Saint Anne's Hospital Brown University Health

Community Health Needs Assessment Implementation Strategic Plan

October 1, 2025 – September 30, 2028

As a result of the 2025 Community Health Needs Assessment (CHNA) prepared for Saint Anne's Hospital (SAH) as of September 9, 2025, Saint Anne's Hospital Brown University Health executive leadership team, and other individuals critical to the organizational planning process with input from the SAH Community Health Benefits/Health Equity Advisory Committees (CBAC/HEC) have created an implementation strategic plan detailing action item plans covering the period from October 1, 2025 through September 30, 2028. In compliance with regulatory requirements, the triennial CHNA was launched in October 2025, to provide the blueprint for the community benefits priorities for the next three-year cycle, 2026 – 2028. Based on the complex health issues in the community, SAH has strategically planned ways to address significant needs to maximize the improvement of the overall health and wellness of residents within its community. As reported in the 2025 CHNA, available online at https://www.brownhealth.org/locations/saint-annes-hospital/about-saint-annes-hospital/community-health-and-outreach/community SAH identified the following issues as significant health needs currently facing its community:

- Access to Healthcare Services and Training - Reducing Health Disparities
- Behavioral Health – Mental Health, Substance Use Disorder (SUD), Trauma, ACES Study, Access to Services
- Health-related Social Needs (HRSN)/Social Drivers of Health (SDoH) - Housing Insecurity/Homelessness, Food/Nutrition Insecurity/Poverty
- Chronic Disease Management and Wellness – Community-based Health Education

last updated: 2-6-26

Significant Health Need: Access to Healthcare Services: Reducing Disparities			
Strategies & Objectives Planned for Implementation	**Target Population (s)**	**SAH Resources /Partner Collaboration(s) to Address Need**	**SAH Community Impact – FY2026 - Oct. 25-Sept.30 RED INK – Community Partners/Collaborations**
1.1 Use the findings of the 2025 Community Health Needs Assessment (CHNA) to provide the community benefits strategic plan for 2026-2028. ***Impact: Calendar Year (CY) 2025 completed 2025 Community Health Needs Assessment (CHNA)***	Under-served, un-insured, or under-insured individuals. At-risk populations who experience greater health disparities.	SAH Community Health Benefits Advisory Committee (CBAC), SAH Patient & Family Advisory Committee (PFAC), SAH Health Equity Committee (HEC) Southcoast Community Health Alliance (SoCHA) - Southcoast Health, Citizens for Citizens, PACE, HealthFirst Family Care Center,	**Awarded TJC Certification in Health Care Equity 10/23/25** **Exceeded HQEIP Performance Improvement Project (PIP1)– FUH 7 days performance goal for target population. HQEIP PY2 (2025)** **Southcoast Community**

		SSTAR Family Care Center, Greater New Bedford Community Health Center, Fall River and New Bedford Health Departments. Greater Fall River Partners for a Healthier Community Steering Committee/Coalition Brown University Health Community Health Institute MassHealth Hospital Health Care Equity Incentive Program/HQEIP Quit Works	**Health Alliance (SoCHA) community discussion of 2025 CHNA findings and strategies 12/4/2025.** **SoCHA interview with FRMedia/BCC about the findings of the 2025 CHNA 1-14-26. Link to interview below: https://frmedia.org/regional-healthcare-agencies-release-assessment-of-the-southcoast/ (posted 1-22-26)**
1.2 Provide Financial Counselors to assist patients and community members with accessing health insurance. Provide health insurance navigation in an individual's first /preferred language. ***Access to health insurance coverage= access to health care*** ***Impact: CY 2025 assisted 2,754 individuals access health insurance***	Un-insured or under-insured individuals	SAH Financial Counselors MassHealth- FY'26 1st Qtr. hired **trilingual (Eng, Span & Port) FC –replacement FTE.**	**FY'26 YTD (Oct. - Jan.) SAH Provided health insurance enrollment assistance to 1,074 individuals.** **City of Fall River- Mary Kinnane & HealthFirst provide insurance enrollment assistance by appt.**
1.3 Provide an Oncology Financial Counselor (OFC) to assist patients with accessing treatment services, co-pay programs and non-profit foundations that provide free and/or low-cost access to expensive oncology drugs. The OFC also assists patients by reducing structural barriers to accessing health insurance, navigating complex billing issues, problems with prescriptions, and other issues to improve patient experience and health outcomes. ***Impact CY'25 - 985 patient contacts, $103,000 patient paid amounts for oncology medications saved, $53,000 in co-pay assistance grants from non-profits foundations helped 8 patients.***	Uninsured or under-insured individuals. Populations who experience greater health disparities	SAH Oncology Financial Counselor Oncology Social Workers Non-profit Foundations	**FY'26 -1st Qtr. Report Pending**

1.4 Provide Patient Navigators in key service lines to improve continuity of care and access. Help patients overcome barriers to accessing screening or treatment services. Provide access to one-on-one education and/or group support. Ensure culturally and linguistically appropriate care. Improve quality of care and patient health status/outcomes by improved coordination of complex care. ***Impact: CY2025 (Jan.- Dec.) - dedicated patient navigation services provided to 376 oncology patients, 220 breast health patients and 1,680 behavioral/mental health patients.***	Populations who often have lower screening rates and/or experience greater health disparities, including people from historically disadvantaged racial and ethnic populations, patients with lower incomes; patients with Limited English Proficiency (LEP)/English as a Second Language (ESL), patients with behavioral health/mental health & SUD.	SAH Patient Care Navigators	**FY'26 -1st Qtr.** **Navigation provided to:** **Oncology –94 patients** **Breast - 55 patients** **BH- 420 patients** **Child & Family Services (CFS), Open Access Program provides care coordination-integrated primary care, social services, mental health & substance disorders. CFS is the Community Behavioral Health Center (CBHC) serves Fall River, 24/7 Mobile Crisis Intervention or community-based evaluations**
1.5 Provide transportation assistance for medical appointments. ***Impact: CY2025 (Jan.- Dec.) - Transportation, 828 rides, provided to 140 patients for access to attend cancer treatment appointments.***	Oncology patients who would not otherwise be able to attend treatment.	SAH Drivers and designated vehicles Oncology Social Workers	**FY'26- 1st Qtr. provided transportation to 35 patients for a total of 207 trips.** ***Appendix A - by-City/Town**
1.6 Provide access to taxi vouchers for transportation at discharge for hardship ***Impact: CY2025 (Jan.- Dec.) - $20,054.00 in taxi vouchers for 1,476 patients without access to transportation at discharge.***	Patients who do not have access to transportation .	Budget for Taxi Vouchers: **FY'26- YTD (Oct. - Jan.)** **Oct. '25 -$2,385.00** **Nov. '25 -$2,151.00** **Dec. '25 -$1,839.00** **Jan. '26 - $1,251.00** ***YTD Total - $7,626.00*** Area Taxi Services that accept SAH vouchers SAH Clinical Staff	**FY'26- YTD (Oct. - Jan.)- Provided access to transportation at discharge for <u>561</u> patients** **Mass 211 provides free rides for certain services (medical appts, court, pantries) for Fall River & New Bedford residents. * See Appendix B for Mass 211 Lyft Program details.**

1.7 Meet all performance metrics for Joint Commission National Patient Quality & Safety Goals and for participation in the MassHealth Quality & Equity Incentive Program (QEIP) to reduce disparities in patients' health status. • Incorporate Health Equity into the Hospital Strategic Plan with defined leadership including a hospital-based Health Equity Committee (HEC) • Improve collection of patients' self-reported race, ethnicity, disability and language data for analysis and planning • Screen all patients for their health-related social needs (HRSNs) • Address patient's self-reported HRSNs with targeted resources • Stratify HRSNs by patients 'self-reported socio-demographics to identify trends in health disparities • Conduct two Process Improvement Projects (PIPs) on topics approved by MassHealth and in partnership with affiliated MassHealth Accountable Care Organization (ACO) o PIP1 – FUH within 7 days of d/c for dx mental illness/self-harm o PIP2 – Reduce Disparity in 30 *COPD* Re-admissions for non-white individuals who smoke I***mpact: CY'25 Achieved Joint Commission Certification in Health Care Equity***	Populations who often experience greater health disparities, including people from historically disadvantaged racial and ethnic populations, patients with lower incomes; patients with Limited English Proficiency (LEP)/English as a Second Language (ESL), patients with behavioral health/mental health & substance use disorder. Patients who are members of MassHealth ACO	SAH Senior Leadership & Health Equity Committee (HEC), MassHealth Health Equity Team, IPRO Consultants, Affiliated ACO Partners, dedicated IT Support, The Joint Commission	**Awarded TJC Certification in Health Care Equity 10/23/25** **Exceeded PIP1 – FUH 7 days performance goal for target population. HQEIP PY2.** ***2026- 2028*** **Universal Screening of patients for health-related social needs (HRSNs) - 98%** **Address patients' self-reported HRSNs with targeted resources** **Stratify HRSNs by patients' self-reported socio-demographics to identify trends in health disparities improved by EPIC**
1.7 Promote student and workforce development: • Support access to higher education and clinical training in health care/related disciplines. • Offer Observation/Shadowing Program • Support Inclusion Excellence and Cultural Competency o Multi-cultural Health (MHC) Scholarships o Need-based Scholarships to promote global equity Host and participate in Health Care Career Days & Fair I***mpact: CY'25 - ICK nursing program opened in CY25, SAH supported two first year nursing students (total expense $1,500)***	SAH employees Students pursuing advanced studies in health/health-related careers. Economically disadvantaged international students pursuing advanced studies.	SAH Professional Development Department SAH Clinical Preceptors SAH Shadow Mentors SAH Multicultural Health Committee, MCH scholarships $6,000 annually Local College/University Nursing, Physical Therapy & other healthcare educational programs Nursing Program Institut Catholique de Kabgayi (ICK) Rwanda. $1,500 annually.	**FY'26** **New partnership with NEU & Prima CARE accelerated BSN program.** **Student Preceptor Programs** **Shadow Program** **MHC Scholarships – 2027 launch** **Need-based ICK Scholarships (2)- global support for nursing education.**

Significant Health Need: Behavioral Health – Mental Health, Substance Use Disorder, Trauma, ACES Study – Access to Services			
Strategies & Objectives Planned for Implementation	**Target Population (s)**	**SAH Resources/Community Partnerships(s) to Address Need**	**SAH Community Impact FY26 - Oct. 25 – Sept. 30 RED INK - Community Partners/Collaborations**
2.1 Maintain dedicated specialized behavioral health navigators (BHN) to provide assessment, resources, and referral to treatment for Emergency Department patients and inpatients with mental illness and/or substance use disorder. SAH facilitates & documents referrals to community-based behavioral health providers, including ACO eligible members and ACO community-based case managers to improve compliance with after discharge community-based care. Long-term goal to develop a "***HELP***" Hub in the ED- ***Health Equity by Listening to our Patients*** – a resource hub for behavioral health care and/or health-related social needs (HRSN) of our patients to facilitate referrals & rapid access to low-barrier BH/SUD clinics and open access case management services in community health centers and behavioral health providers. ***Impact – CY25 – Met all performance goals for the MassHealth Hospital Quality & Equity Incentive Program (HQEIP). The program focuses on reducing health outcome disparities for high-risk patient populations.***	Patients with behavioral health/mental health and/or substance use disorder often experience greater health disparities and stigma, including patients who are members of MassHealth ACOs.	SAH BHN, MD's & Mid-levels ACO Case Managers Child & Family Services Open Access, 24/7 Crisis Center & Mobile Crisis Van HealthFirst Family Care Center SSTAR Family Care Center Connect/Protect Advisory Board Other BH Community Providers Area Non-profit Human Service Agencies	**PIP1 – MOUs with Revere Medicaid Care Network Contracted Community Partners – CCBC, FSA and Community Care Partners** **CCP- HQEIP PY3 – Performance Indicator FUH-7 days.** **DOJ "Connect to Protect" Project – FY2026, year 2 Implementation.** Target FY'27 "***HELP***" Hub in the ED- ***Health Equity by Listening to our Patients*** – a resource hub for behavioral health care and/or health-related social needs (HRSN) (2027-2028)

2.2 Re -hire for the Certified Addiction Nurse (CARN) role to provide consultations to patients with substance use disorder (SUD) including alcohol both in the ED and inpatient units. SAH launched the CARN program in Jan. 2015. The position has been vacant since March 18, 2022. CARN also does direct street outreach in collaboration with community partners to provide harm reduction and support to treatment. **/mpact: Jan. 2015 – March 2022 provided substance use disorder (SUD) consults and discharge planning to over 900 patients with SUD. Provided in-person & virtual training in caring for patients with SUD and the de-stigmatization of SUD to over 1,000 health care providers including nursing students and faculty**. ***One of the first acute care***	Patients with substance use disorder often experience greater health disparities and stigma, including patients who are members of MassHealth ACOs.	Dedicated Certified Addiction Nurse (CARN) SSTAR Mobile Health Unit, Seven Hills Behavioral Health, Peer2Peer and Thrive, FIRST Step Inn, Fall River PD and the Fall River Department of Health & Human Services Child & Family Services Crisis Center & Mobile Crisis Van & Open Access	**FY2027-2028 timeframe – if approved**

hospitals to support the CARN role (2014).			
2.3 Re-establish agreement with Steppingstone's Peer2Peer Recovery Project to resume access to Recovery Coaches for patients with substance use disorder. SAH Community Benefits funds an Outreach & Engagement session between the patient and Recovery Coach prior to program enrollment to expose patient to "hope at the bedside" through Peer Recovery support. The program was launched in Jan. 2018 and paused in April 2023, due to non-payment issues and eventual Steward bankruptcy. ***Impact: Jan 18, 2018- April 1, 2023, 571 patients with SUD were connected to recovery coaching services. Several patient testimonials attribute their personal survival to the program***.	Patients with substance use disorders often experience greater health disparities and stigma.	SAH Clinical Staff Steppingstone Inc. Peer-to-Peer Recovery Coach Program	**FY'26 - 3rd Qtr. Start Program Proposal & documents submitted via Workday Strategic Solutions 1-28-26, pending assignment to a BUH procurement specialist.**
2.4 Reduce overdose and overdose fatalities by providing access to free Narcan, an overdose reversal drug to patients and family members of patients at risk of overdose. **I*mpact: CY25 reduced preventable deaths due to overdose.***	Patients with SUD who are at high risk for overdose often experience greater health disparities and stigma.	SAH ED Clinicians The FAST Team MA Department of Public Health	**2026 - 2028** **The State supplied nasal Narcan continues in FY'26. Two doses dispensed in Oct/Nov. '25. The average per month is 4-6 doses per Brian Spadaro Chief Pharmacist.**
2.5 Continue to be the partnering hospital with the Fall River Fire Department's "***Safe Stations"*** program, developed to expand access to treatment, program allows individuals with SUD to present at any of the City's 6 Fire Stations and receive immediate access to services. ***Impact: divert medically cleared individuals from acute EDs with direct admission to treatment facilities for SUD.***	Patients with substance use disorder often experience greater health disparities and	SAH ED Clinicians, FRFD/EMS, Steppingstone Peer Recovery Program, SSTAR, FAST Team	**2026-2028** **SAH program founding member.**
2.6 Continue SAH representation on the Advisory Board for the Department of Justice (DOJ) 3- year grant "***Connect to Protect"*** awarded to the City of Fall River in 2025, to address the complex needs of individuals who are homeless and have chronic health diseases and health-related social needs through a coordinated and collaborative approach from the City's many health and human services providers. 2025 marked the planning year with 2026 and 2027 the intervention implementation period. ***Impact: CY 25 SAH asked to join Connect to Protect Project Advisory Board***	Patients with behavioral health/mental health and/or substance use disorder often experience greater health disparities and stigma	SAH BHN, MD's & Mid-levels FRFD/EMS, Steppingstone Peer Recovery Program, SSTAR, City of Fall River FAST Team, Child & Family Services Open Access, 24/7 Crisis Center & Mobile Crisis Van, other BH Community Providers and area Non-profit Human Service Agencies	**FY'25** **SAH joined Advisory Board** **FY'26 Goal to get MOU with Connect to Protect through BUH procurement and legal. Working on getting buy-in from SAH ED leadership.** **FY'27 show reduction in the involvement of law enforcement with patients/community members with SUD & MH.**

Significant Health Need: Health- Related Social Needs (HRSN)/Social Drivers of Health (SDoH) - Housing Insecurity – Homelessness, Food/Nutrition Insecurity – Poverty – Education – Employment – Social Supports – Green Spaces –Built Environment			
Strategies & Objectives Planned for Implementation	**Target Population (s)**	**SAH Resources/Community Partnerships(s) to Address Need**	**SAH Community Impact – FY26- Oct. 25 – Sept. 30 RED INK- Community Partners/Collaborations**
3.1 Screen all SAH patients for HRSNs and provide need-specific assistance, including referrals to community-based services and resources (e.g. copy of the Greater Fall River Resource Guide in preferred language – English, Spanish, Portuguese, Haitian-Creole). **Impact: CY25 -Universal Screening of patients for health-related social needs (HRSNs). 99% compliance rate.**	Populations who often experience greater health disparities, including people from historically disadvantaged racial and ethnic populations, patients with lower incomes; patients with Limited English Proficiency (LEP)/English as a Second Language (ESL), patients with behavioral health/mental health & substance use disorder and stigma, including patients who are members of MassHealth ACOs.	SAH Clinical staff, United Neighbors of Greater Fall River, other Community-based health care providers and human service organizations. Affiliated ACOs MassHealth Health Equity Team	**Universal Screening of patients for health-related social needs (HRSNs)** **Address patients' self-reported HRSNs with targeted resources** **Stratify HRSNs by patients' self-reported socio-demographics to identify trends in health disparities improved by EPIC.** **Patients who self-report race as Black or Other disproportionately experience health disparities:** **Food Insecurity at 15 % versus Whites at 6%** **Medicaid members at 12%** **Housing Insecurity at 12% versus Whites at 4%** **Medicaid members at 8%** **Transportation Insecurity at 21% versus Whites at 6%** **Medicaid members at 12%** ***See attached PP***
3.2 Pilot a medical respite program in collaboration with a community health care center for patients who are homeless and waiting in the ED for placement in an appropriate residential or partial program. Reduce BH boarding in the ED. Connect medically cleared BH patients to BH services in a more	Patients with behavioral health/mental health and/or substance use disorder who are medically cleared to discharge but boarding in the ED	SAH ED Clinical Team Community Health Center Health Insurance Providers	**Long-term goal - target 2028**

coordinated and timely manner Improve patient and family experience of care in the ED.			
3.3 Continue collaboration with United Neighbors of Greater Fall River (UNGFR) since 2018 to provide printed color copies of the Greater Fall River Resource Guide (The Guide). The Guide, printed in English, Spanish, Portuguese, and Haitian/Creole provides a list of resources in the community to assist with basic needs, including a complete listing of local food pantries, soup kitchens, and agencies that provide services for mental health and addiction issues. The guides are updated regularly by United Neighbors, with the date of revision on the front cover. UN maintains an on-line version, updated in real-time. The link to the online version is on our website. Saint Anne's Hospital prints large quantities of the guides for use by the City of Fall River, the Fall River schools (public and private, local non-profits, and health care providers, including Saint Anne's Hospital, for assisting patients and family members with their health-related social needs.	Under-served, un-insured, or under-insured individuals. At-risk populations who experience greater health disparities.	SAH Print Shop SAH Clinical Team United Neighbors of Greater Fall River (UNGFR) Fall River Public Schools Community Partner Agencies	**Guides updated Sept. 2025** **SAH provides in-kind printing support** **Ongoing in FY26 - 2028**
4.1 Support improved Food/Nutrition Security through access to local community food pantries that provide clients with healthy, fresh, non-processed food. ***Impact: CY'25 Greater Fall River Community Food Pantry provided access to <u>healthy</u> foods for over 6,913 Food Insecure households.***	Individuals/families experiencing Food/Nutrition Insecurity.	The Greater Fall River Community Food Pantry (GFRCPF) The Boston Food Bank	**Ongoing FY26** **Oct. '25 - $1,550.64** **Nov '25 - $1,500.00** **Dec. '25 - $1,576.00** **GFRCFP was presented with an award by DPH for healthy food choices.**
4.2Host on-site Community Farmers Market that accepts MA Healthy Incentive Program (HIP)/Supplemental Nutrition Assistance Program (SNAP) benefits and Farmers Market Nutrition Coupons (FMNC) for seniors, and Women, Infants & Children (WIC) program. ***Access to Healthy Food = Access to Health Care*** ***Impact: CY25 – 85% of all market sales made using SNAP/HIP or other entitlement benefits*** ***Season 8 will open June 9, 2026***	Individuals/families experiencing Food/Nutrition Insecurity.	SAH (host-site –Tues.) Lane Gardens & C&M Farms Southeastern MA Agricultural Partnership (SEMAP) Mass in Motion Fall River City of Fall River Council on Aging (COA) HealthFirst Family Care Center (host site –Wed.) Fall River Housing Authority (FRHA) (host site –Fri.) MassHealth Member Benefits	**Planning for FY'26 - 8th season** **Marcia Picard reported Fall River recognized by the CLF for innovative Farmers Market wellness programming by having volunteers with lived experience educate market customers about HIP benefits –SNAP recipients auto-eligible**
Significant Health Need: Chronic Disease Management -Wellness -Community-based Health Education			

Strategies & Objectives Planned for Implementation	Target Population (s)	SAH Resources/Community Partnerships(s) to Address Need	SAH Community Impact FY26- Oct. 25- Sept. 30 RED INK- Community Partners/Collaborations
5.1 5th year in a row awarded to lead the region's **Stroke Public Awareness Collaboration Project,** including educating on the signs and symptoms of stroke, and teaching individuals how to monitor their own blood pressure (BP) and providing free blood pressure cuffs to risk-eligible individuals. ***Impact: CY25 provided stroke prevention education to 2,400 community members including teaching blood pressure self-monitoring skills; distributed 608 free BP monitors to risk eligible.***	Populations who often have lower screening rates, lower levels of health literacy and medication compliance, and/or experience greater health disparities.	SAH – lead organization Fall River Emergency Medical Services (EMS) - partnering organization Juneteenth Planning Committee Fall River Housing Authority FIRST STEP Inn Homeless Shelter Veterans Association of Bristol County (VABC) Other community organizations	**Continuing in FY26 – looking to target Hispanic/Latinx population in 2026 – looking for collaborators**
5.2 Deliver community education on "***Stop the Bleed***" a program to teach bystanders how to save lives until First Responders. ***Impact: CY25 provided lifesaving "Stop the Bleed" education to over 275 community members, including at high school wellness fairs.***	Individual (s) suffering traumatic injury in non-clinical settings	Paramedic/Clinician certified "***Stop the Bleed"*** trainer. Non-clinical bystanders Fall River EMS	**Continuing in FY26 in collaboration with Fall River EMS outreach education.**
5.3 Continue offering free skin cancer screenings and provide educational materials about skin cancer translated into Spanish & Portuguese. Close disparities in skin cancer screening rates by race & ethnicity and increase early diagnosis and treatment of melanomas. ***Impact: CY25 sponsored a free skin cancer screening with a board-certified dermatologist at the Hudner Oncology Center on June 17, 2025. This screening event is a visual screening designed to examine specific areas of concern; 35 individuals screened, and 8 (23%) were referred for further follow-up care.***	Populations who often have lower screening rates and/or experience greater health disparities.	Oncology/Cancer Registry staff Board Certified Dermatologist	**Planning skin screenings for spring and fall FY 2026**
5.4 Participate in community events to promote health & wellness and chronic disease management with focus on the importance of healthy eating/nutrition on optimizing health outcomes for spine/neurological, orthopedic and/or general surgery and for maintaining overall good health. ***Impact – CY25- participated in over 250 community events, highlighting wellness, safety and health promotion, health care training and career education, chronic disease prevention and management, community health concerns, non-profit fundraising events to support community – based programs and basic needs. SAH leaders serving on local non-profits boards and other opportunities to volunteer in service to the***	Populations who often have lower screening rates, engage in risky or unhealthy behaviors, have poor or unhealthy eating habits causing malnutrition & obesity, have lower levels of health literacy and/or experience greater health disparities.	SAH Clinical Staff Community Partners Fall River Public Schools Brown University Health Community Health Institute	**Ongoing in FY2026/ Seek Partners input** **Sponsoring & participant in the 3rd annual community –wide *Spring into Wellness*, March 28th, Fonseca Elementary School Fall River (M. Picard).** **Sponsor & participant at HealthFirst Care Center's 2nd annual May 9 "Fashion, Food,**

community.			**Cultural Fusion – featuring SAH 120th anniversary (Fanny).**

Saint Anne's Hospital Brown University Health Community Benefits Advisory Committee (CBAC)

*****Brittany Lynch, LICSW, Director, Transitions in Care/Social Work, Saint Anne's Hospital
*Patty Pfeiffer, Quality Director, Saint Anne's Hospital
Destinee Barnes, Project Director, Peer2Peer Recovery Project, Steppingstone Incorporated
Joseph Botelho, Project Manager, Peer2Peer Recovery Project, Steppingstone Incorporated
Shannon Rooney, Administrative Assistant, Peer2Peer Recovery, Project, Steppingstone Incorporated
*****Carole Billington, MSN, RN, NEA-BC, President/Chief Nursing Officer, Saint Anne's Hospital
*****Lisa Blanchette, Director, Revenue Cycle, Saint Anne's Hospital
Lisa DeMello Martin, MSN, RN, ACNS-BC, Clinical Nurse Specialist/Stroke Coordinator, Saint Anne's Hospital
*****Marcia Picard, Executive Director and School Wellness Coordinator, Greater Fall River Partners for a Healthier Community (CHNA25)
Marin Woods, RD, LDN, Clinical Nutrition Manager, Saint Anne's Hospital
*Maeghan Quinlan RD, LDN, Clinical Dietitian, Saint Anne's Hospital
*Tracy (Teresa) Ibbotson, M.Ed., Administrative Director, Community Health Benefits, Saint Anne's Hospital
Deborah Avila-Carreiro, Nutrition Services Manager, Bristol Aging & Wellness
*****Naomi Patricio, Supervisor, Health Insurance Specialists, Saint Anne's Hospital
Kyla Farias, Coordinator, Education & Outreach Prevention, Bristol County Children's Advocacy Center, a program of JRI
*****Jessica Stone, Grant Writer and Community Liaison, Southeast Center for Independent Living
*****Denise Paulson, CMI, Manager, Interpreter Services, Saint Anne's Hospital
Sister Glorina Jugo, OP, Member, SAH Community Board of Directors; Director, Spiritual Care; Chair, Mission Committee, Saint Anne's Hospital
Fanny Tchorz, Director of Interpreter Services, Health First Family Care Center
*****Mary-Lou Mancini, Member, SAH Community Board of Directors; Community Member and Liaison to the Patient and Family Advisory Council (PFAC), Saint Anne's Hospital
Nikki Fontaine, Director of Outreach Services, City of Fall River
Lynn Iadicola, Volunteer Partners for a Healthier Community Substance Addiction Task Force, and Community Representative
Barbara Beckmann, Director of Clinical Programs, Child & Family Services, Fall River
Sonia Mancini, Asst. Director of Clinical Programs, Child & Family Services, Fall River
David Perry, President, Greater Fall River Community Food Pantry
Rachael Sirois, Resource Development Director, Boys and Girls Club of Fall River
*Tia Castellano, Director/CEO, Bristol Black Collective, Fall River
Patty Armstrong, Resource Development Director, United Way of Greater Fall River
*****Laura Bradley, CEO/President, Thrive for Humanity
*****Tracy Albernaz, Community Organizer, United Interfaith Action (UIA) of Southeastern MA
*Alan Oliver, Driver, Oncology Services, Saint Anne's Hospital, Volunteer Member of UIA

***Member of the Hospital Health Equity Committee (HEC) - a chartered working sub-committee of the CBAC, focused on reducing health disparities within the SAH patient population.**

Conclusion

This Saint Anne's Hospital Brown University Implementation Strategic Plan will be reviewed for approval by Brown University Health Board of Trustees Feb. 2026.
SAH will submit a copy of this Implementation Strategy with its 2025 Community Benefits report to the MA AGO April 1, 2026.

SAH will document progress on the implementation strategies presented as part of its commitment to the community it serves each year in its Form 990 tax return filings as required by the IRS.

For any questions contact:
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Appendices:

1.5*Appendix A: Oncology transportation assistance for medical appointments by city/town and by # rides and # patients (10-1-25 through 12-31-25)

City/Town	Number of Rides	Number of Patients
Bourne	6	1
FAIRHAVEN	2	1
FALL RIVER	66	16
NEW BEDFORD	77	11
SOUTH DARTMOUTH	2	1
SWANSEA	53	4
TAUNTON	1	1

1.6*Appendix B – Mass 211 Lyft Program- Results of Direct Research by Tracy Gerety –Ibbotson 1-8-26

In follow up to the discussion at the CBAC meeting 1-7-26, I did direct research on the Mass 211 Lyft Free Ride Program and below outlines what I experienced and learned:

- Dialing 211 connected me to an automated response welcoming me to "Mass 211 - a program of your local United Way"
- Then I had language options, #1-English, #2- Spanish, #3- all other languages
- Then I was given a list of extensions by topic/issue of concern –resources for given for specific need
    - Press 27 - Housing & Utilities Payment Assistance
    - **Press 28 - Transportation**

- Press 23 - Child Care
- Press 24 - BH for Children/Adolescents
- Press 25 - "Just to Talk" Suicide Prevention
- Press 33 - Mental Health /Substance Use
- Press 20 - Emergency Preparedness/Storm Information
- Press 21 - For a Mass 211- Staff Member

Only Fall River or New Bedford residents are eligible for the program

- Fall River residents can receive RT service to an appt outside of FR (within a certain radius of FR).
- Mass 211 call line is open, M-F, 7 am - 4 pm. FR/NB resident can call 2 days before a scheduled appointment on a Sat or Sun to reserve RT transportation.
- The program is designed to be a short-term solution - residents are only allowed for 3 RT rides or up to 5 One Way rides (exceptions can sometimes be made)
- Program is operational, usage is monitored by call in phone# - usage is monitored closely
- Rides allowed for medical & non-medical appointments (e.g., job interviews, care management appointments, food pantries, grocery stores, pharmacy, etc.)