Community Health Improvement Plan

Mercy Hospital St. Francis

Fiscal Year 2023-2025

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 St. Francis completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors in April 2019. Building upon the success of the 2016 and 2019 regional health assessments, in 2021 partners again sought to better understand the health status, behaviors and needs of the populations served. The resulting 2022 Regional Health Assessment (RHA) combines more than 200 hospital and community indicators, including feedback from stakeholders and citizens, across a 30-county region that includes southwest Missouri, southeast Kansas and northeast Oklahoma.
The CHNA identified three prioritized health needs the hospital plans to focus on addressing during the next three years: Diabetes, Cancer and Substance use and recovery. The complete CHNA report is available electronically at mercy.net/about/community-benefits.

Mercy St. Francis is affiliated with Mercy, one of the largest Catholic health systems in the United States. Located in Mt. View, Mo, Mercy St. Francis's primary service area spans four counties across Central Missouri. #Mercy St. Francis Hospital is a Joint Commission accredited facility designated by the State of Missouri as a Critical Access Hospital. 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 St. Francis 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: Diabetes

Goal 1: Decrease the prevalence of pre-diabetes and diabetes in St. Francis.

PROGRAM: 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: 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): 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: 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: 1. Cost of program coordinator time 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.

Prioritized Need #2: Cancer

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: 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): 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:

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. MSU Care Clinic

Prioritized Need #3: Substance Use and Recovery

Goal: Increase prevention initiatives and substance use disorder treatment programs for uninsured and at-risk persons.

PROGRAM 1: Engaging Patients in Care Coordination (EPICC)
PROGRAM DESCRIPTION: The EPICC program, in partnership with the 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: • Community Health Leaders maintain ongoing relationship with BHN and other community partners, through participation in regional meetings and facilitation of data sharing and process improvement. • ED personnel facilitate referrals to BHN peer Recovery Coaches from the ED.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** • Increase the number of referrals of ED patients with opioid dependence to the EPICC program by 25% each year. ***Medium-Term Outcomes:*** • Increase the number of appointments scheduled by EPICC peer Recovery Coaches at hospital outreach by 30% each year. • Maintain at least a 50% engagement rate at two-week follow-up each year. ***Long-Term Outcomes:*** • Patients reached by the EPICC program will demonstrate a 10% reduction in ED utilization over 3 years. • Patients reached by the EPICC program will demonstrate a 10% reduction in inpatient readmissions over 3 years. • Reduce opioid-related deaths by 15% over 3 years.
PLAN TO EVALUATE THE IMPACT: • BHN will track number of program referrals. • BHN will track number of appointments scheduled. • BHN will track percent engagement rate. • Mercy will track the number of MAT waivered clinicians. • Mercy will report number of nonfatal overdoses in ED. • Mercy will record ED utilization rates and inpatient readmissions.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: • Support and education for ED staff to identify and facilitate EPICC referrals. • Staff time and indirect costs necessary to maintain ongoing partnership with BHN and community agencies, and to support MAT waivers for Mercy clinicians.
COLLABORATIVE PARTNERS:

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III. Other Community Health Programs

Mercy St. Francis 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		
	Diabetes Support Group	Persons served
	Dialysis services for indigent patients	Persons served, cost of services
	Community Health Fairs & Screenings	Persons served
	Community health education talks	Persons served
	Hospital medication assistance program	Persons served
	Transportation assistance programs	Persons served, cost of services
Health Professions Education	Internal Medicine Residency Program	Number of residents
	Health professions student education – nursing, imaging, therapy, pharmacy, medical student, lab, emergency medical technician, and advanced practice nursing	Numbers of students
	Trauma informed care	Number of coworkers
Financial and In-Kind Contributions	First Aid and EMS Standby for community walks and runs	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. Three health issues identified in the 2019 CHNA process—heart disease, cancer, and substance abuse—were not chosen as priority focus areas for development of the current Community Health Improvement Plan due Mercy's current lack of resources available to address these needs and the intention to focus on the four prioritized health needs. These issues will be addressed indirectly in implementation strategies developed to meet the prioritized needs in areas that may overlap. For example, efforts to reduce the incidence of type 2 diabetes in the community may also reduce the incidence of heart disease. Additionally, related community partnerships, evidence-based programming, and sources of financial and other resources will be explored during the next three-year CHIP cycle. Mercy St. Francis will consider focusing on these issues should resources become available. Until then, Mercy St. Francis 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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Your life is our life's work.