



Community Health Improvement Plan

Mercy Hospital
Joplin

Fiscal Year 2019 - 2021



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 Joplin completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors in May 2019. The CHNA took into account input from the county health department, community members, members of medically underserved, low-income, and minority populations and various community organizations representing the broad interests of the community of Joplin. The CHNA identified three prioritized health needs the hospital plans to focus on addressing during the next three years: Access to Care, Mental Health, Diabetes, Lung Disease, and Cardiovascular Disease. The complete CHNA report is available electronically at mercy.net/about/community-benefits.

Mercy Joplin is affiliated with Mercy, one of the largest Catholic health systems in the United States. The opening of Mercy Hospital Joplin brings an unprecedented leap forward in health care while fulfilling a promise not just to rebuild but build a stronger community. Mercy's commitment to Joplin dates to 1896 when the Sisters of Mercy began caring for this community.

This three-year Community Health Improvement Plan (CHIP), aimed at addressing the prioritized health needs identified in the CHNA, will guide the coordination and targeting of resources, and the planning, implementation and evaluation of both new and existing programs and interventions. The 2019 CHNA and this resulting CHIP will provide the framework for Mercy Joplin as it works in collaboration with community partners to advance the health and quality of life for the community members it serves.

II. Implementation Plan by Prioritized Health Need

Prioritized Need #1: Mental Health

GOAL 1: Provide care to postpartum patients that have an increased risk of depression.

PROGRAM 1: Depression screenings.
PROGRAM DESCRIPTION: According to the CDC, we know that in Missouri the prevalence of self-reported symptoms of postpartum depression are 12.8% and on the rise. Mercy Behavioral Health is committed to employing a full time LCSW to provide mental health care services to postpartum patients with depression. The LCSW and Mercy Behavioral Health serves as the point of contact for the patients and manages the program.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: <ol style="list-style-type: none">1. Hire a full time LCSW to work in the Mercy Joplin community2. Identify potential patients with services needed for postpartum depression.3. Provide outreach to community members and serve as a resource for the program and provide services available to uninsured patients.4. Provide assistance to patients in navigating appointment scheduling, transportation, and meeting other needs that may be barriers to accessing care.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): <p>Short-Term Outcomes:</p> <ol style="list-style-type: none">1. Identify five new mothers per quarter that have been provided services for depression2. Create referral source to Mercy Behavioral Health3. Create marketing campaign and material to promote program on an annual basis4. The LCSW will establish care with 50% of new mothers experiencing depression5. The average first appointment show rate for the program will be greater than 75%. <p>Medium-Term Outcomes:</p> <ol style="list-style-type: none">1. Promote annual marketing campaign to raise awareness2. Patients participating will meet with the LCSW/Provider twice per year to better manage their health and well-being. <p>Long-Term Outcomes:</p> <ol style="list-style-type: none">1. Patients participating in the program will have improved health outcomes and health literacy to be better engaged in their health care decisions.2. Reduce the prevalence of self-reported symptoms of postpartum depression by 5% in the Joplin community.
PLAN TO EVALUATE THE IMPACT: <ol style="list-style-type: none">1. Track number of LCSW visits. (Output)2. Track total number of first new patient appointments made. (Short-term)3. Tabulate demographic profile of patients served. (Short-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Provide 1.0 FTE of staff dedicated to the program.
2. LCSW time, travel, and other indirect expenses needed to deliver care.

COLLABORATIVE PARTNERS:

1. Jasper County Health Department
2. The Alliance of Southwest Missouri
3. Mercy Hospital Carthage

Prioritized Need #2: Diabetes

Goal 1: Diabetes Self-Management

PROGRAM 1: Diabetes Self-Management

PROGRAM DESCRIPTION: 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.

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

1. Provide care to the uninsured and underinsured Joplin population that has diabetes
2. Provide resources and educational opportunities for the community

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Increase access by working with coworkers who are actively engaged in the community.
2. Build relationships with Mercy Health Foundation and Community Benefit leaders, will help raise community awareness of Mercy Diabetes services.
3. Promote two diabetes campaigns per year through marketing campaigns and social media
4. Increase appropriate screenings for pre-diabetics

Medium-Term Outcomes:

1. Increased completed health exams (specifically – eye, foot, and dental) by 10%
2. Decrease length of inpatient stay to two days
3. Implement a Diabetes Prevention Program by 2021
- 4.

Long-Term Outcomes:

1. Reduce preventable hyperglycemia by 20% by year three of program patients
2. Increase active community participation/attendance in DPP by 20%

PLAN TO EVALUATE THE IMPACT:

1. Initially, the diabetes program will determine potential cost savings of the program.

<ol style="list-style-type: none"> 2. Then, a continual effort will be made on a quarterly to semi-annual basis to review progress and outcomes 3. Participate in the Diabetes team meetings on a monthly or quarterly basis 4. Provide reports to community board on effectiveness of DPP
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: <ol style="list-style-type: none"> 1. Time, resources, funds, indirect expenses 2. Training and education expenses
COLLABORATIVE PARTNERS: <ol style="list-style-type: none"> 1. Community Clinics, Mercy Northwest Arkansas Community Health,

Goal 2: Diabetes Bridge Program

PROGRAM 2: Diabetes Bridge Program
PROGRAM DESCRIPTION: Provide a Diabetes Bridge Clinic that is nurse managed, protocol-based, physician supervised model of outpatient care.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: <ol style="list-style-type: none"> 1. Coordinate patients from an inpatient or emergency department setting, to a clinic setting within five days of the encounter. 2. Increase educational opportunities for those that are limited by financial/insurance reasons or time constraints.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): Short-Term Outcomes: (First Year) <ol style="list-style-type: none"> 1. Build relationships with Mercy Health Foundation and Community Benefit leaders, will help raise community awareness and funds for the Mercy Diabetes Bridge Program. 2. Increase patient satisfaction scores by 10% 3. Increased weight loss 10% of each program participant 4. Direct 100% of new patients to appropriate screenings before program participation Medium-Term Outcomes: (1-2 Years) <ol style="list-style-type: none"> 1. Program participants' hypoglycemia is reduced by 20% 2. Program participant's employment rate will be increased by 40% 3. Fundraising goals are increased 10% each year Long-Term Outcomes: (3+ Years) <ol style="list-style-type: none"> 1. To see 80% of population with annual foot exams 2. To see 40% of population with annual eye exams 3. To see 30% of population with annual dental exams
PLAN TO EVALUATE THE IMPACT: <ol style="list-style-type: none"> 1. Participate in the Diabetes team meetings on a monthly or quarterly basis 2. Provide reports to community board on effectiveness of Diabetes Bridge Program

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Time, resources, funds, indirect expenses

COLLABORATIVE PARTNERS:

1. Community Clinics, Mercy Care Managers, Mercy Health Foundation

Prioritized Need #3: Cardiovascular Disease – Community Health Worker

Goal 1: Reduce readmission rates for congestive heart failure (CHF) patients

PROGRAM 1: Reduce readmission rates for patients with congestive heart failure.

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 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: (First Year)

1. The CHW will enroll 20 patients in Mercy financial assistance and 10 in Medicaid.
2. The program will reduce the readmission rate of CHF patients to below 20%
3. CHF patients who volunteer to participate in the program will have nutrition and body weight measured weekly.

Medium-Term Outcomes: (1-2 Years)

1. Patients enrolling in CHF program will demonstrate reduced ED utilization and reduced inpatient admissions. For skilled nursing facilities and the hospital.

2. If CHF participant does not currently have insurance, the CHW will provide other community resources for health care services.
3. ED utilization rate for program participants would be reduced to 15%

Long-Term Outcomes: (3+ years)

1. Patients enrolling in CHW program will have improved health outcomes, improved well-being, and demonstrate improvement in measures of social determinants of health.
2. Program participant's will be able to demonstrate nutritional awareness and physical needs to live a healthier lifestyle.
3. Caregivers of chronic CHF patients will have a better understanding of program needs and resources to aid in a healthier lifestyle.

PLAN TO EVALUATE THE IMPACT:

1. Track number of new and ongoing encounters conducted by each CHW. (Output)
2. Meet weekly with skilled nursing facility administrators to evaluate impact.
3. Track number of patients successfully enrolled in Mercy financial assistance, Medicaid, and Marketplace insurance plans. (Short-term)
4. Measure number of patients successfully establishing a primary care home. (Short-term)
5. Record number of patients receiving community resource and medication assistance. (Short-term)
6. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing CHW services. (Medium-term)
7. 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 full-time Community Health Worker.
2. Office space and indirect expenses dedicated to CHW work.
3. Professional development, both internal and external, for duties of a CHW.
4. Provide funding for patient resources through grants and fundraising.

COLLABORATIVE PARTNERS:

1. Local Skilled Nursing Facilities
2. Mercy Out-Patient & In-Patient Care Managers
3. Mercy Heart Failure Clinic
4. Mercy Health Foundation

Prioritized Need #4: Access to Care: School Based Health Clinic

Goal 1: Increase access to health care through a school-based health clinic

PROGRAM 1: Provide clinical care to the Webb City school district
PROGRAM DESCRIPTION: Provide quality care to faculty, staff, students, and immediate family members of the school district.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: <ol style="list-style-type: none"> 1. Continue the full-time program for an on-campus school-based clinic for Webb City schools to provide access to health care for their students and staff.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): <p><i>Short-Term Outcomes:</i></p> <ol style="list-style-type: none"> 1. Provide health and wellness education, and health screenings to the school district 2. Provide necessary vaccines to 50-100 students per year 3. Increase visits by 10% each year to care for faculty/staff/students <p><i>Medium-Term Outcomes:</i></p> <ol style="list-style-type: none"> 1. Work with Mercy marketing and communications to develop strategic plan for outreach on an annual basis 2. Create wellness programs to incentivize 20% of faculty and staff of the district to lead a healthy lifestyle 3. Provide appropriate educational opportunities and classes for the district <p><i>Long-Term Outcomes:</i></p> <ol style="list-style-type: none"> 1. Reduce staff sick days by 20% 2. Increase student attendance 3. Become a full time operational clinic
PLAN TO EVALUATE THE IMPACT: <ol style="list-style-type: none"> 1. Weekly meetings with staff to review clinic performance measures. 2. Regular meetings with school administrators to share clinic results. 3. Track total visits and new patient visits to clinic. 4. Develop tracking sheet for various populations that visit the clinic.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: <ol style="list-style-type: none"> 1. Full time staff to manage and operate clinic 2. Fund the appropriate budget for the part time clinic to be successful 3. Provide marketing assistance and dollars to promote the program
COLLABORATIVE PARTNERS: <ol style="list-style-type: none"> 1. Mercy Clinic Administration, Webb City School District Administration. Local EMS/Fire 2. Mercy Clinic Stones Corner

III. Other Community Health Programs

Mercy JOPLIN 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	Parkinson’s Support Group	Persons served - 408
	Bereavement Support Group	Persons served - 40
	Diabetes Education	Persons served, unknown
	Community Health Fairs & Screenings	Persons served - 30
	Dietician Services	Persons served - unknown
Community Based Clinical Services	Community Clinic donated charges and services	Persons served - 311
Health Professions Education	Health professions student education – nursing, imaging, therapy, pharmacy, medical student, respiratory students, lab, emergency medical technician, and advanced practice nursing	Number of students – 66 Benefit – 132,674
Financial and In-Kind Contributions	Marketing and Customer Services	Benefit – 3,304
	MHA Health Institute Donations	Benefit – 27,958
	Blood Drives	Benefit - 439

	Charity Meals and Lodging	Persons Served – 33,441
	Community Boards and Involvement	Benefit – 2,945
	Food & Facilities for Support Groups	Persons Served – 2,170
	Food & Facilities Provided for Schools & Special Seminars	Persons Served - 882
	Food & Facilities Provided to Community Organizations	Persons Served - 330
Community Building Activities – Workforce Development	Leadership Development Training for Community Members	Persons Served – 535 Benefit – 2,128
	M.A.S.H. program for high school students	Number of students
	Teen and college student volunteer programs	Number of students
Community Building Activities – Environmental Improvements		Cost of project

IV. Significant Health Needs Not Being Addressed

A complete description of the health needs prioritization process is available in the CHNA report. 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:

- **Lung Disease:** Lung Disease is our highest identified health need in our community, but there are many factors related to this disease that will be addressed through community collaborations. Such as, advocating for a Tobacco 21 ordinance to be added to the City of Joplin to combat the number of underage persons being exposed to nicotine. 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.
- **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.

Mercy
14528 S. Outer Road
Chesterfield, MO 63107
314.579.6100



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