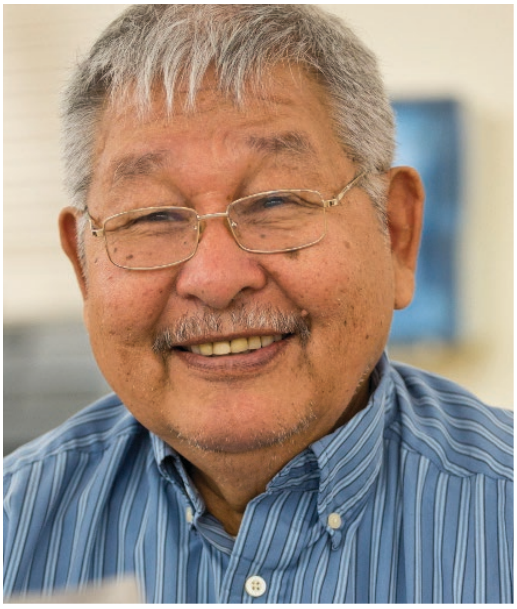
2019

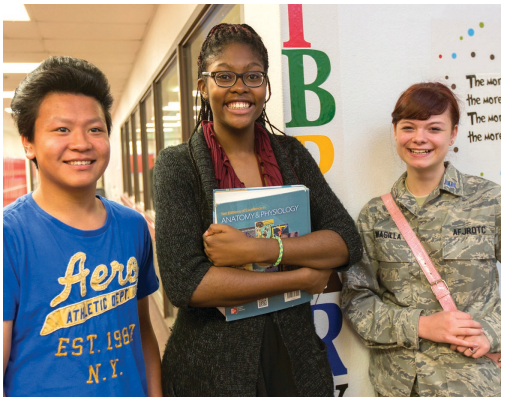
Mat-Su Community Health Needs Assessment (CHNA)

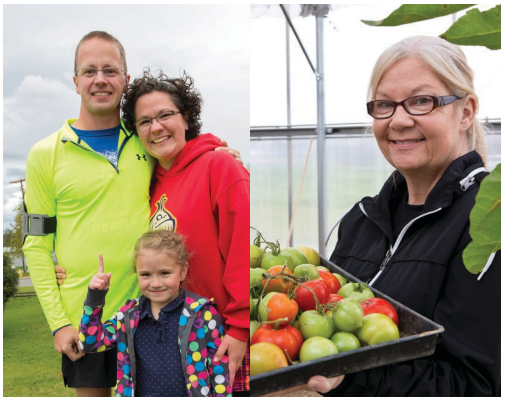
IMPLEMENTATION PLAN



Mat-Su Regional Medical Center

Mat-Su Health Foundation





General Information

Contact Person:

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Date Written Plan Was Adopted by Organization's Authorized Governing Body:

Mat-Su Regional Medical Center (MSRMC):
Via email vote initiated on 4/21/20
Mat-Su Health Foundation (MSHF): 4/20/20

Date Written Plan Was Required to Be Adopted:

May 15, 2020

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
777 N Crusey St Ste A201
Wasilla, AK 99654

Estimated 2020 Implementation Plan Budget Total For Each Facility:

Mat-Su Regional Medical Center: at least $1.6 million
Mat-Su Health Foundation: at least $2.4 million

List of Community Health Needs Identified in Written Report

List of Community Health Needs and Strengths identified in CHNA written report:

The 2019 Mat-Su Community Health Needs Assessment (CHNA) has 16 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 sources:

- U.S. Census, American Community Survey
- Alaska Department of Labor & Workforce Development
- Alaska Department of Education and Early Development
- U.S. Bureau of Economic Analysis
- State of Alaska, Department of Health and Social Services, Division of Public Health, Behavioral Risk Factor Surveillance System
- Alaska Trauma Registry programs
- 2019 Mat-Su Household Survey

Qualitative data were gathered through a technique called Photovoice, a form of participatory action research.

The following is a high-level overview of the status of key CHNA indicators and the CHNA pages where this information can be found.

Demographics Snapshot (CHNA Page 7)

- Mat-Su continues to grow – the population increased from 91,697 in 2011 to 105,743 in 2018
- **Progress:** (1 indicator) average unemployment rate
- **Regress:** (2 indicators) % of individuals living in poverty and % of individuals with a physical disability

Healthcare Access Snapshot (CHNA page 7)

- **Progress:** (7 indicators) % adults who could not see a doctor due to cost in past year; % who have a usual primary care provider – adults and seniors; % with medical insurance – adults and seniors; mental health providers to population ratio; preventable hospital stays per population.
- **Regress:** (2 indicators) % of seniors who could not see a doctor due to cost and primary care physician to population ratio

Healthy Weight Snapshot (CHNA page 8)

- **Progress:** (2 indicators) weight profile of traditional high school students and seniors
- **Regress:** (3 indicators) weight profile of kindergarten – 8th grade students, alternative high school students and adults

Chronic/Infectious Disease Snapshot (CHNA page 8)

- **Progress:** (5 indicators) coronary heart disease death rate, stroke death rate, diabetes - seniors, colorectal cancer death rate, and colorectal cancer screening ever age 50+
- **Same:** (1 indicator) diabetes – adults
- **Regress:** (6 indicators) cancer death rate, lung cancer death rate, mammogram, cervical cancer screening, chlamydia and gonorrhea rates

Behavioral Health Snapshot (CHNA page 9)

- **Progress:** (6 indicators) % who binge drank in last month – traditional and alternative high school students; % who binge drank in the past month – adults; % marijuana use ever – middle and alternative high school.
- **Same:** (1 indicator) average number of poor mental health days in the past month – adults
- **Regress:** (7 indicators) % who felt sad or hopeless almost daily for two weeks – traditional and alternative high school students; % who considered suicide ever – middle school students; % who considered suicide in the past year – traditional and alternative high school students; suicide death rate; % marijuana ever – traditional high school

Safety and Injury Snapshot (CHNA page 10)

- **Progress:** none
- **Same:** (3 indicators) % bullied at school in past 12 months – traditional high school; % electronic bullied past 12 months – traditional high school; % witnessed parent hurt by spouse or partner ever – adult
- **Regress:** (9 indicators) % dating violence in past 12 months – traditional and alternative high school; % forced intercourse ever – traditional and alternative high school; % bullied at school, past 12 months – alternative high school; % electronic bullied past 12 months – alternative high school; % had unwanted sexual activity ever – adults; % threatened or physically hurt by partner ever; unintentional injury death rate

Social Connection and Racism Snapshot (CHNA page 11)

- **Progress:** (4 indicators) % report it is very likely or likely I have someone I can ask for help with my children; % report I have volunteered in the last year; % report people in my community do favors for each other very often, often, or sometimes; and % report I have attended social gathering, state fair, or other social event in last year
- **Same:** (2 indicators) % report I have 1-5 people I can count on to help with a practical problem; % report I do favors for people in my community very often or sometimes
- **Regress:** (1 indicator) % who report I have no one I can count on to help with a practical problem

Maternal Child Health Snapshot (CHNA page 11)

- **Progress:** (2 indicators) infant mortality rate and post-neonatal infant mortality rate per 1000 births
- **Same:** (3 indicators) low birth weight births; preterm births and % smoke cigarettes during last 3 months of pregnancy – mothers
- **Regress:** (2 indicators) % used marijuana during pregnancy; % used alcohol during pregnancy

Senior Health Snapshot (CHNA page 12)

- **Progress:** (1 indicators) average number of poor mental health days in last month
- **Regress:** (5 indicators) % state that health is good, very good, or excellent; % had flu shot or pneumonia shot in last 12 months; % who had colonoscopy/sigmoidoscopy in last 5 years; average number of poor physical health days in last month

List of Collaborating Organizations

In order to conduct the 2019 Mat-Su CHNA, the Mat-Su Health Foundation (MSHF) and Mat-Su Regional Medical Center (MSRMC) collaborated with a number of organizations who agreed to participate in the Photovoice project or on the Steering Committee and/or in the Photovoice data collection effort. Collaborating organizations included:

- Alaska Family Services
- Alaska Mental Health Trust Authority
- CCS Early Learning
- Chickaloon Traditional Council
- Kabayan Inc., Filipino Community of Mat-Su
- Knik Tribal Council
- Latinx
- Mat-Su Health Services
- Mat-Su Regional Medical Center
- MyHouse
- Parents With a Purpose
- People of a Certain Age (Older Residents)
- Providence Health and Services Alaska
- Public Health Nursing
- Southcentral Foundation
- Sunshine Community Health Center
- United Way of Mat-Su
- Williwaw Community Residents

Health Needs Planned to Be Addressed by Facility

List of Health Needs the Facility Plans to Address

Upon completion of the data collection, the following goals for the community that rose to the top in the survey data and the Photovoice project were identified by the Steering Committee.

1. A community without discrimination that promotes equity for all residents regardless of race, ethnicity, or ability
2. Communities and residents practicing and celebrating their spirituality and culture
3. A healthy environment for outdoor activities including subsistence/recreational activities
4. Strong social connections between residents
5. Residents with excellent mental health and coping skills
6. Families and youth who have healthy relationships and are safe and not at risk for bullying and violence
7. Accessible economic opportunities that allow for the ability to afford safe housing and healthy food (assistance needed with affordable transportation, English as a 2nd language instruction, accessible higher education)
8. Affordable and accessible healthy recreational activities for youth, families, and seniors
9. Accessible behavioral health care
10. Affordable and accessible preventive care including fall prevention, cancer screenings, sexually transmitted disease prevention, and vaccinations

The Steering Committee ranked the goals two different ways:

1. By importance to address for the whole borough
2. By the feasibility to improve for sub-regions of Mat-Su

TABLE 1 - **STEERING COMMITTEE RANKING OF CHNA GOALS**

Top Ranked Goals	All of Mat-Su (Importance)	Core Area (Feasibility)	Parks Hwy Area (Feasibility)	Upper Su (Feasibility)	Glenn Hwy (Feasibility)
Resident economic stability	●			○	
Safe and healthy relationships	●	○	●	●	○
Strong social connections	●	●			●
Freedom from discrimination related to race, ethnicity, disability	●				●
Excellent mental health	○				
Affordable/accessible healthy recreation		●	●		●
Accessible behavioral healthcare		●	○	●	
Affordable/accessible preventive care		●	●	●	
Healthy environment			●	●	●

RANKING: Darker color = higher ranking in importance or feasibility

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

MSHF, through its mission to improve the health and wellness of Alaskans living in Mat-Su, along with MSRMC, through its mission to provide progressive, competent and quality healthcare for our growing community through the teamwork of families, doctors, employees and volunteers, as well as through collaboration with numerous partners, have identified eight (8) goals to address a number of the top priority health-related needs and issues. The action plan for these collaborative strategies can be found in Table 4. In addition to these priority collaborative strategies, MSHF and MSRMC will each focus individual efforts on selected goals and implementation strategies in Tables 2 and 3.

TABLE 2 - **MAT-SU HEALTH FOUNDATION PRIORITIES**

Priority Need/Goal	Objective
1. Resident economic stability	Fund and convene around workforce development; advocate for policies such as presumptive eligibility; fund and convene around affordable housing and transportation and food security
2. Safe and healthy relationships	R.O.C.K. Mat-Su will continue work on increasing family contact for families involved in the child welfare system
3. Strong social connections	Implement Connect Mat-Su (Information and Referral Service) and ROCK Mat-Su community events; fund Youth 360
4. Freedom from discrimination/racial equity	Employee trainings; analyze Mat-Su population health data for disparities; implement Healthy Equity Blueprint for MSHF
5. Excellent Mental Health	Fund Behavioral Health in Schools program; Crisis Now work; cohort learning process on managed care for providers; advocate for policy changes
6. Affordable/accessible healthy recreation	Fund Mat-Su Trails and Parks Foundation, afterschool programs and Youth 360
7. Affordable/accessible preventative care	Fund Fall prevention/Seniors; policy work on price transparency and AK Healthcare Transformation Project
8. Healthy Environment	Community gardens, trails and parks funding; policy related to livability (8-80)

TABLE 3 - **MAT-SU REGIONAL MEDICAL CENTER PRIORITIES**	
Priority Need/Goal	**Objective**
1. Resident economic stability	Workforce development; Project Search to employ people with disabilities, PTO donation program, vendor fairs with community resources
2. Safe and healthy relationships	Employee Bullying Prevention Training; Columbia Suicide screening
3. Strong social connections	Patient and Family Advisory Council (PFAC) to inform hospital care and connections; social gatherings: health fairs, senior circle, volunteer program, State Fair Programs (Stop the Bleed and CPR); birthing classes, breastfeeding classes, baby boot camp, softball team
4. Freedom from discrimination	ESS Eligibility screenings and assistance for qualifications; review and revamp interpretation services, financial assistance for patients, equal opportunity employer
5. Excellent behavioral health care/ Accessible behavioral health care	BH Inpatient unit; tele-psychiatry services, BH screening for all patients, Columbia Suicide Risk Assessment in all patient access areas; youth mental health focus through collaboration with outpatient youth and peer providers (True North and My House)
6. Safe and healthy relationships	For older residents, youth and families - linked to safe, healthy relationship goals
7. Affordable/accessible healthy recreation	Sponsor community events and walks
8. Affordable/accessible preventative care	Screening and education programs, Bike Rodeo; provide meeting space for community groups
9. Health environment	Recycled materials returned to Medline, wheelchair and walker loaner program, LED lights, hospital master plan

Health Needs Facilities Do Not Intend to Address Comprehensively

During the Mat-Su CHNA process, the data revealed key themes, needs and issues that were considered in the prioritization process. After the data was tabulated and analyzed and the prioritization process was completed, 10 top priority themes were identified and affirmed by the CHNA Steering Committee.

A total of eight (8) overarching goals were identified by the Steering Committee that are intended to address the 10 top priority issues. Through their collaborative or individual implementation strategies, MSHF and MSRMC have addressed all of the priority areas to some degree.

Implementation Plan Collaborative Strategies Timeline

TABLE 4 - **TIMELINE FOR IMPLEMENTATION OF COLLABORATIVE STRATEGIES**

Goal	2020	2021	2022
Goal 1: Resident economic stability 1. Assess impact of COVID 19 on Mat-Su community and coordinate response strategies among MSRMC, FQHCs, and LINKS to ensure access to care for at-risk populations. 2. Coordinate access to care coverage with local FQHCs including an expansion plan		#1, 2	All
Goal 2: Affordable/accessible preventative care 1. Increase HUMS ED referrals 2. Develop Plans of Safe Care for high-risk babies 3. Explore MSRMC becoming Senior Friendly Hospital	#1	#2,3	All
Goal 3: Strong social connections 1. Explore "Welcome Wagon Concept" - the idea of a community collaboration that would welcome new individuals to the community and provide them with information on available resources			All
Goal 4: Safe and healthy relationships 1. Coordinate response to positive DV screen among organizations 2. Strengthen DV Coalition	#1	#2	All
Goal 5: Accessible behavioral healthcare/Excellent behavioral healthcare 1. Establish semi-annual MSRMC/MSHF/Provider meetings for sector level transition planning 2. Identify other places that are doing BH well and plan a Learning Trip for community providers and MSRMC 3. Reassess need for Psych ED beds 4. Promote peer support at hospital	#1,4	#2,3	All
Goal 6: Workforce Development 1. MSRMC/MSHF staff meet quarterly to coordinate workforce development efforts including, scholarships, Red Carpet program, recruitment, loan repayment initiative, etc.		#1	All
Goal 7: Freedom from discrimination related to race, ethnicity, disability/affordable/ accessible preventative care 1. Racial Ethnic Discrimination: Staff awareness/Education, analyze health disparities across groups in Mat-Su population and MSRMC patients, decrease barriers to seeking care 2. Decrease barriers for people with disabilities seeking healthcare		#1, #2	All

Implementation Plan 2020-2022

The overall collaborative implementation strategies and action plan includes the following – Year 1 activities are identified in Table 5:

TABLE 5 - GOAL (PERSONS RESPONSIBLE)– ACTIVITIES/OUTCOMES & IMPACT INDICATORS

Goal 1: Resident economic stability (Medicaid Enrollment: MSRMC CFO, MSHF Vice President of Programs) (FQHC Coordination: MSRMC CEO and MSHF CEO)

Action Steps (Outcomes)

1. Assess impact of COVID-19 on Mat-Su community and coordinate response strategies among MSRMC, FQHCs, and LINKS to ensure access to care for at-risk populations
2. Coordinate access to care coverage with local FQHCs, including an expansion plan

(# of agencies participating and # of individuals enrolled; # of FQHCs participating; # of residents enrolled in Medicaid; % of residents seen at FQHCs)

Indicators

- % of the population with income below the poverty level
- % of children who qualify for free and reduced lunch
- % of population with health insurance
- % that could not see a doctor due to cost
- % with primary care provider
- Primary care physician to population ratio

Goal 2: Affordable/accessible preventative care (HUMS: MSHF Healthy Minds Program Officer, MSRMC COO, MSRMC Chief ED Physician, HUMS Director) (Plans of Safe Care: R.O.C.K Director, MSRMC Director of OB) (Senior work: MSHF Healthy Aging Program Officer, MSRMC COO)

Activities (Outcomes)

1. Increase HUMS ED referrals
2. Develop Plans of Safe Care for high-risk babies
3. Explore MSRMC becoming Senior Friendly Hospital

(New plan for MSRMC staff to refer ED patients; # of high utilizers referred from ED; Rock/MSRMC coordinating meetings, Exploration of Age-Friendly Hospital model)

Indicators

- % of high utilizers seen weekly at ED and referred to HUMS
- % of participants with decrease in Emergency Department utilization
- PSC program implemented at MSRMC in coordination with R.O.C.K. Mat-Su
- Age-friendly hospital analysis completed

Goal 3: Strong social connections (MSHF Healthy Families Program Officer, R.O.C.K Director, MSRMC COO)

Action Steps (Outcomes)

1. Explore idea of a community collaboration (Welcome Wagon) that would welcome new individuals to the community and provide them with information on available resources
2. Welcome Wagon Feasibility White Paper completed

(If implemented, # participating organizations and # residents impacted)

Indicators

- % of residents who report they have someone they can count on
- % who do favors for others
- % who volunteered in past year
- % who attended social gathering in last month

Goal 4: Safe and healthy relationships (MSHF Healthy Families Program Officer, Alaska Family Services CEO, MSRMC Emergency Department Director)

Activity (Outcomes)

1. Coordinate response to positive DV screen among organizations
2. Strengthen DV Coalition

(Process and leadership gaps identified; # agencies adopting uniform process to respond positive screens)

Indicators

- % adults threatened or physically hurt by partner
- % of high school students reporting dating violence

Chart continued on following page.

Goal 5: Accessible behavioral healthcare/Excellent behavioral healthcare
(MSHF Healthy Minds Program Officer, MSRMC Director of Behavioral Health Services)

Action Steps (Outcomes)

1. Establish semi-annual MSRMC/MSHF/Provider meetings for sector level transition planning
2. Identify other places that are doing BH well and plan a Learning Trip for community providers and MSRMC
3. Reassess need for more Psych ED beds
4. Promote peer support at hospital

Indicators

- Mental health provider ratio
- Average # of poor mental health days reported by adults
- Youth and adult suicide ideation and death rates

Goal 6: Workforce Development needs met for all goals (MSHF Workforce Development Program Officer, MSRMC CEO, MSRMC Director of Human Resources)

Action Steps (Outcomes)

1. MSRMC/MSHF staff meet quarterly to coordinate workforce development efforts including, scholarships, Red Carpet program, recruitment, loan repayment initiative, etc.

   (Quarterly MSMRC/MSHF meetings to coordinate workforce development efforts; # of collaborative efforts per year)

Indicators

- # and amount of scholarships awarded
- # of physicians and other health professionals recruited to MSRMC
- # of physicians and other health professionals recruited to Mat-Su

Goal 7: Freedom from discrimination related to race, ethnicity, disability/affordable/accessible preventative care (MSRMC CEO and MSHF CEO)

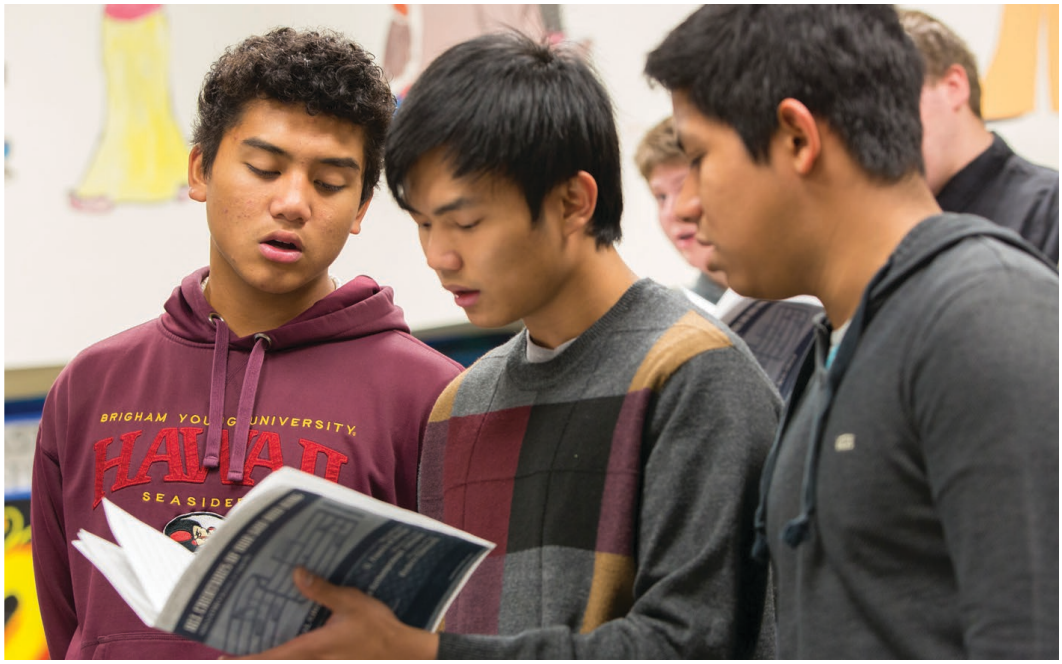
Activities (Outcomes)

1. Racial Ethnic Discrimination: Staff awareness/ Education, analyze health disparities across groups in Mat-Su population and MSRMC patients, decrease barriers to seeking care
2. Decrease barriers for people with disabilities seeking healthcare

   (Data analyzed to identify disparities; hospital walk through completed to identify barriers for people with disabilities; community "walk through" to identify barriers to seeking care in the outpatient world)

Indicators

- % residents indicating racism exists or has increased
- # and type of barriers eliminated for people with disabilities seeking care



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