



Community Health Improvement Plan

Mercy Hospital
Joplin

Fiscal Year 2023 - 2025



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.

Table of Contents

I.	Introduction	4
II.	Implementation Plan by Prioritized Health Need	5
	Prioritized Need #1: Access to Care	
	• Behavioral Health	
	• Community Health Worker Program	
	Prioritized Need #2: Diabetes	
	Prioritized Need #3: Medication assistance program	
III.	Other Community Health Programs Conducted by the Hospital	10
IV.	Significant Community Health Needs Not Being Addressed	12

I. Introduction

Mercy Joplin completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Community Board of Southwest Missouri/Southeast Kansas Directors in May 2022. The CHNA considered 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 four prioritized health needs the hospital plans to focus on addressing during the next three years: Lung Disease, Cardiovascular Disease, Mental Health, and Diabetes. The complete CHNA report is available electronically at mercy.net/about/community-benefits.

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 2022 CHNA and this resulting CHIP will provide the framework for Mercy Hospital Joplin as it works in collaboration with community partners to advance the health and quality of life for the community members it serves.

II. Prioritized Need #1: Access to Care

Implementation Plan by Prioritized Health Need

Prioritized Need #1a: Access to Care - Behavioral Health

GOAL: Increase access to mental health care

PROGRAM 1: Concert Health Collaboration
PROGRAM DESCRIPTION: Mercy Joplin will collaborate with Concert Health through the Mercy Behavioral Health hub to support primary care providers in providing mental and behavioral health services to patients in need. The model provides a behavioral care manager to interact directly with patient, performing assessment, initiating treatment, and communicating and collaborating with the primary care physician. Concert Health provides a psychiatric consultant who meets with care manager regularly, reviews patient’s chart, and makes recommendations for medication and ongoing treatment.
ACTIONS THE HEALTH SYSTEM INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: <ol style="list-style-type: none"> 1. Mercy will partner with the Mercy ministry-wide behavioral health hub to implement the Concert Health Collaboration in primary care clinics. 2. Train providers in use of platform 3. Promote the initiative 4. Identify gaps in care
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): <ol style="list-style-type: none"> 1. By the end of FY23, the initiative will go live in Mercy NWA primary care clinics. 2. By the end of FY23, 400 referrals will have been made to Concert Health, and 200 patients will become active patients. 3. By the end of FY23, primary care physicians will demonstrate understanding and acceptance of the initiative 4. Clinic patients enrolled in the initiative will demonstrate improved medication adherence and improved clinical outcomes. 5. Increase access to community resources through referrals to Community Health Workers
PLAN TO EVALUATE THE IMPACT: <ol style="list-style-type: none"> 1. Track number of primary care physicians participating in program. 2. Track number of referrals to Concert Health per month. 3. Track referrals from Concert Health to Community Health Workers
PROGRAMS AND RESOURCES THE HEALTH SYSTEM PLANS TO COMMIT: <ol style="list-style-type: none"> 1. Cost of coworker and physician time. 2. Operational budgeted support as appropriate. 3. Indirect expenses related to EMR and clinic operations
COLLABORATIVE PARTNERS: <ol style="list-style-type: none"> 1. Mercy Behavioral Health Hub

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| <ol style="list-style-type: none"> 2. Mercy Virtual Care Center 3. Concert Health 4. Mercy Clinics |
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Prioritized Need #1b: Access to Care – Community Health Workers

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

PROGRAM: 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, 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 Medicaid and financial assistance and connecting patients with community resources and medication assistance.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: <ol style="list-style-type: none"> 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): <ol style="list-style-type: none"> 1. By the end of each month, each CHW will have recorded 20 new and 20 ongoing encounters. 2. By the end of each fiscal year for the next three years, each CHW will enroll 80 patients in Mercy financial assistance 10 in Medicaid 3. Each CHW will assist at least 100 patients per year with community and medication assistance resources. 4. Patients enrolling in CHW program will demonstrate reduced ED utilization. 5. Patients enrolling in CHW program will demonstrate a reduction in their total cost of care. 6. Clinic patients enrolling in CHW program will demonstrate reduced no-show rate for follow-up clinic appointments.
PLAN TO EVALUATE THE IMPACT: <ol style="list-style-type: none"> 1. Track number of new and ongoing encounters conducted by each CHW.

2. Track number of patients successfully enrolled in Mercy financial assistance and Medicaid.
3. Track number of patients receiving community resource and medication assistance.
4. Analyze ED utilization clinic no-show rates for patients enrolled in CHW program.
5. Analyze total cost of care for patients enrolled in CHW program.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Compensation and benefits for Community Health Workers.
2. Mileage and travel expenses required for CHW work.
3. Office space and indirect expenses dedicated to CHW work.

COLLABORATIVE PARTNERS:

1. Care Partner Network
2. Mercy Clinics

Prioritized Need #2: Diabetes/Obesity/Nutrition

Goal: Decrease the prevalence of pre-diabetes and diabetes in the Joplin community

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. Program began in January 2017 and achieved full CDC recognition in June 2018.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: <ol style="list-style-type: none">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): <ol style="list-style-type: none">1. 50 new participants per fiscal year will enroll in the program and complete the first 4 sessions.2. Program retention rate will be at least 60%3. Average weight loss for participants completing the program will be at least 4%.4. Percent of participants completing program who have a reduction in HbA1C to normal levels will be at least 50%.
PLAN TO EVALUATE THE IMPACT: <ol style="list-style-type: none">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.2. Track number of provider referrals to DPP.3. Track the program retention rate for participants completing the first 4 sessions.4. 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).5. 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.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: <ol style="list-style-type: none">1. Cost of program coordinator time2. Financial assistance for participants unable to afford the cost of the program.3. Indirect expenses related to meeting space and overhead.
COLLABORATIVE PARTNERS: <ol style="list-style-type: none">1. Community Clinic of SWMO

Prioritized Need #4: Medication assistance program

Goal 4: Increase access to comprehensive, high-quality health care services.

PROGRAM 1: Dispensary of Hope
PROGRAM DESCRIPTION: Prescription medicines are critical for managing many common diseases and disorders. When people can't get the medicines they need, treatable conditions may get worse. Evidence shows that the most effective approaches for reducing delays and difficulty in getting prescription medicines involve addressing financial barriers and increasing insurance coverage. The Dispensary of Hope is a charitable medication distributor that delivers critical medicine donated by pharmaceutical manufacturers for free to the people who need it the most but cannot afford it. By partnering with Dispensary of Hope, Mercy Pharmacy can get access to their charitable formulary, connecting self-pay patients with the most dire financial need to essential medicines across a range of drug classes, including insulins, anti-infectives, and psychotropics.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: <ol style="list-style-type: none">2. In contract with the Dispensary of Hope, Mercy Pharmacy will manage charitable formularies within participating pharmacies, including maintaining inventory and making weekly orders.3. Mercy will use attestation form to enroll qualifying patients in the Dispensary of Hope program, and will promote the formulary with Mercy providers and co-workers across relevant departments, including Hospitalists and ED physicians, Care Management, Diabetes Education, Behavioral Health, and Mercy Clinic.4. Mercy will communicate with community partners, including other healthcare providers, to promote the use of the formulary for patients in need.5. Mercy will work to connect qualifying patients with Mercy Financial Assistance and Medicaid and Medicare as applicable.6. Mercy will standardize Dispensary of Hope processes, including Dispensary of Hope renewal processes, across communities to ensure seamless co-worker and patient experience and to improve patient outcomes.
HP2030 ALIGNMENT <ul style="list-style-type: none">• Objective AHS-06: Reduce the proportion of people who can't get prescription medicines when they need them
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): Short-Term Outcomes: <ol style="list-style-type: none">1. # 30-day prescriptions filled /month2. # patients served / month3. # patient encounters / month Medium-Term Outcomes: <ol style="list-style-type: none">1. Dollars saved for patients Long-Term Outcomes: <ol style="list-style-type: none">2. % reduction in ED visits3. % reduction in total cost of care
PLAN TO EVALUATE THE IMPACT: <ol style="list-style-type: none">1.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

<ol style="list-style-type: none"> 1. Annual contract fees to Dispensary of Hope for formulary access (\$12,500 per year per pharmacy) 2. Pharmacist support for formulary management 3. Marketing and communications support, in the form of flyers, rack cards, enrollment cards, etc. 4. Training for co-workers to understand enrollment process for Dispensary of Hope
<p>COLLABORATIVE PARTNERS:</p> <ol style="list-style-type: none"> 1. Dispensary of Hope 2. Internal: Mercy Pharmacy, Community Health & Access, Care Management, Hospitalists, Mercy Clinic, Concert Health 3. External providers

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	Bariatric Support Group	Persons served
	Diabetes Support Group	Persons served
	Community Health Fairs & Screenings	Persons served
	Community health education talks	Persons served
	Parkinson’s Disease Support Group	Persons Served
	Respite Care for homeless discharged patients	Persons served, housing assistance
Health Professions Education	Student shadow and training opportunities	Person’s Served

Financial and In-Kind Contributions	Time donated for wellness screenings with local homeless shelter	Persons Served
Community Building Activities – Workforce Development	Health professions student education – nursing, imaging, therapy, pharmacy, medical student, lab, emergency medical technician, and advanced practice nursing	Number of students
Community Building Activities – Environmental Improvements		Cost of services

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:

- **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 currently has a program, in coordination with area skilled nursing facilities, on addressing the needs and readmission rates of those with congestive heart failure. 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 highest identified health need in our community, but there are many factors related to this disease that will be addressed through community collaborations. Mercy Hospital Joplin representatives are actively engaged in community collaborations that promote a tobacco free lifestyle to fight this disease and are active in promoting screening options for the community to detect certain lung cancers sooner. 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 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

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