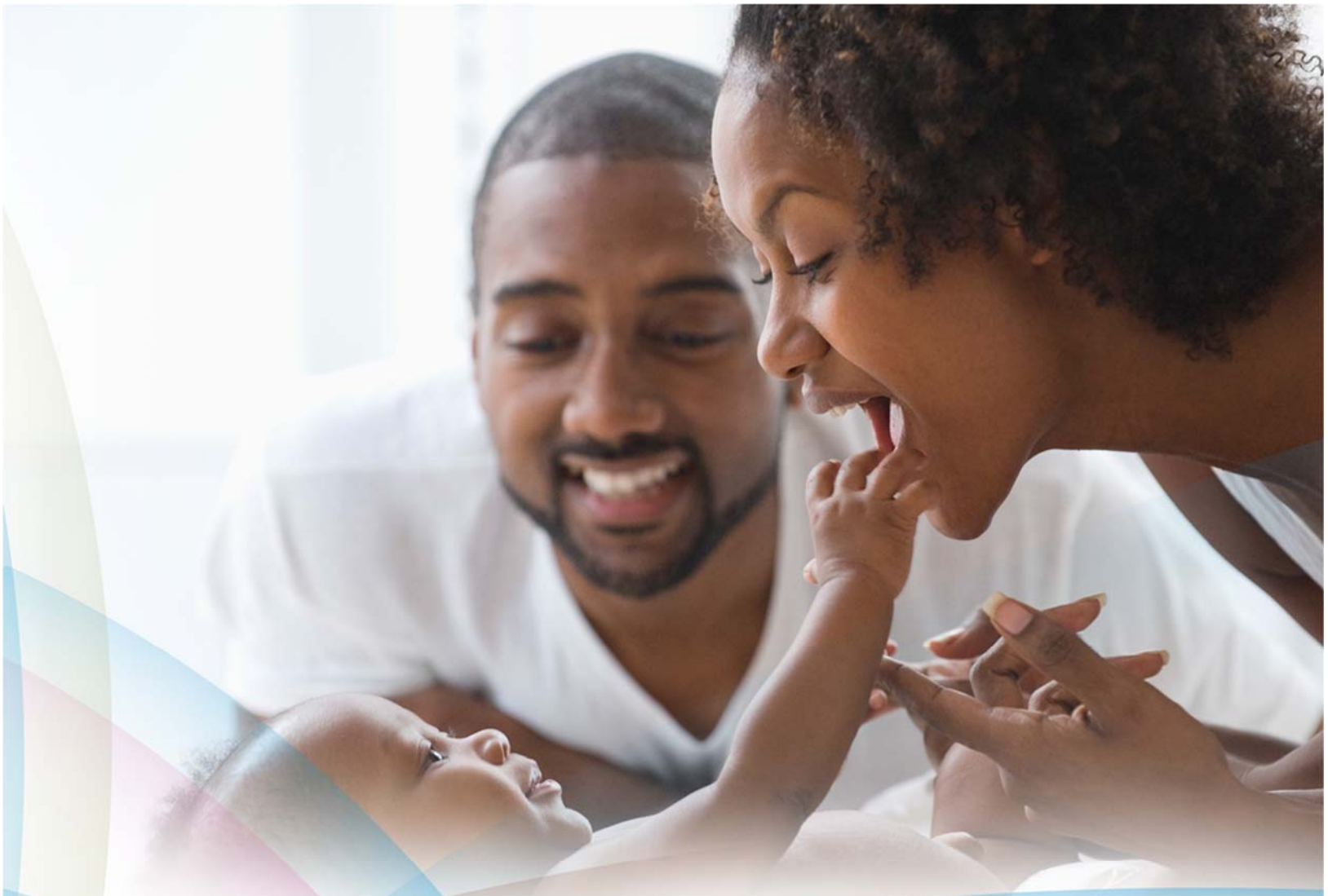

Community Health Improvement Plan

Mercy Hospital St. Louis

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

Mercy Hospital St. Louis (MHSL) is a 979-bed, single-occupancy-room hospital located in St. Louis, Missouri. It is one of five hospitals in Mercy's East Community and the only Level 1 (highest level) trauma center in St. Louis County. MHSL's campus includes Mercy JFK Clinic, which focuses on serving the health needs of individuals who are uninsured or underinsured; Mercy Heart and Vascular Hospital; the David C. Pratt Cancer Center; and Mercy Children's Hospital, the only full-service pediatric hospital in St. Louis County and one of only two hospitals in the state of Missouri to have a Level III (highest level) neonatal intensive care unit.

MHSL's primary service area is St. Louis County. Throughout the county, MHSL operates Mercy Clinic physician offices, outpatient hospital services, and Mercy Urgent Care Centers. In 2015, Mercy also opened the world's first virtual care center, located in St. Louis County. The center addresses critical community health needs, such as transportation barriers to accessing care affecting lower-income and non-ambulatory patients, and provider shortages in the surrounding rural communities comprising MHSL's extended service area.

Mercy's mission is to deliver "compassionate care and exceptional service" to every community member. In dedication to this mission, our work includes the development of a Community Health Needs Assessment (CHNA) during the last year, which included both St. Louis City and County Public Health sectors, a first for our region, as well as traditional and non-traditional partners in both medical and community-based agencies and organizations. To do this, we gathered and analyzed health-related information and statistics from St. Louis, St. Louis County. This information includes interviews with public health experts and those who represent the broad interests of the community served by the hospital, and surveys of community residents and local physicians.

The CHNA identified five top-priorities and of the five, four have been chosen as health needs for the Mercy Hospital St. Louis community. We will strive diligently to address these needs with a Health Equity lens over the next three years:

Access to Care
Behavioral Health/Substance Abuse
Maternal Child Health
Chronic Disease Prevention and Management

As always, we seek to develop a rich and rewarding network of partnerships with our neighbors. We welcome any thoughts you may have on ways to achieve our goal for a healthier community.

II. Implementation Plan by Prioritized Health Need

Prioritized Need #1: Access to Care

Goal 1: Increase access to health care for uninsured and at-risk persons.

PROGRAM 1: Community Health Worker
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 culture competence of care. CHWs work one-on-one with at-risk patients and community members, acting as patient advocates, assisting patients in applying for insurance, 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 Mercy clinics, emergency department, inpatient settings, community events, and through the use of reports and dashboards. 2. Assist uninsured patients with applying for Mercy financial assistance, Medicaid programs or other relevant programs. 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. By the end of each month, each CHW will have recorded 5 new and 10 ongoing encounters. 2. By the end of each fiscal year for the next three years, each CHW will enroll 30 patients in Mercy financial assistance, 25 in Medicaid, and 10 in Marketplace insurance plans. 3. CHWs will assist with coordination with the Community Referral Coordinator 50 patients without a current primary care provider to establish care with a PCP at a Mercy clinic, FQHC, free clinic or other clinic. 4. Each CHW will assist at least 50 patients per year with community and medication assistance resources. ***Medium-Term Outcomes:*** 1. Patients enrolling in CHW program will demonstrate reduced ED utilization and reduced inpatient admissions. 2. Patients enrolling in CHW program will demonstrate a reduction in their total bad debt.

Long-Term Outcomes:

1. Patients enrolling in CHW program will have improved health outcomes, improved well-being, and demonstrate improvement in measures of social determinants of health.

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, Medicaid, and Marketplace insurance plans. (Short-term)
3. Measure number of patients successfully establishing 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. (Medium-term)
6. Analyze pre and post intervention bad debt for cohort of patients utilizing CHW services. (Medium-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

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

COLLABORATIVE PARTNERS:

1. Integrated Health Network (IHN)
2. HEAL Partnership Work Group
3. St. Louis Community College

PROGRAM 2: Community Referral Coordinator

PROGRAM DESCRIPTION: The Community Referral Program assists uninsured or underinsured patients in gaining appropriate health insurance coverage, establishing primary care medical homes at a Federally Qualified Health Center or with independent or Mercy providers, and accessing the community resources they need to support their health. The program is strongly focused on assisting people who face barriers to care caused by financial hardship or other circumstances and is supported by sub-contracted services provided by the Integrative Health Network (IHN). The IHN's Community Resource Coordinator (CRC) works full-time on-site at Mercy Hospital Jefferson (MHJ), collaborating closely and in an integrated way with hospital staff, including the Community Health Worker (CHW).

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

1. Uninsured or underinsured patients who come into the Emergency Department will be assisted in securing an insurance plan that meets their financial needs and circumstances.
2. ED patients who lack a Primary Care Provider (PCP) will receive personalized referrals and assistance with appointment setting.
3. Economically hard-pressed ED patients will be connected to resources and external partners to assist with non-medical health determinants, through the CRC, MHJ's CHW or Crisis Nursery Family Empowerment Social Worker. The CHW may conduct home visits as necessary to follow up with patients seen in the ED.

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 30 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. 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. (Output)
2. IHN will track the number of patients encountered with or without an established primary care home. (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)

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. Discretionary charitable funds to empower the CRC to address pressing social determinants of health without delay.

COLLABORATIVE PARTNERS:

1. Integrative Health Network

PROGRAM 3: John F. Kennedy Clinic

PROGRAM DESCRIPTION: The JFK Clinic serves the health needs of individuals who are uninsured or underinsured that fall within the Federal Poverty Guidelines.

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

1. Conduct an internal inventory of existing JFK services or programs (i.e. Internal Medicine, Obstetrics, Gynecology, Pediatrics, Pharmacy services, Dental, Outpatient services and test and hospital admissions at Mercy Hospital St. Louis)

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. By the end of FY20, the internal and external assessments will be completed.

Medium-Term Outcomes:

1. Review data from any existing documents/of how many persons served and impacted
2. Identify gaps in service and other best practice options

Long-Term Outcomes:

1. By the end of FY22 initial outcome data will be presented

PLAN TO EVALUATE THE IMPACT:

1. Impact evaluation approach will be dependent on assessment. Measurement tools will include but are not limited to: Analyses of available outcomes data, for example; utilization, readmission, and contribution margin.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Operational budgeted support as appropriate
2. Philanthropy support as needed

COLLABORATIVE PARTNERS:

1. St. Louis Integrated Health Network
2. Community Health Workers

PROGRAM 4: WestFlo Clinic

PROGRAM DESCRIPTION: The WestFlo Clinic will serve the health needs of individuals who are insured, uninsured or underinsured that fall within the Federal Poverty Guidelines and seek primary and specialty care.

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

1. WestFlo will provide quality primary and specialty healthcare for the Southeast West Florissant Community and surrounding areas.
2. This clinic will use a CHW to help patients navigate through the Social Determinants of Health

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. WestFlo Clinic will open Spring of 2020

Medium-Term Outcomes:

1. Review data over a 6-month period/of how many persons served and impacted
2. Identify gaps in service, greatest need of patients

Long-Term Outcomes:

1. By the end of FY22, the pilot will be implemented, and initial outcome data presented

PLAN TO EVALUATE THE IMPACT:

1. Impact evaluation approach will be dependent on assessment. Measurement tools will include but are not limited to: Analyses of available outcomes data, for example; utilization, readmission, and contribution margin.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Operational budgeted support as appropriate
2. Philanthropy support as needed

COLLABORATIVE PARTNERS:

1. St. Louis County Health Dept
2. Operation Food Search

Prioritized Need #2: Behavioral Health

GOAL 1: Increase access to mental health care for uninsured and at-risk persons.

PROGRAM 1: Mental Health Services Inventory/Assessment/Pilot
PROGRAM DESCRIPTION: The hospital will collaborate with community partners to conduct a current assessment of behavioral health services offered, identify any existing gaps and pilot creative collaborative approaches to meet community behavioral health needs.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Conduct an internal inventory of existing Mercy behavioral health services (i.e. Inpatient, Outpatient, Intensive Outpatient Programs (IOP), Counseling Services, Classes, Support Groups, Regional Access Center services, Virtual Care Center (VCC) initiatives). 2. Conduct an external inventory of existing local community services offered by other health systems, non- profit and for-profit agencies. 3. Review data from any existing documents/community assessments, resource list inventories and focus group reports. 4. Identify gaps in service, explore Mercy VCC solutions and other best practice options (for example, intensive outpatient programs (IOPs), and develop a plan to pilot a minimum of one initiative.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. By the end of FY20, the internal and external assessments will be completed. ***Medium-Term Outcomes:*** 1. By the end of FY21, community need gaps will be identified and a plan, including funding support, will be presented for pilot initiative(s). ***Long-Term Outcomes:*** 1. By the end of FY22, the pilot will be implemented, and initial outcome data presented
PLAN TO EVALUATE THE IMPACT: Impact evaluation approach will be dependent on program piloted. Measurement tools will include, but are not limited to: 1. Number of Internal Behavioral Health Programs 2. Numbers of patients and community members served. 3. Analyses of available outcomes data, for example, utilization, readmission, and contribution margin.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Cost of coworker time 2. Operational budgeted support as appropriate 3. Philanthropy support as needed
COLLABORATIVE PARTNERS: 1. St Louis Behavioral Health Network (BHN) 2. National Alliance for Mental Illness NAMI

Prioritized Need #2: Substance Use

GOAL 1: Increase prevention initiatives and substance abuse treatment programs for uninsured and at-risk persons.

PROGRAM 1: Substance Use Services Inventory/Assessment/Pilot

PROGRAM DESCRIPTION: The hospital will collaborate with the Ministry Controlled Substances Operational Task Force, local Mercy Behavioral Health teams and community partners to conduct a current assessment of services offered, identify any existing gaps and pilot creative collaborative approaches to meet community need.

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

1. Conduct an internal inventory of existing Mercy behavioral health services (i.e. Inpatient, Outpatient, Intensive Outpatient Programs (IOP), Counseling Services, Classes, Support Groups, Regional Access Center services, Virtual Care Center (VCC) initiatives).
2. Conduct an external inventory of existing local community services offered by other health systems, non- profit and for-profit agencies.
3. Review data from any existing documents/community assessments, resource list inventories and focus group reports.
4. Identify gaps in service, explore Mercy VCC solutions and other best practice options (Intensive Outpatient Program (IOP), Medication Assisted Treatment (MAT) and pilot a minimum of one initiative.
5. Promote and utilize the Prescription Drug Monitoring Program (PDMP). Explore integration into Epic.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. By the end of FY20, the internal and external assessments will be completed.

Medium-Term Outcomes:

1. By the end of FY21, community need gaps will be identified and a plan, including funding support, will be presented for pilot initiative(s).

Long-Term Outcomes:

1. By the end of FY22, the pilot will be implemented, and initial outcome data presented

PLAN TO EVALUATE THE IMPACT:

Impact evaluation approach will be dependent on program piloted. Measurement tools will include, but are not limited to:

1. Number of Internal Substance Use Programs
2. Program Referrals and numbers of patients and community members served
3. Appointments Scheduled
4. Engagement Rate at 2-week follow-up
5. Increase in number of Medication Assisted Treatment (MAT) providers as applicable.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Ministry Controlled Substances Operational Task Force and Medical Marijuana Task Force
2. Catherine's Fund support
3. Community Health Leader research/project management support
4. Operational budgeted support as appropriate
5. Philanthropy support as needed

COLLABORATIVE PARTNERS:

1. St Louis Behavioral Health Network (BHN)
2. National Council on Alcohol and Drug Abuse (NCADA)

PROGRAM 2: Emergency Room Enhancement Project (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:

1. Increase the number of adult high utilizers in the Emergency Department with mental health needs referred to the ERE program by 15% each year (FY 19= 64 referrals)
2. 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= 29 referrals)

Medium-Term Outcomes:

1. Increase the number of adult appointments scheduled by ERE intervention partners with community and hospital providers by 25% percent each year. (FY 19= 44 appointments)
2. Increase the number of youth appointments scheduled by ERE intervention partners with community and hospital providers by 25% percent each year. (FY 19= 26 appointments)
3. Increase cumulative adult engagement rate by 5% percent each year.
4. Increase cumulative youth engagement rate by 10% percent each year.

Long-Term Outcomes:

1. Patients reached by the youth ERE program will demonstrate a 10% reduction in ED utilization over 3 years
2. Patients reached by the adult ERE program will demonstrate a 10% reduction in inpatient readmissions over 3 years
3. Patients reached by the youth ERE program will demonstrate a 10% reduction in inpatient readmissions over 3 years

PLAN TO EVALUATE THE IMPACT:

1. BHN will track number of ERE program referrals
2. BHN will track number of appointments scheduled
3. BHN will track percent engagement rate
4. Mercy will report on ED utilization rates and ED readmissions

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Support and education for ED staff to identify and facilitate ERE referrals

2. Staff time and indirect cost necessary to maintain ongoing partnership with BHN and community agencies
COLLABORATIVE PARTNERS: 1. St. Louis Behavioral Health Network (BHN)

PROGRAM 3: Hospital Community Linkages (HCL)

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 facilitate referrals to HCL liaison

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Increase the number of adult high utilizers in the Emergency Department with mental health needs referred to the ERE program by 15% each year (FY 19= 64 referrals)
2. 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= 29 referrals)

Medium-Term Outcomes:

1. Increase the number of adult appointments scheduled by ERE intervention partners with community and hospital providers by 25% percent each year. (FY 19= 44 appointments)
2. Increase the number of youth appointments scheduled by ERE intervention partners with community and hospital providers by 25% percent each year. (FY 19= 26 appointments)
3. Increase cumulative adult engagement rate by 5% percent each year.
4. Increase cumulative youth engagement rate by 10% percent each year.

Long-Term Outcomes:

1. Patients reached by the HCL program will demonstrate a 10% reduction in ED utilization over 3 years
2. Patients reached by the HCL program will demonstrate a 10% reduction in inpatient readmissions over 3 years

PLAN TO EVALUATE THE IMPACT:

1. Outline what you are actually going to track, measure, record and indicate whether it is an output (eg. Number of participants) or short, medium or long term outcome.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Time, resources, funds, indirect expenses

COLLABORATIVE PARTNERS:

1. Community partners

PROGRAM 4: 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. 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 opiod dependence to the EPICC program by 25% percent each year (FY 19 =104)

Medium-Term Outcomes:

1. Increase the number of appointments scheduled by EPICC peer recovery coaches through hospital outreach by 25% percent each year (FY 19 =90)
2. Maintain at least a 65% percent engagement rate.

Long-Term Outcomes:

1. Patients reached by the EPICC program will demonstrate a 10% reduction in ED utilization over 3 years
2. Patients reached by the EPICC program will demonstrate a 10% reduction in inpatient readmissions over 3 years
3. Reduce opiod related deaths by 15% (33.6 opiod deaths per 100k in St. Louis County)

PLAN TO EVALUATE THE IMPACT:

1. BHN will Track number of program referrals
2. BHN will Track number of appointments scheduled
3. BHN will Track percent engagement rate
4. Mercy will record # of MAT waivered clinicians
5. Mercy will record number of nonfatal overdoses in emergency department
6. Mercy will record ED utilization rates and inpatient readmissions

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Support and education for ED staff to identify and facilitate EICC referrals
2. Staff time and indirect cost necessary to maintain ongoing partnership with BHN and community agencies

COLLABORATIVE PARTNERS:

1. Behavioral Health Network of Greater St. Louis

Prioritized Need #3: Maternal and Child Health

Goal 1: To decrease the rate of Maternal/Infant mortality among African American women and children in St. Louis

PROGRAM 1: Centering Pregnancy
PROGRAM DESCRIPTION: Centering Pregnancy is a national program that has a proven record of better birth outcomes for women and their babies. Centering is prenatal care that includes an individual health check up with additional time and attention in a group setting.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Prenatal support, Parental education, Provision of baby items, Education support, Mental Health Counseling
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. Enhance patient experience by 20% 2. Increase knowledge of self- care by 20% 3. Increase self-confidence by 20% 4. Increase cohort community building and support y 20% 5. Increase time with providers by 20% ***Medium-Term Outcomes:*** 1. Improving birth weight outcomes by 10% 2. Reduces preterm delivery by 10% 3. Increase more mothers to breastfeed by 10% 4. Helps address racial disparities in maternity care by 10% ***Long-Term Outcomes:*** 1. Increased changes in status of health or life conditions by 20% 2. Patient satisfaction increased by 20% 3. Increased patient attitude of feeling supported by 20% 4. Improved knowledge of healthy diet and exercise by 20% 5. Improved knowledge of attitudes regarding smoking and alcohol use by 20% 6. Improved knowledge and attitude of breastfeeding by 20%
PLAN TO EVALUATE THE IMPACT: 1. Tracking measures for triage/ER visits, exchange calls, gestational age at delivery, birth weight and breastfeeding.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Scales, heart monitors, blood pressure cuffs, doppler and class materials
COLLABORATIVE PARTNERS: 1. Catholic Charities Good Shepherd

Prioritized Need #4: Chronic Disease Prevention: Diabetes

Goal 1: Decrease the prevalence of prediabetes/diabetes in St. Louis

PROGRAM 1: Diabetes Prevention Program

PROGRAM DESCRIPTION: The Diabetes Prevention Program (DPP) is a CDC evidence-based lifestyle change program, led by a trained lifestyle coach, to reduce the risk of developing type 2 diabetes in adults with prediabetes or who are at risk for diabetes.

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

1. Conduct the year-long program consisting of 26 class sessions, offering various class times and meeting locations to meet the needs of the participants.
2. Maintain a roster of trained lifestyle coaches to offer the program.
3. Publicize the program to primary care physicians and community members.
4. Maintain a fully recognized DPP program by ensuring that participants meet program goals and data is submitted to CDC as required.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. At least 10 new participants per fiscal year will enroll in the program and complete the first 4 sessions.
2. Retention rate for participants attending at least 4 sessions will be greater than 50%.
3. Average weight loss for participants completing the program will be at least 5%.
4. Percent of participants completing program who have achieved at least 150 minutes of physical activity/week will be at least 70%

Medium-Term Outcomes:

1. At least 60% of participants completing the program will reduce their HbA1C or fasting glucose levels to normal.

Long-Term Outcomes:

1. Rates of diabetes and prediabetes will be reduced in St. Louis.

PLAN TO EVALUATE THE IMPACT:

1. Track number of new participants who enroll in the program and complete the first 4 sessions in each fiscal year and cumulative total since program inception. (Output)
2. Track number of participants who have completed their first of year of the program in each fiscal year and cumulative total since program inception. (Output)
3. Track the program cumulative retention rate for participants completing the first 4 sessions. (Short-term)
4. Track the percent of participants annually receiving partial or full financial assistance to cover program costs. (Short-term)
5. Calculate and record the average weight loss for all participants under the NWA DPRP recognition code completing the program who have attended at least 3 or more sessions and had a time span between the 1st and last session of at least 9 months (consistent with CDC-reported program data). Report this outcome in December and

June of each year (number of participants included in measure and % weight loss). (Short-term)

6. Record the percent of participants completing their first year of the program in the fiscal year who have achieved at least 150 minutes of physical activity/week. (Short-term)
7. Record the percent of participants completing their first year of the program each fiscal year who have reduced their HbA1C or fasting glucose to normal levels. (Medium-term)
8. Calculate changes in HbA1C levels for participants completing their first year of the program each fiscal year (Medium-term):
   a. Average beginning HbA1C
   b. Average ending HbA1C
   c. Average percent change in HbA1C
9. Calculate changes in fasting glucose levels for participants completing their first year of the program each fiscal year (Medium-term):
   a. Average beginning fasting glucose
   b. Average ending fasting glucose
   c. Average percent change in fasting glucose

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Cost of program coordinator time (grant offset).
2. Financial assistance for participants unable to afford the cost of the program.
3. Indirect expenses related to meeting space and overhead.

COLLABORATIVE PARTNERS:

1. Normandy School District
2. Beyond Housing

PROGRAM 2: Diabetes Education

PROGRAM DESCRIPTION: Reduce the disease burden of diabetes and improve the quality of life of persons with prediabetes or living with diabetes.

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 how to collect data
2. Determine target audience
3. Determine how to refer patients 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 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 American Diabetes Association

III. Other Community Health Programs

Mercy St. Louis 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**
Community Health Improvement Services	Alternative Therapies Program	12,000
	WIC Assistance / Dietician Services	2,192
	Community Health Fairs & Screenings	1,000
	Patient Benefit Advisors	15,696
Health Professions Education	Internal Medicine Residency Program	555
	Health professions student education – nursing, imaging, therapy, pharmacy, medical student, lab, emergency medical technician, and advanced practice nursing	1,890
Financial and In-Kind Contributions	Community Building -Cash/In-kind Contributions	$10,553
	Flu Shots	2,000 vaccines
	Meals on Wheels Nutrition Services	5,805 meals served
Community Building	Coalition Building/Board Memberships	3,585
Health Care Support Services	340B Program	$1,095,016
	Health Care Support Services	1,601

Subsidized Health Services	Emergency and Trauma	2,044

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 MHSL has limited resources, not every community need will be addressed. Throughout the CHNA process, the following need arose as a community concern. However, it will not be addressed as a top priority because other organizations are more appropriate to address this need.

- Violence in the Community

Infectious disease physicians at Mercy will continue to address this issue through collaborative work. Mercy will not, however, take a lead role on this issue as there are some limitations to the organization's partnerships in this area as a Catholic Health System.

- Sexually Transmitted Infections

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 outreach priorities.

Next Steps
After carefully reviewing the data and mapping existing resources, MHSL is developing an implementation plan with evidence-based strategies. The plan will be submitted to a committee of appointed members from Mercy Hospital St. Louis, for their approval. The final version of the CHNA and Implementation Plan will be available to the public on the Mercy Hospital St. Louis website, www.mercy.net/communitybenefits.

NOTES:

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Mercy

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