

**MERCY HOSPITAL JOPLIN**  
**Community Health Improvement Plan (CHIP)**  
**2016 – 2019**

An IRS-mandated Community Health Needs Assessment (CHNA) was recently completed for each hospital within the Mercy Joplin Community:

- Mercy Hospital Joplin
- Mercy Hospital Carthage
- Mercy Hospital Columbus

The CHNA reports for each hospital may be accessed at:

<https://www.mercy.net/about/community-benefits>.

Upon completion of these assessments, the IRS requires hospitals to implement a three-year plan to improve the community's health through strategies that address a significant community health need, as identified through the CHNA. The Community Health Improvement Plan (CHIP) must:

1. Describe the actions that the hospital intends to take to address the health need, the anticipated impact of these actions, and the plan to evaluate such impact
2. Identify the programs and resources that the hospital plans to commit to address the health need
3. Describe any planned collaboration between the hospital and other agencies in addressing the health need.

The following pages represent the CHIP for Mercy Hospital Joplin. The health needs that have been prioritized in this CHIP are:

- Diabetes Self-Management
- Access to Care
  - Teen Pregnancy
  - School Based Health Clinics

The Community Benefit Subcommittee for Mercy Hospital Joplin will oversee the Community Health Improvement Plan and monitor its progress.

**Mercy Hospital Joplin  
Community Health Improvement Plan (CHIP)**

**PRIORITY AREA/COMMUNITY NEED: Diabetes Self-Management**

**Narrative:** Provide chronic disease self-management and support for those with diabetes mellitus type 1 or type 2, who are 18 and older, and are underinsured or uninsured in the Joplin community and surrounding area.

**Leaders/Departments/Community Partners involved:** Dr. Gretchen Shull, Dani Hawkins, and Mercy Health Foundation

**Goal #1:** Improve access to health care and provide chronic disease self-management to our target population by using multidisciplinary teams to address all key functions of diabetes, facilitate integration of chronic care management into the organization's usual system of care, and create a system that provides a patient centered model.

**Objective #1:** The Mercy Diabetes Community Collaborative (MDCC) will provide care to the uninsured and underinsured that will result in improvements in HbA1c, blood pressure, and LDL levels.

- Activity/Program: Care management program for persons with a primary or secondary diagnosis of diabetes, and for persons with diabetes and a co-occurring chronic illness.
- Activity/Program: Conduct quarterly team meetings with care managers
- Activity/Program: Increase access by working with coworkers who are actively engaged in the community. Strong relationships with Mercy Health Foundation and Community Benefit leaders, will help raise community awareness of Mercy Diabetes services.

**Objective #2:** Provide a Diabetes Bridge Clinic that is nurse managed, protocol-based, physician supervised model of outpatient care that will reduce admissions/readmissions and emergency services utilization.

- Activity/Program: Coordinate patients from an inpatient or emergency department setting, to a clinic setting within five days of the encounter.
- Activity/Program: Increase educational opportunities for those that are limited by financial/insurance reasons or time constraints.

**Objective #3:** Create an Inpatient Hyperglycemia Diabetes Team

- Activity/Program: Create an Inpatient Glucose Rounding Team and Glucose Management Committee.
- Activity/Program: Provide coordination of care and support to engage patients, families, and their health providers.

**Objective #4:** Create Diabetes Ambassadors through primary care.

- Activity/Program: Education and intensive training to be provided by Endocrinologist and diabetes expert nurses and dieticians to APP's or nurses that work in primary care settings.

**Evaluation Plan for Goal:** Initially, the diabetes program will determine potential cost savings of the program. Then, a continual effort will be made on a quarterly to semi-annual basis to review progress and outcomes.

- **Outputs:**
  - Decrease length of inpatient stay
  - Reduce hypoglycemia
  - Reduce preventable hyperglycemia
  - Increased completed health exams (specifically – eye, foot, and dental)
  - Direct patients to appropriate screenings
  - Provide appropriate, expanded educational opportunities and classes
  - Provide better resources to those of diverse backgrounds
- **Short-term Outcomes:** Through the work of this collaboration, patients will have the necessary resources to better manage their diabetes. This collaboration will result in improved patient satisfaction and patient perception of teamwork.
- **Long-Term Outcomes:** By identifying this community need and providing a community collaboration, our long-term outcome would be:
  - 40% of patient's quitting or attempt to quit smoking
  - 80% of the population with annual foot exams
  - 40% with annual eye exams
  - reduce readmissions by > 50%
  - Reduce A1c by 1% or greater
  - 50% of the population with urine microalbumin screening completed

## **PRIORITY AREA/COMMUNITY NEED: Access to Health Care - Teen Pregnancy**

**Narrative:** Provide clinical and educational support for maternal child health, specifically targeting teen pregnancy. Support would be for those that are underinsured or uninsured in the Joplin community and surrounding area.

**Leaders/Departments/Community Partners involved:** Life Choices, Mercy Hospital Carthage, Mercy Hospital Joplin, and Mercy Health Foundation

**Goal #1:** Improve access to health care and provide clinical care to our partner organizations by using multidisciplinary teams to address community needs for teen pregnancy.

**Objective #1:** Create a system of care management that provides a patient centered approach to...

- Activity/Program: Through the Choices Medical Services: Provide medically accurate access for the community clinic experiencing an unplanned pregnancy.
  - Have Choices Clinic open three days a week
- Activity/Program: Offer free Clinic services with pregnancy testing, ultrasound verification, early prenatal intervention and easily diagnose and treat for Gonorrhea and Chlamydia screen.
  - Three days a week access with a need to consider increasing to five days a week for this service.
- Activity/Program: Provide early intervention OB consultation by Mercy
- Activity/Program: Assist and encourage area patients to understand prenatal care can be maintained in Carthage until Birth and then go to Mercy.
  - Marketing to show care is in Carthage but birthing will be in Joplin.
- Make sure that Hispanic care providers are present to assist with language and cultural issues.
  - Coordinate to have Hispanic translators to facilitate good communication and advertising.
- Consider Mobile Unit use for social norming sexual health services.

**Objective #2:** Provide a system of care that provides a patient centered approach that results in lifestyle behavior and choice improvements

- Activity/Program: Continue LifeChoices Compass program in area school districts for 7th, 8th, and 9th grades.
- Activity/Program: New Project ID will be piloted in Carthage for the first time ever in 2017 for 5th and 6th graders.
- Activity/Program: Parental classes from the clinic work to increase choice improvement moving forward.

**Evaluation Plan for Goal:** Mercy Joplin will continue the partnership with LifeChoices to determine potential investments of the program and services. Mercy Joplin is currently adding professional staff to support these goals and efforts to increase access. Then, a continual effort will be made on a quarterly to semi-annual basis to review progress and outcomes.

- **Outputs:**
  - Reduce patient costs due to emergency department visits
  - Reduce preventable sexually transmitted infections through education
  - Increased health exams
  - Direct patients to appropriate screenings and health care providers
  - Provide appropriate, expanded educational opportunities to local school districts
  - Provide better resources to those of diverse backgrounds
- **Short-term Outcomes:** Through the work of this collaboration, patients will have the necessary resources to better manage and seek treatment for their health concerns. This collaboration will result in improved patient satisfaction and increase access to health care, independent of cultural and socio-economic barriers.
- **Long-Term Outcomes:** By identifying this community need and providing a community collaboration with LifeChoices, our long-term outcome would be:
  - Increased rates of school completion or graduation
  - Reduced rates of pregnancy and childbearing among participants
  - Increase support during all phases of prevention
  - Increase community participation and collaboration through program planning and review
  - Provide better comprehensive intervention programs through education

**PRIORITY AREA/COMMUNITY NEED: Access to Health Care – School Based Health Clinics**

**Narrative:** Increase access to health care through school based health clinics.

**Leaders/Departments/Community Partners involved:** Aaron Lewis, Rachael Ferguson, PA., Russell Kennedy, DO., and Dr. Tracy Godfrey

**Goal #1:** Improve access to health care and provide clinical care to the local school districts.

**Objective #1:** Provide quality care to faculty, staff, students, and immediate family members of the school district.

- Activity/Program: Provide health and wellness education to the school district
- Activity/Program: Provide necessary vaccines to students
- Activity/Program: Create wellness programs to incentivize faculty and staff of the district to lead a healthy lifestyle

**Objective #2:** Provide occupational medicine services to the school district.

- Activity/Program: Educate and certify current personnel to appropriately perform testing.
- Activity/Program: Provide school district with cost saving prices for occupational medicine services

**Objective #3:** Create marketing campaign at the beginning of each school year to promote services to local stakeholders.

- Activity/Program: Work with Mercy marketing and communications to develop strategic plan for outreach
- Activity/Program: Provide patient resources in the patient's culture, language and literacy context.

**Objective #4:** Provide telemedicine services for other school districts.

- Activity/Program: Actively promote the benefits of telemedicine to local school administrators.

**Evaluation Plan for Goal:** The Mercy school based medicine program will continue to build on its relationship with the Webb City School District. End of semester reviews will be necessary to track patient visits and compare those results to previous semesters. Those results will be vital for Mercy to share with other prospective clients.

It is the goal of Mercy to look at opportunities to grow this service, and it is vital to build relationships with local school districts. It is important for us to conduct meetings with local administrators to show the value of on-campus clinical health care. Meetings may be scheduled each semester or more frequently depending on the desire of the particular school district.

- **Outputs:**
  - Increase access to care for faculty/staff/students
  - Reduce staff sick days
  - Increase student attendance
  - Increased annual wellness exams for district staff
  - Direct patients to appropriate primary care physicians
  - Provide appropriate educational opportunities and classes for the district
  - Provide better health care access to those of diverse backgrounds
  
- **Short-term Outcomes:** Convenience of care is our quickest win for any school we may partner with. We have found that teachers, staff and students have saved a tremendous amount of time in receiving health care from an on-site clinic. A decrease in vacation hours being used to go see a doctor is an immediate result.
  
- **Long-Term Outcomes:** By identifying this community need and providing a school based health clinic, our long-term outcome would be:
  - 20% increase in student attendance
  - 40% of the school district staff receive proper immunizations
  - Provide primary care for those with chronic illnesses
  - Significant decrease in annual insurance premiums
  - 20% decrease in over used vacation time by district staff
  - Maintain occupational medicine service for the school district
  - Provide behavioral health services through the clinic or by telemedicine

## Other Identified Health Needs Not Being Addressed

Mercy Joplin identified the health needs established through the Community Health Needs Assessment, and determined that it was best to engage in programs and partnerships that already exist. During this cycle of the Community Health Improvement Plan, Mercy Joplin will not be addressing the following identified health needs:

- **Cardiovascular Disease:** Cardiovascular Disease is an identified need in our community, but there are many factors related to this disease that will be addressed through community collaborations. Mercy Joplin representatives are actively engaged in community collaborations that promote healthier lifestyles to fight this disease. Additionally, this disease will not be resolved as quickly as other health needs that are currently identified in this CHIP
- **Lung Disease:** Lung Disease is our second highest identified health need in our community, but there are many factors related to this disease that will be addressed through community collaborations. Mercy Joplin representatives are actively engaged in community collaborations that promote a tobacco free lifestyle to fight this disease. Additionally, this disease will not be resolved as quickly as other health needs that are currently identified in this CHIP
- **Mental Health:** Mental Health is our third highest identified health need in our community, determined by our CHNA, but there are many factors related to this health problem that will be addressed through community collaborations. Mercy Joplin representatives are actively engaged in community collaborations, such as the Community Health Coalition, that will be addressing this health need in current projects and implementation strategies. Additionally, this health issue will not be resolved as quickly as other health needs that are currently identified in this CHIP
- **Cancer:** Cancer is a significant health need in our community, but there are many factors related to this disease that will be addressed through our local hospital oncology departments and community collaborations. Mercy Joplin representatives are actively engaged in community collaborations that promoting healthier lifestyles that effect the various diseases of cancer. Mercy Columbus's Mobile Mammography Unit will continue to provide screenings in the Joplin community and look to new opportunities to reach those that are underserved or underinsured. Additionally, this disease will not be resolved as quickly as other health needs that are currently identified in this CHIP
- **Oral Health:** Oral health and access to oral health care providers are a significant need in our community. Due to lack of community resources and the lack of hospital expertise in caring for oral health problems, Mercy Joplin will not be addressing this health need.