Community Health Improvement Plan

Mercy Hospital South

Fiscal Year 2019 - 2021

Mercy

Your life is our life's work.

Our Mission:

As the Sisters of Mercy before us, we bring to life the healing ministry of Jesus through our compassionate care and exceptional service.

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I. Introduction

As part of the Patient Protection and Affordable Care Act (PPACA) passed in March 2010, every non-profit hospital is required to conduct a community-based needs assessment every three years. Mercy Hospital South (MHS) partnered to conduct a community health needs assessment (CHNA) and is developing a subsequent implementation plan with strategies to address identified needs.

Beginning in early 2017, Mercy Hospital South (formerly St. Anthony's) and Mercy Hospital St. Louis joined the **St. Louis Partnership for a Healthy Community (STLPHC)** which is comprised of a broad range of stakeholders from within the public health system and individual advocates who subscribe to a comprehensive definition of health. The membership of STLPHC was intended to represent the wide range of entities that impact health in the St. Louis region: it includes both the City of St. Louis Department of Health and the St. Louis County Department of Health, area hospital systems, government agencies/departments, coordinated care organizations, community-based organizations, academic institutions, and business partners in the City of St. Louis and St. Louis County.

The work of this partnership resulted in the **St. Louis Region Community Health Assessment and Community Health Improvement Plan** completed in August of 2018. Partnering on a needs assessment and joining the membership gave Mercy a chance to align efforts with community partners with the goal to eliminate duplication, prioritize needs and enable collaborative efforts. The resulting needs assessment was the main focus of establishing priorities set by Mercy Hospital South and its governing Community Health Council.

In addition, Mercy Hospital South collaborated with Barnes-Jewish West County Hospital (BJWCH), Missouri Baptist Medical Center (MBMC), St. Luke's Hospital (SLH), St. Luke's Des Peres Hospital (SLDPH), Mercy Hospital St. Louis (MHSL) and the St. Louis County Department of Health (STLDOH) on a Key Stakeholder analysis with community leaders in the summer of 2018.

The St. Louis Regional Community Health Assessment and Community Health Improvement Plan, along with the Key Stakeholder analysis done with hospital partners helped to identify and prioritize health problems and risk factors in the Mercy Hospital South service area. Mercy Hospital South identified three top-priority health needs for the Mercy Hospital South community. We will strive diligently to address these needs over the next three years:

Access to care

Behavioral Health/Substance Abuse

Chronic Disease Prevention & Management

II. Implementation Plan by Prioritized Health Need

Prioritized Need #1: Access to Care

Goal: Increase access to health care for uninsured and at-risk persons.

PROGRAM 1: **Community Health Worker Program**
PROGRAM DESCRIPTION: Community Health Workers (CHWs) serve as liaisons/links between health care and community and social services, screening for needs related to social determinants of health, and facilitating access to services and improving the quality and cultural competence of care. CHWs work one-on-one with at-risk patients and community members, acting as patient advocates, assisting patients in applying for Medicaid and financial assistance and connecting patients with community resources.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Identify uninsured and at-risk patients and community members in need of assistance in the emergency department, inpatient settings, community events, and using reports and dashboards. 2. Assist uninsured patients with applying for Mercy financial assistance and Medicaid programs or other relevant programs. 3. In coordination with the Community Resource Coordinator (CRC), assist patients without an established primary care provider in establishing care with a primary care clinic or provider. 4. Screen patients for needs related to social determinants of health and connect patients to community resources to meet identified needs. 5. Connect patients with other community resources, including medication resources, as needed.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. The CHW will conduct outreach or connect with 10 patients/encounters per week. ***Medium-Term Outcomes:*** 1. By the end of each fiscal year for the next three years, the CHW will enroll 50 patients in Mercy financial assistance and help facilitate 20 Medicaid applications. 2. The CHW will assist at least 50 patients per quarter with community and medication assistance resources. ***Long-Term Outcomes:*** 1. Patients enrolling in CHW program will demonstrate a 10% reduction in ED utilization and a 10% reduction in inpatient admissions. 2. Patients enrolling in CHW program will demonstrate a 10% reduction in their total bad debt.
PLAN TO EVALUATE THE IMPACT: 1. Track number of new and ongoing encounters conducted by each CHW. (Output) 2. Track number of patients successfully enrolled in Mercy financial assistance and the number of Medicaid applications initiated or completed. (Short-term) 3. Log number of patients referred to CRC to establish a primary care home. (Short-term)

4. Record number of patients receiving community resource and medication assistance. (Short-term)
5. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing CHW services. (Long-term)
6. Analyze pre- and post- intervention bad debt for cohort of patients utilizing CHW services. (Long-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Salary and benefits for full-time Community Health Worker.
2. Office space and indirect expenses dedicated to CHW work.

COLLABORATIVE PARTNERS:

1. HEAL Partnership

PROGRAM 2: Community Referral Coordinator (CRC) Program

PROGRAM DESCRIPTION:

The CRC Program uses Community Referral Coordinators to connect patients from inpatient units and/or emergency departments of hospital with a primary care home for follow-up and preventative care. The program focuses on serving underinsured and uninsured patients; however, works with all patients in need of a medical home. The program focuses on assessing each patient's individual needs, current resources and available options for outpatient medical care. CRCs partner with patients to establish primary care medical homes at Federally Qualified Health Centers or with independent Mercy providers. This program is supported by contracted services provided by the St. Louis Integrated Health Network (IHN). The IHN's Community Referral Coordinator (CRC) works full-time on-site at Mercy Hospital South (MHS), collaborating closely and in an integrated way with hospital staff including medical providers, Care Coordinators and Community Health Workers (CHWs).

ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. Identified patients (both in the Emergency Department and Inpatient Units) with NO PCP and a barrier to care, such as being uninsured or underinsured, receive CRC navigational supports to plan for outpatient care after discharge. This can include personalized referrals, appointment setting and assistance with exploring insurance options or financial assistance to obtain and maintain outpatient care.
2. CRC provides support for patients already established with a Federally Qualified Health Center to ensure coordinated outpatient care is received after discharge from the Emergency Department or Inpatient Unit.
3. For patients with identified social determinant of health needs, the CRC will connect patient with the Community Health Worker (CHW) or Crisis Nursery Family Empowerment Social Worker for further assistance.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. The CRC will engage 9-12 new patients per working day.
2. The CRC will maintain a 50% encounter to referral ratio.

Medium-Term Outcomes:

1. CRCs will track and report quarterly connection rates for all patients who were scheduled by the CRC. The goal for connection rate for the IHN CRC Program for 2019 is 56%.

Long-Term Outcomes:

1. Patients reached by the CRC program will demonstrate 10% reduced ED utilization and 10% reduced inpatient admissions.
2. Patients enrolling in CRC program will demonstrate a 10% reduction in their total bad debt.

PLAN TO EVALUATE THE IMPACT:

1. IHN will track patient encounters, both in the Emergency Department and on the inpatient side, as well as clients referred as family or friends of a patient. (Short-term, Output)
2. IHN will track the number of patients encountered with or without an established primary care home. (Short-term, Output)

3. IHN will track how many encounters resulted in a scheduled appointment, what types of appointments are scheduled (Primary Care, Specialty, Behavioral Health, etc.), and where appointments are made. (Short-term)
4. IHN will track how many appointments are kept by patients, and at which facilities. (Medium-term)
5. IHN will work in partnership with Mercy Decision Support to conduct a yearly analysis. IHN will provide a data set to Mercy Decision Support with 6 months of encounter data per Mercy site to measure utilization (ED and Inpatient) 6 months prior to the date of CRC encounter to 6 Months after. Financial impact of the change in utilization will also be computed in partnership with Mercy Finance Department. (Long-Term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Storage and work space and indirect expenses dedicated to supporting the work of the Community Referral Coordinator.
2. Contract / significant resource investment by the hospital

COLLABORATIVE PARTNERS:

1. Integrated Health Network (IHN)

PROGRAM 3: Health Leads

PROGRAM DESCRIPTION:

Health Leads is a national health care organization that connect low-income patients with the resources they need to be healthy. Staff at Mercy Clinics utilize the Health Leads platform to utilize a screening tool to identify social determinants that affect patient's medical care. If needs are identified, work is done to get patients the resources they need. Patients are then contacted weekly by phone to ensure resource connection and to address questions.

ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. Identify at-risk patients in need of assistance in Mercy clinics through a targeted questionnaire at check-in.
2. Assist uninsured patients to apply for Mercy financial assistance, Medicaid programs, and Marketplace insurance plans.
3. Assist patients without an established primary care provider in establishing care with a primary care clinic or provider.
4. Screen patients for needs related to social determinants of health and connect patients to community resources to meet identified needs.
5. Connect patients with other community resources, including medication resources, as needed.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Implement Health Leads at 20 primary care clinics in Mercy Clinic South by July 1, 2020.
2. Ensure clinics maintain a screening rate of at least 50% monthly.

Medium-Term Outcomes:

3. Ensure initial client contact within 1 week of screening.

Long-Term Outcomes:

4. Patients reached by the Health Leads program will demonstrate 10% reduction in ED utilization and 10% reduced inpatient admissions.
5. Patients enrolling in Health Leads program will demonstrate a 10% reduction in their total bad debt.
6. Patients enrolling in Health Leads program will demonstrate a 10% overall improvement towards the contribution margin

PLAN TO EVALUATE THE IMPACT:

1. Track number of patients screened at participating clinics, and number of positive screenings. (Output)
2. Track number of patients successfully enrolled in Health Leads program. (Short-term)
3. Record number of patient needs that are successfully closed (successfully and equipped) versus the number closed unsuccessfully (disconnection/could not reach) and assess trends for establishing objectives for outcomes. (Medium-term)
4. Assess trends in needs closed successfully and equipped versus needs closed unsuccessfully (disconnection/could not reach).
5. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing Health Leads services. (Long-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Salary and benefits for two full-time Health Leads Program Managers.
2. Office space for Managers and Advocates and indirect expenses dedicated to Health Leads work.

COLLABORATIVE PARTNERS:

1. Health Leads USA
2. Maryville University
3. Community resource organizations
4. Community volunteers

PROGRAM 4: Hancock Clinic Partnership

PROGRAM DESCRIPTION:

The Hancock School Based Community Clinic serves students and staff of the Hancock School District as well as any verified residents of the 63125 ZIP code at no out-of-pocket expense to patients (the majority of which are uninsured). The Hancock Clinic serves all residents of the Lemay/63125 area which is an economically depressed area. 100% of the students in the school district quality for free/reduced lunches. The clinic serves all ages in the community with half (50%) of the patients being 18 years of age and younger and half being 19+. Many patients look to the Hancock Clinic as their medical home and primary source of care. Services provided include general services, women's health, basic labs and mental health to this high need and high-risk population. Recent additions include dietary/lifestyle education, STD testing and free labs for uninsured patients.

ACTIONS THE PROGRAM INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. Identify uninsured or at-risk community members in need of primary care.
2. Provide needed basic health care services to families, students and staff in the 63125 community without charge.
3. Establish Mercy Hospital South dedicated appointments to funnel patients from 63125 seen by MHS CRC in ED to establish primary care home.
4. Connect patients with other community resources, including medication resources, as needed.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Establish scheduled patient visits from Mercy Hospital South CRC to establish primary care home
2. The Hancock Clinic will see an average of 16 patients per week.

Medium-Term Outcomes:

3. Increase of patient visits at Hancock Clinic 10% yearly (FY 19=826)

Long-Term Outcomes:

1. Patients reached by the Hancock Clinic will demonstrate a 10% reduction in ED utilization over three years.
3. Patients reached by the Hancock Clinic will demonstrate a 10% reduction in inpatient readmission over three years.

PLAN TO EVALUATE THE IMPACT:

1. Track number of patients of the Hancock Clinic (Short-term)
2. Determine a way to analyze ED utilization and inpatient admissions data for cohort of patients utilizing Hancock Clinic services. (Long-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Funding to support Hancock Clinic Initiatives
2. CRC support to funnel patients from 63125 in need of a primary care home

COLLABORATIVE PARTNERS:

iFM Community Medicine
Hancock School District

PROGRAM 5: Crisis Nursery Outreach Center Partnership

PROGRAM DESCRIPTION:

The St. Louis Crisis Nursery provides short-term, safe havens for more than 7,200 children a year whose families are faced with an emergency or crisis. Through a Licensed Clinical Social Worker (LCSW), the Crisis Nursery Outreach Center at Mercy Hospital Jefferson (MHJ) assists area families with children birth through 12 years with crisis counseling, community referrals, home visitation, and parent education groups to prevent child abuse and neglect and promote healthy families. The program also provides community families in need with donations of food bags, diapers, cleaning supplies and other needed household items.

ACTIONS THE PROGRAM INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. LCSW will be integrated into the hospital by attending meetings and huddles to promote services.
2. Through the Family Empowerment Program (FEP), provide families with children birth through 12 years with services that help minimize stress, reduce isolation and empower families to achieve goals that ensure stability and safety.
3. Provide trauma-informed parent education to families in need of social support and resources.
4. Offer crisis counseling through a LCSW, available at the hospital, at offices or in the community.
5. Support families in need through home visits with a LCSW.
6. Connect families with other community resources, including diapers, formula and clothing, as needed.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Increase referrals of patients, families, and community members to Crisis Nursery services, including the FEP, Parent Education Groups, and community resource assistance—by 15%.
2. Increase referrals of Mercy coworkers to the Crisis Nursey services by 20%.

Medium-Term Outcomes:

1. Increase of goods distribution by 10% each year.
2. Families enrolled in the FEP will meet with LCSW at least one time per month throughout course of the year.

Long-Term Outcomes:

1. Improve scores on the Perceived Stress Scale by an average of 10% at the end of the FEP.
2. Improve scores on the Nurturing Skills Competency Scale by an average of 10% the end of the FEP.
3. Improve scores on the Family Protective Factors Survey by an average of 10% at the end of the FEP.

PLAN TO EVALUATE THE IMPACT:

1. Track number of home visits conducted by Crisis Nursery Coordinator. (Output)
2. Track number of office visits conducted by Crisis Nursery Coordinator. (Output)
3. Track number of field visits conducted by Crisis Nursery Coordinator. (Output)
4. Track number of participating families in Family Empowerment Program. (Output)
5. Track number of Parent Education Group participants. (Output)
6. Record number of community members receiving community resource assistance for basic need items (food, diapers, clothing, etc.). (Short-term)

7. Record the number of referrals made to community resources. (Short-term)
8. Assess families enrolled in FEP with outcome rating scale, Perceived Stress Cale, Nurturing Skills Competency Scale, Family Protective Factors Survey and the Adult-Adolescent Parenting Inventory to assess any changes in stress level, knowledge, skills, attitudes, protective factors, and general well-being. Assessments will be taken at pre-, mid- and post-intervention depending on survey tool in order to document change.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Storage and work space and indirect expenses dedicated to supporting the work of the Family Empowerment/Crisis Nursery Coordinator.

COLLABORATIVE PARTNERS:

1. St. Louis Crisis Nursery
2. Birthright
3. Nurses for Newborns
4. Parents as Teachers
5. School Districts (School Social Workers and Counselors)
6. Women Infant Children
7. Baby Ministry of DeSoto
8. St. Vincent de Paul
9. Head Start

Prioritized Need #2: Behavioral Health/Substance Abuse

Goal: Increase access to mental health services and support for at-risk persons.

PROGRAM 1: Hospital Community Linkages: Emergency Room Enhancement (Youth and Adult ERE)

PROGRAM DESCRIPTION: The Behavioral Health Network's ERE project facilitates an integrated 24/7 region-wide approach that targets high utilizers of emergency rooms who present with behavioral health symptoms, with the primary goal of reducing preventable hospital readmissions. Patients identified through the ERE project are connected to a peer support specialist who provide assistance with linking to community resources and inpatient and outpatient services. The program provides after-hours/weekend scheduling, as well as telephonic and mobile outreach crisis services for consumers referred to the ERE project.

ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. Community health leaders maintain ongoing relationship with the BHN and community partners through participation in regional meetings and facilitation of data sharing and process improvement.
2. ED personnel facilitate referrals to ERE intervention partners.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

2. Increase the number of adult high utilizers in the Emergency Department with mental health needs referred to the ERE program by 20% each year (FY 19=61 referrals)
3. Increase the number of youth high utilizers in the Emergency Department with mental health needs referred to the ERE program by 25% each year (FY19= 30 referrals)

Medium-Term Outcomes:

4. Increase the number of adult appointments scheduled by ERE intervention partners with community and hospital provides by 20% each year (FY 19=46)
5. Increase the number of youth appointments scheduled by ERE intervention partners with community and hospital provides by 25% each year (FY=27)
6. Increase adult cumulative engagement rate by 5% each year
7. Increased youth cumulative engagement rate by 5% each year

Long-Term Outcomes:

8. Patients reached by the ERE will demonstrate a 10% reduction in ED utilization over three years.
9. Patients reached by the ERE will demonstrate a 10% reduction in inpatient readmission over three years.

PLAN TO EVALUATE THE IMPACT:

1. BHN will track number of program referrals. (Output)
2. BHN will track number of appointments scheduled. (Output)
3. BHN will track percent engagement rate. (Medium-term outcome)
4. Mercy track ED utilization rates and inpatient readmissions. (Long-term outcome)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Support and educate ED staff to identify and facilitate referrals 2. Staff time and indirect costs necessary to maintain ongoing partnership with BHN
COLLABORATIVE PARTNERS: 1. Behavioral Health Network of Greater St. Louis (BHN) 2. Behavioral Health Response (BHR)

PROGRAM 2: Hospital Community Linkages (HCL) – Inpatient Project

PROGRAM DESCRIPTION: The HCL Inpatient project utilizes a designated liaison to identify and refer potential behavioral health consumers, facilitate referral and ensure discharge documentation is transferred for continuity of care. The HCL program is part of an integrated 24/7 region-wide approach that targets high utilizers of inpatient settings, with the primary goal of reducing preventable hospital readmissions.

ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. Community health leaders maintain ongoing relationship with the BHN and community partners through participation in regional meetings and facilitation of data sharing and process improvement.
2. Clinical staff to facilitate referrals to HCL liaison.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Increase the number of referrals of adult behavioral health consumers to the HCL program by X% each year (FY 19=144 referrals)

Medium-Term Outcomes:

2. Increase the number of appointments scheduled by HCL liaisons with community and hospital provides by 10% each year (FY 19=111)
3. Maintain and average appointment kept rate of 70% each year (FY 19 Average-69%)

Long-Term Outcomes:

4. Patients reached by the HCL will demonstrate a 10% reduction in ED utilization over three years.
5. Patients reached by the HCL will demonstrate a 10% reduction in inpatient readmission over three years. Serve a greater number of individuals with mental health needs.

PLAN TO EVALUATE THE IMPACT:

1. BHN will track number of program referrals. (Output)
2. BHN will track number of appointments scheduled. (Output)
3. BHN will track percent show rate. (Medium-term outcome)
4. Mercy track record ED utilization rates and inpatient readmissions. (Long-term outcome)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Support and educate clinical staff to identify and facilitate referrals
2. Staff time and indirect costs necessary to maintain ongoing partnership with BHN

COLLABORATIVE PARTNERS:

1. Behavioral Health Network of Greater St. Louis (BHN)
2. Behavioral Health Response (BHR)

PROGRAM 3: Engaging Patients in Care Coordination (EPICC)

PROGRAM DESCRIPTION: The EPICC program, in partnership with the Behavioral Health Network of Greater St. Louis (BHN) connects opioid overdose survivors treated in emergency rooms to recovery support and substance use treatment services, including Medication Assisted Treatment (MAT). Individuals must be over the age of 18 and meet diagnostic criteria for opioid dependence. Intensive referral and linkage services are provided by peer Recovery Coaches.

ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. Facilitate referrals to BHN peer Recovery Coaches from the Emergency Department.
2. Increase availability of medication assisted treatment (MAT) by supporting buprenorphine waivers for Mercy clinicians.
3. Promote opioid overdose education and Narcan distribution in the community.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Increase the number of referrals of patients with opioid dependence to the EPICC program by 15% each year (FY 19= 212).

Medium-Term Outcomes:

2. Increase the number of appointments scheduled by EPICC peer recovery coaches at hospital outreach by 10% each year (FY 19=188)
3. Maintain an average appointment kept rate at two-week follow-up of 65% each year (FY 19 Average-56%)

Long-Term Outcomes:

4. Patients reached by EPICC will demonstrate a 10% reduction in ED utilization over three years.
5. Patients reached by EPICC will demonstrate a 10% reduction in inpatient readmission over three years.
6. Reduce opioid related deaths by 15% over three years.

PLAN TO EVALUATE THE IMPACT:

1. BHN will track number of program referrals. (Output)
2. BHN will track number of appointments scheduled. (Output)
3. BHN will track percent show rate. (Medium-term outcome)
4. Mercy will track MAT waivered clinicians (Medium-term outcome)
5. Mercy will track number of non-fatal overdoses. (Long-term outcome)
6. Mercy will record ED utilization rates and inpatient readmissions. (Long-term outcome)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Support and educate clinical staff to identify and facilitate referrals
2. Staff time and indirect costs necessary to maintain ongoing partnership with BHN

COLLABORATIVE PARTNERS:

1. Behavioral Health Network of Greater St. Louis

Prioritized Need #3: Chronic Disease Prevention/Diabetes

Goal: Increase access to Diabetes preventative care.

PROGRAM 2: Hospital Diabetes Collaborative Program
PROGRAM DESCRIPTION: Reduce the disease burden of diabetes and improve the quality of life of persons with prediabetes or living with diabetes. Program planning is currently in the beginning stages.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Partner with area hospitals to create a mechanism to reduce diabetes burden. 2. Increase the proportion of persons with diabetes who receive formal diabetes education. 3. Increase the proportion of persons with diabetes whose condition has been screened.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. Determine target audience. 2. Determine how to collect data. 3. Determine how to refer patients in to the program. ***Medium-Term Outcomes:*** 1. Develop a program to reduce risks based on the 2019 American Diabetes Association Standards of Medical Care (A1c below 7). 2. Implement the program across hospital systems across the St. Louis region for a six-month period to collect baseline data. ***Long-Term Outcomes:*** 1. Increase preventative care by 10%. 2. Increase diabetes education by 10%.
PLAN TO EVALUATE THE IMPACT: 1. Track number of patients who receive formal diabetes education. 2. Track number of patients whose condition has been screened. 3. Track patients A1c level.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Support and education for clinical staff on collaborative efforts. 2. Staff time and indirect costs necessary to maintain ongoing partnership with hospital collaborative and community agencies.
COLLABORATIVE PARTNERS: 1. Christian Hospital, Missouri Baptist Medical Center, Barnes-Jewish West County Hospital, St. Luke's Hospital, St. Luke's Des Peres Hospital 2. St. Louis County Department of Health Diabetes Coalition 3. St. Louis City Department of Health

III. Other Community Health Programs

Mercy South conducts other community health programs not linked to a specific prioritized health need. These programs address a community health need and meet at least one of the following community benefit objectives: improve access to health care services, enhance the health of the community, advance medical or health care knowledge or relieve or reduce government burden to improve health. The need for these programs was identified through documentation of demonstrated community need, a request from a public health agency or community group, or the involvement of an unrelated, collaborative tax-exempt or government organization as partners in the activity or program carried out for the express purpose of improving community health. Although this is not an exhaustive list, many of these programs are listed below.

Community Benefit Category	**Program**	**Outcomes Tracked (FY 2019)**
Community Health Improvement Services	AARP Driver Safety Program	Persons served: 47
	Diabetes Outreach & Education	Persons served: 219
	Hospice Outreach & Education	Persons served: 193
	New-tritious You	Persons served: 176
	Oncology Services Outreach & Services	Persons served: 1,964
	Stroke Education	Persons served: 398
	Acute Rehab Support Group	Persons served: 269
	Trauma Services Outreach	Persons served: 1,354
	Behavioral Health Support Groups	Person's served: 1,000+
	Transportation Services	Person's served: 6,330
Community Based Clinical Services	Hancock Schools Community Clinic Partnership	Person's served: 812
Health Professions Education	Nurses and Nursing Students	Numbers of students: 268
	Other Health Professionals	Numbers of students: 254
	Community Based Vocational Instruction (CBVI)	Number of students: 24
Financial and In-Kind Contributions	Parents as Teachers Partnership	$15,000
	Other (includes cash, in-kind donations, fundraising costs, food & supplies to shelters, etc)	$32,000
Community Building Activities – Workforce Development	MHS STL Caps Program	Number of students: 218

IV. Significant Health Needs Not Being Addressed

In any case of prioritization, there will be some areas of needs that are identified that are not chosen as a priority. Because Mercy Hospital South has limited resources, not every community need will be addressed. Throughout the CHNA process, the following needs arose as a community concern. However, they will not be addressed at this time due to the need already being addressed by another community organization or due to a limitation of resources:

- Violence Prevention
- Maternal/Child and Sexual Health

While these needs listed will not be specifically addressed in our priorities, they will most likely be impacted indirectly through the work in our other community health priorities. Mercy Hospital South will support, as able, the efforts of partner agencies and organizations currently working to address these needs within the community.

NOTES:

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