Steps (Timeline)	Responsibility	Impact will be measured and evaluated through these indicators:
<p>A. Build out the Emergency Department As Part of BH Crisis System.</p> <ul style="list-style-type: none"> ED staff will participate in the development of a multidisciplinary team, mobile crisis team, and community-based coordinated care project initiative. (Ongoing) The MSRMC ED will provide Social Work staff to work with the Crisis Intervention Team and coordinate discharge for patients who are linked to the multidisciplinary team and community-based coordinated care program that focuses on high utilizers. (Ongoing) MSRMC will maintain Crisis Intervention Instructors and all security guards will be required to take this training also. (Ongoing) All High Utilizers will be managed via a multidisciplinary care plan, with the plan to merge via the statewide Health Information Exchange. (2017) Work towards the creation of a Psychiatric ED as part of the hospital expansion plan. (2020) 	<p>B. Support the Development of Needed BH Crisis Services.</p> <p>Continue to support the development of the Crisis Intervention Team, Multidisciplinary Team and the Community-based Coordinated Care Project by providing funding for facilitation and training, to create these components of the continuum of care. (2017)</p>	<ul style="list-style-type: none"> MSHF Staff MSRMC ED Staff MSRMC Crisis Intervention Team Multi-disciplinary Team Community-based Coordinated Care Program Urgent Care Clinic Staff Community Behavioral Health Providers First Responders 	<ul style="list-style-type: none"> Percent of SAMHSA behavioral health model of care present in Mat-Su Percent of MSRMC ED behavioral health patients who are high utilizers Percent of MSRMC ED staff trained in Crisis Intervention Percent of first responders trained in Crisis Intervention
<p>C. Increase Emergency Department BH staffing:</p> <ul style="list-style-type: none"> Social Worker coverage will be expanded to seven days per week to cover the ED, Urgent Care Clinic and inpatient hospital beds, and will be a resource to providers in the community. (2017) Develop effective behavioral health care in the MSRMC ED and Urgent Care Clinic to meet the needs of patients in crisis by increasing the number of behavioral health staff such as, advanced nurse practitioners, psychiatrist or tele-psychiatry, and peer-support staff. The 2017 goal is for placement of an advanced psychiatric practitioner in the ED with support to the Urgent Care Clinic. (2017) 		<ul style="list-style-type: none"> MSRMC Administration MSRMC ED Staff Urgent Care Clinic Staff 	<ul style="list-style-type: none"> Date Psychiatric ED up and running Psychiatric Practitioner for the ED hired

GOAL 1: Residents Have Access to an Effective and Complete Behavioral Health Continuum of Care

MSRMC Action Steps (Timeline)	MSHF Action Steps (Timeline)	Responsibility	Impact will be measured and evaluated through these indicators:
<p>D. Improve the Environment for BH Patients in Emergency Department: Arrange physical space in the MSRMC ED to provide a secure space for BH patients that limits disruption to other patient care and staff while meeting the needs of patients to not be re-traumatized. This will be addressed with our hospital expansion plan. (2020)</p>		<ul style="list-style-type: none"> MSRMC Administration MSRMC ED Staff 	<ul style="list-style-type: none"> # of ED and inpatient BH beds at MSRMC # of options for immediate access to detox services for Mat-Su residents
<p>E. Support a Complete BH System of Care.</p> <ul style="list-style-type: none"> Open BH facility which will have Diagnosis, Evaluation, and Treatment (DET) beds, detox services, Sleep Off beds, and other acute mental health services to meet the needs of the community. This will require a certificate of need with the State of Alaska. (2020) Increase access to detox services including collaborating with community partners on the “Bridge” initiative. (2017) 	<p>E. Support a Complete BH System of Care.</p> <ul style="list-style-type: none"> Support the creation of services to fill gaps in the BH continuum of care for Mat-Su residents through grant funding, statewide policy change, and leveraging funding from federal, state, and local sources. (Ongoing) Support Medicaid reform that supports services in a complete continuum of care, and build the capacity of local providers to be sustainable under Medicaid. (Ongoing) Support increased access to detox services including supporting the “Bridge” initiative and completing the Detox Feasibility Study. (2017) Support immediate access to BH services for children and families.(Ongoing) 	<ul style="list-style-type: none"> MSRMC Administration CHS Vice President, Behavioral Health MSHF Staff Mat-Su Behavioral Health Providers Anchorage Behavioral Health Providers AK Mental Health Trust Authority 	<ul style="list-style-type: none"> # of residents using “Bridge” detox option # of types of BH services that have greater than one week waiting time Percent of residents who know where to go for behavioral health services
<p>F. Connect MSRMC BH Patients to Appropriate Outpatient Services: Ensure successful transitions of BH patients out of MSRMC to home or Anchorage facilities. This includes a follow-up system for BH patients including the provision of f/u phone calls.(Ongoing)</p>		MSRMC Social Work and ED staff	<ul style="list-style-type: none"> Percent of BH patient “Bounce Backs” to ED within specified time frame Percent of BH patients who receive a successful follow-up phone call after ED discharge

GOAL 1: Residents Have Access to an Effective and Complete Behavioral Health Continuum of Care

MSRMC Action Steps (Timeline)	MSHF Action Steps (Timeline)	Responsibility	Impact will be measured and evaluated through these indicators:
<p>G. Encourage Appropriate Use of the ED and Improve the Coordination of Care for Patients within and Between in the Emergency Departments Statewide:</p> <ul style="list-style-type: none"> • Work with other Alaska hospitals, the Alaska State Hospital and Nursing Home Association, and the AK Chapter of the American College of Emergency Physicians on the Emergency Department Coordination Project, which is part of Senate Bill 74.(Ongoing) • Subscribe to and implement an electronic information system in the ED to be used to increase the effectiveness of existing care management resources and reduce medically unnecessary ED readmissions.(2017) • Integrate the Prescription Drug Monitoring Program into ED service delivery. (Ongoing) • Improve ED quality of care through consistent delivery of care, including patient education, and adhering to best practice statewide guidelines for prescribing narcotics in the ED. (Ongoing) 	<p>H. Encourage the Connection of Community Services to the MSRMC ED Electronic Information System:</p> <ul style="list-style-type: none"> • Support local medical and behavioral health care providers and clinics to be connected to MSRMC Care Coordination through connection with the ED electronic Information System used by MSRMC. (2018) 	<ul style="list-style-type: none"> • MSRMC Administration • MSRMC ED Staff • Other AK Hospitals ED staff • MSHF Staff • Mat-Su Behavioral Health Providers 	<ul style="list-style-type: none"> • Percent of unnecessary ED visits per year • System initiated for ED patient exchange among hospitals • # of primary care appointments made within 72-96 hours after discharge • # of patients who kept appointment • # of ED prescribers enrolled in prescription monitoring database • # of community health care providers connected to the MSRMC ED electronic information system.

GOAL 1: Residents Have Access to an Effective and Complete Behavioral Health Continuum of Care

MSRMC Action Steps (Timeline)	MSHF Action Steps (Timeline)	Responsibility	Impact will be measured and evaluated through these indicators:
<p>I. Improve the Quality of Behavioral Health Services Delivered at MSRMC</p> <ul style="list-style-type: none"> • Ensure that all patients have access to an equitable behavioral health assessment. (2017) • Establish nursing didactics that will train at a minimum level core BH assessment skills. (Ongoing) • Develop a formal policy and related procedures outlining patient flow and Pride training to all ED staff. (Ongoing) • Create formal competency and ongoing education and policy adoptions needed for ED staff and physicians to better serve patients with BH issues. (Ongoing) 	<p>J. Improve Quality of Behavioral Health Services Delivered in the Community</p> <ul style="list-style-type: none"> • Support training for BH, Medical, and First Responder professionals in the community on best practices in delivering BH care. (2017) • Support Pride training for staff at MSHF and community organizations to better serve Mat-Su residents.(2017) 	<ul style="list-style-type: none"> • MSRMC ED Staff • CHS, Vice President Behavioral Health • MSRMC physicians and nurses • First Responders • MSHF staff • Other community organizations 	<ul style="list-style-type: none"> • # of ED staff educated on behavioral health assessment and Pride training • # of Mat-Su organizations trained and supported on BH quality care practices • # of Mat-Su organizations trained and supported serving LGBTQ residents
<p>K. Maintain Specific Crisis Care Teams and Participate in Data Collection:</p> <ul style="list-style-type: none"> • Maintain the SART (Sexual Assault Response Team) and SCAN (Scan for Child Abuse/Neglect) Team at MSRMC and design data collection and reporting to help inform prevention and treatment effort along with program evaluation.(Ongoing) • Maintain 1.2 FTE in Forensic nursing for SART to include support for ongoing education and equipment needs, including SART examination and interview rooms. (Ongoing) • Provide de-identified, HIPPA compliant data to MSHF for evaluation of BH initiatives. (Ongoing) 	<p>L. Ensure use of Crisis Care data to Improve the System of Care:</p> <ul style="list-style-type: none"> • Support the system of collection, reporting of and analysis of data gathered by MSRMC for evaluation and improvement of care delivery. (2017) 	<ul style="list-style-type: none"> • SART Team • SCAN Team • MSHF Staff • Mat-Su Borough • City of Wasilla • Alaska Family Services • MSRMC Staff • Mat-Su Domestic Violence Coalition 	<ul style="list-style-type: none"> • # of SART visits to MSRMC • # of SCAN visits to MSRMC • Data collected to evaluate ED related implementation plan activities

<p>M. Improve the Quality of Behavioral Health Services and Care Coordination in the Mat-Su Medical and Behavioral Health Community.</p> <ul style="list-style-type: none"> • Sponsor and/or co-sponsor Physician CME offerings on business models that support implementation of evidence-based practices including, primary/BH integration, SBIRT, coordinated care, etc. (Ongoing) • Encourage the representation of at least one behavioral health professional on the Board of Trustees. (2017) • Provide training and culture change activities for MSRMC staff to reduce social stigma related to mental health and substance abuse disorders. (Ongoing) 	<p>M. Improve the Quality of Behavioral Health Services and Care Coordination in the Mat-Su Medical and Behavioral Health Community.</p> <ul style="list-style-type: none"> • Sponsor and/or co-sponsor Physician CME offerings on business models that support implementation of evidence-based practices including, primary/BH integration, SBIRT, coordinated care, etc. (2018) • Support the integration of physical and behavioral health in primary care settings through grant-making, trainings and leveraging statewide and federal funding. (Ongoing) • Regularly convene Mat-Su behavioral health providers to assess gaps in the continuum of care and strategize how to fill these gaps. (2017) • Require the representation of at least one behavioral health professional the Board of Directors.(2017) • Support community and organization-specific training and culture change activities to reduce social stigma related to mental health and substance abuse. (2018) 	<ul style="list-style-type: none"> • MSRMC Staff • MSHF Staff • MSRMC Board of Directors • MSRMC Board of Trustees • MSHF Board of Directors • Mat-Su health care professionals • Other community organizations 	<ul style="list-style-type: none"> • # of physicians receiving CME in behavioral health • # of settings in Mat-Su offering integrated behavioral and physical health care • # of Mat-Su health care settings conducting routine SBIRT screening • # of Mat-Su health care settings conducting routine Trauma screening • # of MSRMC staff trained on social stigma • Percent of residents who report no stigma in seeking behavioral health care
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GOAL 2: All Mat-Su Children and Families are Safe, Healthy and Thriving Through an Engaged and Coordinated Community

MSRMC Action Steps	MSHF Action Steps	Responsibility	Impact will be measured and evaluated through these indicators:
	<p>A. Promote a complete array of initiatives and programs focused on prevention of child maltreatment and promotion of resilience in families and children.</p> <ul style="list-style-type: none"> Fill gaps and take to scale treatment, prevention and promotion strategies that have proven successful in the community so they are accessible to all families. This will be accomplished through grant funding, statewide policy change, and leveraging funding from federal, state, and local sources. (2017) 	<ul style="list-style-type: none"> MSHF Staff Mat-Su child and family providers 	<ul style="list-style-type: none"> # of gaps in array of initiatives and programs for families and children identified in Behavioral Health Environmental Health Report 3
<p>B. Promote quality care provision to Mat-Su Children and Families.</p> <ul style="list-style-type: none"> Support all MSRMC ED staff with self-care practices to address secondary trauma, including a benefit packet EAP (Employee Assistance Program) that provides counseling and support at no fee. (Ongoing) Ensure that hospital processes, policy and staff that affect children and parents are “trauma-informed.” (Ongoing) 	<p>B. Promote quality care provision to Mat-Su Children and Families.</p> <ul style="list-style-type: none"> Support all child and family support workers with self-care practices to address secondary trauma. This will be accomplished through grant funding, statewide policy change, and leveraging funding from federal, state, and local sources.(2018) Support all sectors that touch children and parents to be “trauma-informed.” This will be accomplished through grant funding, statewide policy change, and leveraging funding from federal, state, and local sources. (Ongoing) 	<ul style="list-style-type: none"> MSRMC ED Staff MSRMC HR Department MSHF staff Mat-Su child and family providers 	<ul style="list-style-type: none"> Percent of staff receiving counseling when needed Percent of staff completing trauma-informed education Percent of child welfare, behavioral health and First Responder organizations that offer secondary trauma care for employees # of staff and organizations completing “trauma-informed “ training
<p>C. Promote family-friendly work environments for Mat-Su parents.</p> <ul style="list-style-type: none"> Ensure family-friendly policies exist at MSRMC that include strategies for dealing with work- 	<p>C. Promote family-friendly work environments for Mat-Su Parents.</p> <ul style="list-style-type: none"> Ensure family-friendly policies at MSHF and other Mat-Su workplaces that include 	<ul style="list-style-type: none"> MSRMC Staff MSRMC HR Department MSHF Staff 	<ul style="list-style-type: none"> Existence of family-friendly human resource policies at MSRMC and MSHF

GOAL 2: All Mat-Su Children and Families are Safe, Healthy and Thriving Through an Engaged and Coordinated Community

MSRMC Action Steps	MSHF Action Steps	Responsibility	Impact will be measured and evaluated through these indicators:
<p>related stress reduction, parental leave, employee assistance program, and an environment for addressing behavioral health issues that is stigma-free. (Ongoing)</p>	<p>strategies for dealing with work-related stress reduction, parental leave, employee assistance programs, and an environment for addressing behavioral health issues that is stigma-free. This will be accomplished through grant funding, education and training initiatives, etc. (Ongoing)</p>	<ul style="list-style-type: none"> • Mat-Su employers 	
<p>D. Promote support for the “whole” parent and child in medical settings.</p> <ul style="list-style-type: none"> • Support integrated physical and behavioral health care in MSRMC care settings. (Ongoing) • Conduct universal screening for trauma and basic need assistance, and referral for social service needs in MSRMC care settings.(Ongoing) • Support educational campaigns to educate residents, including MSRMC, Urgent Care Clinic and other primary care staff on ACEs and resilience.(Ongoing) 	<p>D. Promote support for the “whole” parent and child in medical settings</p> <ul style="list-style-type: none"> • Support integrated physical and behavioral health care in medical settings.(Ongoing) • Support universal screening for trauma and basic need assistance and referral for social service needs. This will be accomplished through grant funding, education and training initiatives, etc.(Ongoing) • Support educational campaigns to educate residents and professionals in Mat-Su on ACEs and resilience. (Ongoing) 	<ul style="list-style-type: none"> • MSRMC Staff • MSHF Staff • SART Team • SCAN Team 	<ul style="list-style-type: none"> • # of health care settings in Mat-Su who offer integrated care • # of health care settings in Mat-Su who conduct universal screening for trauma • # of health care settings in Mat-Su who screen for basic need assistance and other social service needs
<p>E. Provide birth-related care that promotes family resilience:</p> <ul style="list-style-type: none"> • Achieve Baby Friendly Hospital status. (Ongoing) • Implement Kangaroo Care in the Mat-Su Regional OB department. (Ongoing) • Explore the need and viability of operating a Level 11 Nursery with Neonatal abstinence program and perinatal substance abuse treatment. (Ongoing) • Align MSRMC and certain birth centers and midwiferies to increase patient care and safety. (Ongoing) 		<ul style="list-style-type: none"> • MSRMC Staff including neonatal/perinatal staff • MSRMC OB Staff 	<ul style="list-style-type: none"> • Date MSRMC received Baby Friendly hospital status • Date Kangaroo Care began • Existence of NAP program • Existence of collaboration initiative(s) among birth facilities

GOAL 2: All Mat-Su Children and Families are Safe, Healthy and Thriving Through an Engaged and Coordinated Community

MSRMC Action Steps	MSHF Action Steps	Responsibility	Impact will be measured and evaluated through these indicators:
<p>F. Increase social connectedness to support families and children</p> <ul style="list-style-type: none"> MSRMC will continue offering to the community Baby Fair, Woman’s Fair, Bike Rodeo, Healthy Women, and other programs designed to support families and children. MSRMC will continue to sponsor family oriented athletic events such as Rotary 5 K and the Night at the Ball Park. 	<p>F. Increase social connectedness to support families and children</p> <ul style="list-style-type: none"> Increase opportunities for social connection in Mat-Su through increasing volunteer opportunities, gatherings in public spaces, and other opportunities. This will be accomplished through grant funding and leveraging funding from federal, state, and local sources. 	<p>MSRMC and MSHF staff and community partners</p>	<ul style="list-style-type: none"> # of events # of participants Existence of central volunteer organizing entity
<p>G. Promote Social and Emotional Competence in Children</p> <ul style="list-style-type: none"> MSRMC will continue supporting children with disabilities through Project Search, and maintain Employee competency through our education department.(Ongoing) 	<p>G. Promote Social and Emotional Competence in Children</p> <ul style="list-style-type: none"> Increase access to early learning for all Mat-Su children. This will be accomplished through grant funding, statewide policy change, and leveraging funding from federal, state, and local sources.(2017) Increase opportunities for school-age children to develop social emotional competence. This will be accomplished through grant funding, statewide policy change, and leveraging funding from federal, state, and local sources. (Ongoing) 	<ul style="list-style-type: none"> MSRMC Staff MSRMC Education Department MSHF Staff CCS Early Learning 	<ul style="list-style-type: none"> # of Project Search participants Percent of children younger than 5 years old participating in early learning
<p>H. Promote knowledge of Parenting and Child Development</p> <ul style="list-style-type: none"> Capitalize on opportunities to provide training on parenting skills and promote resources that inform parents on child development with new parents in the MSRMC Birthing Center, Urgent Care, and Solstice Family Medicine. Offer “centering” prenatal care meetings and other prenatal classes. (2017) 	<p>H. Promote knowledge of Parenting and Child Development</p> <ul style="list-style-type: none"> Support the development of parent support practices and parenting training in the community through grant funding, statewide policy change, and leveraging funding from federal, state, and local sources.(2017) 	<ul style="list-style-type: none"> MSRMC Staff MSRMC OB Urgent Care Solstice Family Medicine MSHF Staff Community Partners 	<ul style="list-style-type: none"> # of parent support initiatives in Mat-Su The existence of policy to ensure the provision of parent education and information and referral to resources for families delivered at MSRMC care delivery sites.

GOAL 3: All Mat-Su Residents Have Adequate Income, Housing, Transportation, Education Levels, Social Connections and Information on Resources and Health to Support Good Health and Access to Physical and Behavioral Health Care

MSRMC Action Steps	MSHF Action Steps	Responsibility	Impact will be measured and evaluated through these indicators:
<p>A. Increase Access to Mat-Su Physical and Behavioral Health Services and Programs:</p> <ul style="list-style-type: none"> • Work with the Community Resource Center (CRC) network to ensure that it has correct information on all MSRMC services.(2017) • Ensure that MSRMC staff and medical staff are informed of and connected to the CRC to ensure successful discharge planning for patients.(2017) • Add patient care navigators for select service lines.(2018) • Work with the community-based Coordinated Care Project initiative to ensure the successful admission and discharge of hospital patients to home and their connection to community-based services. (Ongoing) • Maximize Eligibility Screening Services (ESS) to help patients find resources to pay for medical care. (Ongoing) • Recruit additional internal medicine providers to the community. (Ongoing) • Explore developing a Medicare Clinic with Primary Care Support and collaborate with the community on how to handle the demand of Medicare patients.(Ongoing) • Provide extended hours at the Urgent Care clinic to better accommodate patient work schedules and increase same-day appointments to better meet the needs of patients.(Ongoing) • Expand the hospital-led clinically integrated network project from participation at the primary care level to include other specialties.(Ongoing) • Train MSRMC staff on delivering effective and medically- appropriate care to the homeless youth population, including understanding the barriers to accessing care they face as well as the resources available in the community to support them. (2017) • Establish a calendared screening and health awareness initiative that focuses on diabetes 	<p>A. Increase Access to Mat-Su Physical and Behavioral Services and Programs:</p> <ul style="list-style-type: none"> • Develop a Community Resource Center network to meet the information, referral, and patient navigation needs of community residents related to transportation, social connections, income, housing, education, information and other factors that affect health. This will be accomplished through grant funding, statewide policy change, and leveraging funding from federal, state, and local sources. (2017) • Support the development of community-based Coordinated Care Project initiative which provides patients with integrated physical and behavioral care and helps to coordinate their care providing linkages to necessary services. This will be accomplished through grant funding, statewide policy change, and leveraging funding from federal, state, and local sources. (2017) • Promote access for seniors to primary care physicians that accept Medicare along with a model of chronic disease management for at-risk or identified seniors. This will be accomplished through grant funding, statewide policy change, and leveraging funding from federal, state, and local sources. (2017) • Explore access issues for homeless youth by funding assessment and/or initiatives that serve this population. This will be accomplished through grant funding, statewide policy change, and leveraging funding from federal, state, and local sources. (2017) 	<ul style="list-style-type: none"> • MSRMC Staff • MSHF Staff • Community Resource Center • Coordinated Care Project • Other community partners 	<ul style="list-style-type: none"> • Date Community Resource Center is open • # of people utilizing the Community Resource Center • # of patients participating in Coordinated Care Project initiative who have improved health status • # of eligibility screenings for MSRMC patients • # of identified resources for MSRMC patients • # of internal medicine providers recruited • Date Medicare Clinic opened • Percent of seniors accessing primary care physician network

GOAL 3: All Mat-Su Residents Have Adequate Income , Housing, Transportation, Education Levels, Social Connections and Information on Resources and Health to Support Good Health and Access to Physical and Behavioral Health Care

MSRMC Action Steps	MSHF Action Steps	Responsibility	Impact will be measured and evaluated through these indicators:
<p>awareness (glucose monitoring); cholesterol (level screening/tests); hypertension (blood pressure clinics); fall prevention, and pulmonary-related illness and risk. Such a program could be integrated into a “circuit-rider” program that travels throughout the borough and is connected to the MSRMC Senior Circle Program.</p>			<ul style="list-style-type: none"> • # of patients using extended hours • Percent increase of same-day appointments at MSRMC Urgent Care • # of specialists added to clinically integrated network • Date calendared screening and health awareness initiative established • # of glucose screenings per year • # of cholesterol screenings per year • # of blood pressure screenings per year • # of fall prevention education participants

GOAL 3: All Mat-Su Residents Have Adequate Income , Housing, Transportation, Education Levels, Social Connections and Information on Resources and Health to Support Good Health and Access to Physical and Behavioral Health Care

MSRMC Action Steps	MSHF Action Steps	Responsibility	Impact will be measured and evaluated through these indicators:
			<ul style="list-style-type: none"> # of referrals due to poor screening results
<p>B. Increase Access to Affordable Transportation that Allows Residents to get to Work, Health care appointments, School/Community Activities and other opportunities that Affect the Quality of their Lives</p> <ul style="list-style-type: none"> In accordance with applicable state and federal law, provide transportation vouchers upon discharge to enable patients to get home or to access agencies and programs for which they have a hospital referral. (Ongoing) 	<p>B. Increase Access to Affordable Transportation that Allows Residents to get to Work, Health care appointments, School/Community Activities and other opportunities that Affect the Quality of their Lives</p> <ul style="list-style-type: none"> Support a network of concrete supports and service providers (transportation, housing, food, etc.,) that leverage efforts to adequately meet the needs of Mat-Su families and provide services in a way that maintains their dignity and promotes resilience and self-advocacy. (2018) Fund technical assistance to support the two Mat-Su transit organizations and their future merger. (Ongoing) Support an improved transit system including encouraging deeper coordination with and between existing human service fleets, rides, riders, and the public system that meets the health care access needs of all residents through grants and leveraging funds from federal, state, and other sources. (Ongoing) 	<ul style="list-style-type: none"> MSRMC Staff MSHF Staff Community partners 	<ul style="list-style-type: none"> # of transportation vouchers given out # of transportation vouchers used Percent of adults who reported they didn't have transportation to a medical appointment

GOAL 3: All Mat-Su Residents Have Adequate Income , Housing, Transportation, Education Levels, Social Connections and Information on Resources and Health to Support Good Health and Access to Physical and Behavioral Health Care

MSRMC Action Steps	MSHF Action Steps	Responsibility	Impact will be measured and evaluated through these indicators:
<p>C. Increase Economic Opportunities that Allow Residents to Have a Level of Income that Supports a Healthy Lifestyle and Provides for Safe and Affordable Housing</p> <ul style="list-style-type: none"> Maximize hospital impact on local economy and employment rate by hiring employees from Mat-Su and when possible purchasing from local vendors. Avoid outsourcing of Mat-Su jobs. (Ongoing) 	<p>C. Increase Economic Opportunities that Allow Residents to Have a Level of Income that Supports a Healthy Lifestyle and Provides for Safe and Affordable Housing</p> <ul style="list-style-type: none"> Support local housing and homelessness prevention efforts including efforts to meet the needs of homeless youth, filling the gaps in senior housing, residential hospice beds and skilled nursing beds.(2017) Fund coordinator for the Mat-Su Housing and Homelessness Coalition. (Ongoing) Hire employees from Mat-Su and, when possible, purchase from local vendors. Avoid outsourcing of Mat-Su jobs. (Ongoing) Provide academic and vocational scholarships to Mat-Su residents (Ongoing) 	<ul style="list-style-type: none"> MSHF Staff MSRMC administration Community partners 	<ul style="list-style-type: none"> # of people placed in housing # of homeless youth placed in housing # of seniors placed in housing # of residents placed in Hospice # of residents placed in skilled nursing Percent of locals hired to fill positions # of scholarships provided

GOAL 4: All Mat-Su Residents are a Healthy Weight			
MSRMC Action Steps	MSHF Action Steps	Responsibility	Impact will be measured and evaluated through these indicators:
<p>A. Ensure activities and infrastructure that promote healthy weights through opportunities for physical activity and healthy nutrition.</p> <ul style="list-style-type: none"> • Support community initiatives such as Relay for Life, local running races and maintain employee wellness program. (Ongoing) • Support community nutrition initiatives such as wrap around nutritional counseling services for bariatric patients, provide meeting space for Overeaters Anonymous and contribute to local food drives. (Ongoing) 	<p>A. Ensure activities and infrastructure that promote healthy weights through opportunities for physical activity and healthy nutrition.</p> <ul style="list-style-type: none"> • Support Mat-Su Trails and Parks Foundation to coordinate trail and playground development. (Ongoing) 	<ul style="list-style-type: none"> • MSHF staff • Mat-Su Trails and Parks Foundation • MSBMC • Overeater's Anonymous • Other local non-profit organizations 	<ul style="list-style-type: none"> • Number of trail and playground construction and improvements • Number of community initiatives related to physical activity and health nutrition sponsored by the hospital