Hospital-Initiated Objectives

Mercy Springfield

Process for determining initiatives

Upon identification of the Community Health Needs Assessment priorities, Mercy Springfield began working through its Community Benefit Oversight Committee to identify an initial implementation plan for each priority. This committee had a strategic planning meeting to review current community benefit programs and to look at potential new programs. Subgroups were created with Mercy and community partners to work on implementation plans for the identified priorities. These subgroups are currently working to develop metrics and evaluation tools for the implementation plans. Partners include schools, other health care facilities, businesses, and others.

Current internal and community resources are also under review with the primary assets under consideration being existing programs, community partnerships, other health care facilities in the community, engaged schools, businesses, faith communities, and nonprofit organization support. Focus on disproportionate unmet needs, primary prevention strategies, advancement toward a continuum of care and programs that are collaborative.

Initiative Summary

Icon	Initiative
Heart	Increase the number of uninsured patients who are managing their adult hypertension by 20%
Heart	Increase the number of Cardiac Rehab referrals by 10% of individuals that are at risk of developing heart disease
Heart	Increase the number of co-workers who are enrolled in Health and Wellness Connection from 700 participants to 1500 participants and add one additional location.
Heart, Lungs	Increase the number of women who breastfeed their infant after delivery from 59% to 70%
Lungs	Increase the number of Pulmonary Rehab referrals by 10% of individuals that have mild or undiagnosed lung disease.
Lungs	Increase the number of referrals of high risk patients to the low dose CT scan for prescreening of lung cancer by 25%
Lungs	Reduce the rate of patients with a COPD diagnosis readmission from 20% to 8%
Head	Improve education to the community regarding chemical dependency and mental illness by increasing support group participation by 5%.
Head	Improve access to mental health education and services through behavioral health clinic services as evidenced by a 10% increase in referrals by PCP’s.
Head	Improve community collaborative relationships with Burrell and other resources to ensure persons with behavioral health needs are admitted to appropriate level of care and decrease readmission into the hospital within 30 day by 2%.
Head	Increase the number of children evaluated for autism through The Diagnostic Autism Clinic by 10%

Mercy Springfield Initiatives

	Increase the number of uninsured patients who are managing their adult hypertension by 20%
Summary	Uninsured patients, who present in the Emergency Department, often have high blood pressure that is untreated. To address this, Mercy will refer uninsured patients that have a primary or secondary diagnosis of Hypertension/High blood pressure to the MSU Care clinic to get the treatment and medication they need.
Best Practice	https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/evidence-reaffirmation-us-preventive-services-task

	Increase the number of Cardiac Rehab referrals by 10% of individuals that are at risk of developing heart disease.
Summary	Patients who come into the hospital for various diagnoses have risk factors for heart disease, including hypertension, obesity, diabetes, high cholesterol, tobacco use, sedentary lifestyle and familial history. Mercy will refer these patients to Cardiac Rehab Phase 3 for exercise and management of risk factors, which could include referrals to diabetes education, tobacco cessation and/or nutrition consults. By doing this, we could prevent many patients from ever developing heart disease.
Best Practice	https://www.healthypeople.gov/2020/healthy-people-in- action/story/colorado-heart-healthy-solutions-program-reduces-risk-factors

	Increase the number of co-workers who are enrolled in Health and Wellness Connection from 700 participants to 1500 participants and add one additional location.
Summary	An individualized, comprehensive free program is designed for co- workers who want actionable change and may need assistance on achieving their health and wellness goals. Co-workers may register for the program by completing a complementary biometric screening and a functional movement screening. Program training sessions will be schedule based on co-worker availability and coaches will hold clients accountable to their goals through regular follow-up.
Best Practice	https://www.cdc.gov/physicalactivity/basics/pa-health/index.htm#ReduceCardiovascularDisease

	Increase the number of women who breastfeed their infant after delivery from 59% to 70%
Summary	Breastfeeding is proven to not only reduce the incidence of asthma and allergies in children, but also reduce hypertension and heart disease in women. Mercy will increase efforts to encourage new mothers to breastfeed through referrals and education.
Best Practice	http://onlinelibrary.wiley.com/doi/10.1111/1552-6909.12530/full

	Increase the number of Pulmonary Rehab referrals by 10% of individuals that have mild or undiagnosed lung disease.	
	Summary	Patients who come into the hospital for various diagnoses have mild or undiagnosed lung disease. Mercy will refer these patients to pulmonary rehab for exercise and management of risk factors, which could include referrals to diabetes education, tobacco cessation and/or nutrition consults. By doing this, we could prevent many patients from developing more severe lung disease.
	Best Practice	http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3213715/

	Increase the number of referrals of high risk patients to the low dose CT scan for prescreening of lung cancer by 25%	
	Summary	High-risk Medicare patients between the ages of 55-77 who have smoked 30 packs a year or greater and are current smokers, or have quit in the last 15 years and have no symptoms at all are qualified for the Mercy High Risk Screening Clinic. The patient will receive counseling from a Nurse Practitioner and receive smoking cessation education if they are current smokers. They will then receive a low dose CT scan to determine if there is any lung disease present. Those that present with lung disease are referred to a pulmonologist and those that are not are invited back for another scan in 12 months. The purpose is twofold: smoking cessation education for those patients that are current smokers and also identifying lung disease in the early stages while it is still treatable.
	Best Practice	

	Reduce the rate of patients with a COPD diagnosis readmission from 20% to 8%	
	Summary	In order for COPD patients to have the best possible outcomes, it is imperative they follow discharge instructions. However, it can be difficult to follow these instructions after leaving the hospital. This initiative provides follow up for at least 30 days with the patient so that Care Managers can monitor their health and help them continue to improve so that the patient does not relapse.
	Best Practice	https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228766331358

	Improve education to the community regarding chemical dependency and mental illness by increasing support group participation by 5%.	
	Summary	Of Mercy Springfield's patient population, 60% have a dual diagnosis of Mental illness and substance abuse which indicates a need for education and improved self-management as evidenced by current participation in addiction recovery groups are 15 clients.
	Best Practice	https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-5

	Improve access to mental health education and services through behavioral health clinic services as evidenced by a 10% increase in referrals by PCP's.
Summary	When a patient presents at their PCP and mentions having a mental health issue, this new process implemented through Mercy will allow the PCP to respond quickly and efficiently by referring that patient to the intake team, who will assist getting the patient to appropriate mental health care.
Best Practice	https://pcmh.ahrq.gov/page/integrating-mental-health-treatment-patient-centered-medical-home

	Improve community collaborative relationships with Burrell and other resources to ensure persons with behavioral health needs are admitted to appropriate level of care and decrease readmission into the hospital within 30 day by 2%.
Summary	Many people with mental and behavioral health needs are admitted to the emergency department recurrently. To reduce the likelihood that patients will return due to mental health needs, Mercy will work collaboratively with Burrell and other community partners to improve the continuity of care and access to care for the mentally ill.. A Burrell partner, strategically placed in the Emergency room, will provide community resources immediately to mental health patients and assist them with getting basic and mental health needs met through community partners.
Best Practice	http://www.thecommunityguide.org/mentalhealth/collab-care.html

	Increase the number of children evaluated for autism through The Diagnostic Autism Clinic by 10%
Summary	The Diagnostic Autism Clinic is a shared community venture between Mercy, Missouri State University and the Arc of the Ozarks. It serves Mercy referred patients and consists of a multi-disciplinary team that provides an initial assessment to determine diagnosis and assist the families with making contact with appropriate community resources. This is a much underserved population that previously had required travel away from southwest Missouri for this specialized care which was a financial burden/barrier for most of these families (which are largely comprised of Missouri Medicaid patients- roughly 75%).
Best Practice	http://link.springer.com/article/10.1023/A:1010738829569