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Mercy Health Saint Mary's

Community Health Needs Assessment Implementation Strategy

Fiscal years 2019-2021

Mercy Health Saint Mary's completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Trustees on June 27, 2018. Mercy Health Saint Mary's performed the CHNA in adherence with certain federal requirements for not-for-profit hospitals set forth in the Affordable Care Act and by the Internal Revenue Service. The assessment took into account input from representatives of the community, community members, and various community organizations.

The complete CHNA report is available electronically at <https://www.mercyhealth.com/about-us/community-benefit/community-health-needs-assessment>, or printed copies are available at Mercy Health Saint Mary's campus.

**Hospital Information and Mission Statement**

Mercy Health Saint Mary's is a not-for-profit health care system and a ministry of Trinity Health, Michigan's largest and the nation's second largest Catholic Health System. Mercy Health Saint Mary's is committed to serving the people of greater Grand Rapids in Kent County, Michigan. Mercy Health Saint Mary's is directed by the core values of reverence, a commitment to those who are poor, justice, stewardship, and integrity.

**Mission**

We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our community.

**Health Needs of the Community**

The CHNA conducted in 2017 identified four significant health needs within the Mercy Health Saint Mary's community. Those needs were then prioritized based on an electronic survey, in which stakeholders and community members were asked to vote for the four health concerns the community should prioritize between 2017 and 2020 (fiscal years 2019-2021). The link to this survey was distributed through partner networks, including promotion through local radio and television. The survey was open between January 18-30, 2018, and garnered 808 responses. Kent County Health Department held a Summit in February 2018 at which results from both VoiceKent and the prioritization survey were presented. The top four priorities listed by the Kent County Health Department are mental health, substance use, obesity, and poor nutrition. The two lists were then presented to the Federally Qualified Health Center (FQHC) Governing Board, the Mercy Health Saint Mary's Community Health & Well-Being Committee, and the Mercy Health Saint Mary's Board of Trustees where engaging discussions were held beginning in February and concluding in June 2018. These groups are comprised of community members and leaders, community organizations, patients of the FQHC designated Community Health Centers, physicians, and Mercy Health Saint Mary's Community Health & Well-Being staff. The four significant health needs identified, in order of priority include:

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| **Mental health** | * Addressing mental health, including stress as it pertains to mental health. One in five Kent County residents felt mental health was one of the greatest health concerns within their communities and was identified as a priority health issue selected by the community to address in 2018. |
| **Substance use** | * Addressing substance use disorders, including all nicotine products. 16.7% of Kent County residents felt substance use was one of the greatest health concerns within their communities and was identified as a priority health issue selected by the community to address in 2018. |
| **Obesity** | * Addressing obesity, including poor nutrition and food insecurity. One in five Kent County residents felt obesity was one of the greatest health concerns within their communities and was identified as a priority health issue selected by the community to address in 2018. |
| **Diabetes** | * Addressing prediabetes and diabetes. 19.6% of Kent County residents felt diabetes was one of the greatest health concerns within their communities. |

**Hospital Implementation Strategy**

The significant health needs identified through the most recent CHNA process were reviewed while taking into account the organizations resources and overall alignment with the hospital’s mission, goals and strategic priorities.

**Significant health needs to be addressed**

Mercy Health Saint Mary's will focus on developing and/or supporting initiatives and measure their effectiveness, to improve the following health needs:

* + **Mental health –** Detailed need specific Implementation Strategy on page 3
  + **Substance use –** Detailed need specific Implementation Strategy on page 5
  + **Obesity –** Detailed need specific Implementation Strategy on page 7
  + **Diabetes –** Detailed need specific Implementation Strategy on page 9

**Significant health needs that will not be addressed**

Mercy Health Saint Mary's (MHSM) acknowledges the input received from the community in regards to the health of their communities. The organization commits to address all four of the priority health needs identified by the community.

This implementation strategy specifies community health needs that the Hospital has determined to meet in whole or in part and that are consistent with its mission. The Hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the three years ending in 2021, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.

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| **CHNA IMPLEMENTATION STRATEGY**  **FISCAL YEARS 2019-2021** | | | |
| **HOSPITAL FACILITY:** | Mercy Health Saint Mary's | | |
| **CHNA SIGNIFICANT HEALTH NEED:** | Mental health | | |
| **CHNA REFERENCE PAGE:** | 50 | **PRIORITIZATION #:** | 1 |
| **BRIEF DESCRIPTION OF NEED:**   * Kent County residents identified the following as the most common barriers to accessing mental healthcare services: cost (44.7%); feeling embarrassment or shame (34.4%); did not know whom to call (27.3%); fear or distrust of the healthcare system (27.2%); and cultural beliefs about health (19.6%). * Cost as a barrier to accessing mental healthcare was most prevalent for individuals with an annual household income of less $25,000. * Among Kent County adults, 7.5% reported their mental and emotional health as poor and 2.1% rated their mental and emotional health as failing. * More than one in ten Kent County residents (13.4%) reported 14 or more poor mental health days in the past 30 days, including approximately one-third of individuals with an annual household income of less than $25,000. * Nearly one-quarter of Kent County middle school students (23.6%) and one-third of high school students (32.2%) reported feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months. * During the past 12 months, 15.8% of high school students seriously considered attempting suicide, 13.3% made a plan, and 6.9% attempted suicide one or more times. Approximately one in five (20.6%) middle school students had ever considered suicide, 13.0% had ever made a plan, and 7.8% had ever attempted suicide.   Source: 2017 Kent County CHNA (<https://accesskent.com/Health/pdf/2017KC_CHNA.pdf>) | | | |
| **GOAL:**   1. Increase access to mental health services 2. Promote awareness and reduce stigma, shame, and embarrassment related to mental health | | | |
| **OBJECTIVE:**   1. Increase the number of primary care offices that offer integrated mental health services by three by 2021. 2. Decrease the perception of stigma by engaging in six community events and conversations on mental health by 2021. 3. Educate and empower providers to provide caring and effective assistance to patients with suicide risk by 2021. | | | |
| **ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:**   1. Employ a mental health provider to offer mental health services in three additional offices 2. Provide event sponsorship to "Stomp Out Stigma" walk with the Mental Health Foundation of West Michigan and/or "NAMIWalks" with the National Alliance on Mental Illness annually from 2019-2021. 3. Host one community conversation for adults and one community conversation for youth annually from 2019-2021 inclusive of mental health statistics, how to detect mental health concerns in oneself and others, and development of an action plan on how to utilize this knowledge when encountering someone experiencing a mental health concern or crisis. 4. Train three providers in Zero Suicide program | | | |
| **ANTICIPATED IMPACT OF THESE ACTIONS:**   1. Increased access to and utilization of mental health services 2. Increased knowledge and comfortability in detecting mental health concerns in oneself and others 3. Improved provider knowledge and confidence in assessing, managing and treatment planning for patients at risk of suicide, including safety planning and reduction of access to lethal means | | | |
| **PLAN TO EVALUATE THE IMPACT:**   1. Track the number of primary care offices that offer integrated mental health services on a biannual basis 2. Track number of patients accessing integrated mental health services on a biannual basis 3. Track the ratio of population to mental health providers on an annual basis from 2019-2021 4. Conduct a pre- and post-test of those attending the community conversations on their knowledge and comfortability in detecting mental health concerns in oneself and others 5. Survey providers trained in the Zero Suicide program using the Zero Suicide Workforce Survey at a minimum, once every three years | | | |
| **PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:**   1. Cash and in-kind financial resources (FY2020 and FY2021 budget to include program expenses) | | | |
| **COLLABORATIVE PARTNERS:**  Mental Health Foundation of West Michigan  National Alliance on Mental Illness  Kent County Population Health Behavioral Task Force  Education Development Center | | | |

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| **CHNA IMPLEMENTATION STRATEGY**  **FISCAL YEARS 2019-2021** | | | |
| **HOSPITAL FACILITY:** | Mercy Health Saint Mary's | | |
| **CHNA SIGNIFICANT HEALTH NEED:** | Substance use | | |
| **CHNA REFERENCE PAGE:** | 123 | **PRIORITIZATION #:** | 2 |
| **BRIEF DESCRIPTION OF NEED:**   * In 2017, 15.4% of Kent County residents reported current cigarette use. This is lower than the state (20.4%) and national (16.4%) average. The national target is 12%. * In 2017, 5.5% of Kent County residents reported current electronic cigarette use. This is higher than the state (4.9%) and national (4.5%) average. * Among Kent County youth, 1.9% of middle school students and 5.8% of high school students reported current cigarette use; half (50.7%) of high school students who are current smokers attempted to quit smoking within the past 12 months. * Per the most recent data available at the time of this report, the number of opioid-related deaths in Kent County in 2017 (93) exceeded those in 2016 (70). Between 1999 and 2015 in Kent County, the drug-induced mortality rate (including deaths from any drug) increased nearly fourfold, from 4.2 per 100,000 to 16.2.   Source: 2017 Kent County CHNA (<https://accesskent.com/Health/pdf/2017KC_CHNA.pdf>) | | | |
| **GOAL:**   1. Increase access to treatment for substance use disorders 2. Increase screening and affordable access to nicotine cessation resources | | | |
| **OBJECTIVE:**   1. Reduce accessibility as a barrier for individuals seeking treatment for substance use by 2020. 2. Increase number of patients who use nicotine products and are referred to cessation resources by two-percent by 2021. | | | |
| **ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:**   1. Implement an Addiction Medicine Program inclusive of medication-assisted treatment (MAT) and case management to address drug-related deaths from narcotics, methadone, and heroin by increasing personnel, training, and system improvements. 2. Provide MAT to 575 individuals and support 370 patients with mental health needs by 2020. 3. Engage clinical leadership to set a standard of referring patients who use nicotine products to cessation resources. | | | |
| **ANTICIPATED IMPACT OF THESE ACTIONS:**   * Increased access to substance use treatment * Increased number of existing and new patients connected to mental health and substance use treatment through the Addiction Medicine Program * Decreased * Increased number of patients who use nicotine products who are referred to cessation resources | | | |
| **PLAN TO EVALUATE THE IMPACT:**   1. Track the number of substance use treatment programs in Kent County annually from 2019-2021. 2. Track the number of new and existing patients accessing mental health and substance use treatment through the Addiction Medicine Program on a biannual basis after implementation 3. Track the drug-induced mortality rate in Kent County annually from 2019-2021 4. Track the number of patients who use nicotine products and are referred to cessation resources on a biannual basis | | | |
| **PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:**  Financial resources (FY2020 and FY2021 budget to include program expenses)  Personnel | | | |
| **COLLABORATIVE PARTNERS:**  N/A | | | |

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| **CHNA IMPLEMENTATION STRATEGY**  **FISCAL YEARS 2019-2021** | | | |
| **HOSPITAL FACILITY:** | Mercy Health Saint Mary's | | |
| **CHNA SIGNIFICANT HEALTH NEED:** | Obesity and poor nutrition | | |
| **CHNA REFERENCE PAGE:** | 137 | **PRIORITIZATION #:** | 3 |
| **BRIEF DESCRIPTION OF NEED:**   * Obesity among Kent County adults increased from 27.6% in 2014 to 34.1% in 2017. This is higher than the state (32.5%) and the national (28.9%) average. The national target is 30.5%. * Obesity increased among Kent County youth as well; in 2014, 9.7% of middle school and 11.4% of high school students were obese, compared to 11.4% of middle school and 12.5% of high school students in 2016. * Nearly one in five (19.7%) of Kent County adults reported no leisure-time physical activity in the past month. One-third of residents (35.0%) reported thirty minutes or more of physical activity at least five times per week. * Middle school students (58.6%) were more likely than high school students (52.0%) to be physically active for 60 minutes per day for at least five of the past seven days. * In 2017, 16% of Kent County adults reported a challenge in obtaining fresh fruits and vegetables within their community. * Among Kent County adults, 14% skipped meals, 12.8% felt hungry and did not eat, 21.3% worried that food would run out, and 18.2% did not have enough food and could not purchase more. * One in five Kent County adults reported they were not always able to buy or receive all the healthy food needed for their families.   Source: 2017 Kent County CHNA (<https://accesskent.com/Health/pdf/2017KC_CHNA.pdf>) | | | |
| **GOAL:**   1. Increase BMI screening, intervention, and education 2. Increase access to fresh food and physical activity opportunities | | | |
| **OBJECTIVE:**   1. Increase BMI screening with a documented intervention from 50% to 90% by 2021. 2. Provide nutrition counseling by a Registered Dietician by 2021. 3. Implement a "Walk with a Doc" program by 2020. 4. Collaborate with community organizations who provide access to fresh food by 2020. 5. Increase by 10% the number of community members who participate in the onsite physical activity classes by 2021. 6. Identify patients who report food insecurity using the Social Determinants of Health (SDoH) screening tool by 2020. | | | |
| **ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:**   1. Engage clinical leadership to set a standard of documenting an intervention with every BMI screening above 25 and encourage follow-up provider visits to monitor progress. 2. Hire and integrate a full time Registered Dietician who is credentialed in weight management and rotates clinical sites to improve access to nutrition counseling for patients. 3. Implement a "Walk with a Doc" program hosting a community walk on a monthly basis after implementation. 4. Utilize vouchers to introduce and incentivize access to community farm markets by 2020. 5. Develop an action plan to increase capacity, increase number of locations where classes are offered, assess types of classes offered to appeal to all cultural preferences, and assess financial assistance resources if cost is a barrier for the onsite physical activity classes by 2021. 6. Utilize the SDoH screening tool, which includes questions on food insecurity and provide community resources who address food access by 2020. 7. Ensure SDoH screening tool and interventions are visible within the EHR for improved coordination of care. 8. Assess community resources and identify opportunities for collaboration, support, and advocacy as a means of sustainability. | | | |
| **ANTICIPATED IMPACT OF THESE ACTIONS:**   1. Increased number of patients with BMI over 25 who have received an intervention to address weight management 2. Increased access to nutrition counseling services 3. Increased number of patients referred to a Registered Dietician 4. Decreased number of people who report no leisure-time physician activity in the past 30 days 5. Increased number of people who report they consume at least one fruit or one vegetable per day 6. Increased opportunities for safe, indoor physical activity 7. Decreased number of patients who report food insecurity 8. Consistent screening to identify those who are food insecure | | | |
| **PLAN TO EVALUATE THE IMPACT:**   1. Track the number of BMI screenings including a documented intervention on a biannual basis 2. Track the number of patients referred to a Registered Dietician on a biannual basis 3. Conduct a pre- and post-test for participants of the "Walk with a Doc" program on whether physical activity has increased since joining the program and gauge participant interest in additional physical activity opportunities and connect them to additional community resources 4. Conduct a pre- and post-test for participants on whether fruit and vegetable consumption has increased since utilizing the community farm markets 5. Track the number of community member participation in onsite physical activity classes assessed on a quarterly basis 6. Establish a baseline of patients experiencing food insecurity | | | |
| **PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:**   1. Personnel 2. Cash and in-kind financial resources (FY2020 and FY2021 budget to include program expenses) | | | |
| **COLLABORATIVE PARTNERS:**  YMCA  Urban Roots  Our Kitchen Table  Community Food Club  Food pantries  Access of West Michigan  Seeds of Promise  Heartside Gleaning Initiative | | | |

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| **CHNA IMPLEMENTATION STRATEGY**  **FISCAL YEARS 2019-2021** | | | |
| **HOSPITAL FACILITY:** | Mercy Health Saint Mary's | | |
| **CHNA SIGNIFICANT HEALTH NEED:** | Diabetes | | |
| **CHNA REFERENCE PAGE:** | 141 | **PRIORITIZATION #:** | 4 |
| **BRIEF DESCRIPTION OF NEED:**   * Among Kent County adults, 10% of respondents have been told by a doctor that they have diabetes (excluding gestational diabetes). This is lower than the state (11.2%) and national (10.5%) average. This is an increase from 9.6% in 2014. * The population subgroups most likely to have been told they have diabetes were residents aged 65 years or older, African Americans, and individuals with an annual household income less than $25,000. * The diabetes-associated mortality rate in Kent County has historically been lower than the state and national average, and has been decreasing over time. In 2016, Kent County's rate (11.2 per 100,000) was less than half the statewide rate (26.9 per 100,000) and the national rate (24.8 per 100,000).   Source: 2017 Kent County CHNA (<https://accesskent.com/Health/pdf/2017KC_CHNA.pdf>) | | | |
| **GOAL:**   1. Connect individuals to resources to address prediabetes and diabetes | | | |
| **OBJECTIVE:**   1. Increase number of provider referrals to education and management opportunities for those with prediabetes by 15% annually from 2019-2021. 2. Improve access to the Diabetes Improvement Program class by 2020. 3. Provide community education on prediabetes and diabetes by 2020. | | | |
| **ACTIONS THE HOSPITAL FACILITY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:**   1. Educate providers on the referral process to connect patients with prediabetes to a Diabetes Prevention Program class. 2. Host three Diabetes Improvement Program classes at Mercy Health facilities. 3. Develop and conduct three outreach events to provide education on the signs or prediabetes and diabetes and connect individuals to community resources. | | | |
| **ANTICIPATED IMPACT OF THESE ACTIONS:**   1. Increased number of patients with prediabetes or diabetes who are connected to education and management opportunities to address contributing factors to diabetes such as nutrition, physical activity, and weight management | | | |
| **PLAN TO EVALUATE THE IMPACT:**   1. Track the number of referrals made to the Diabetes Prevention Program and Diabetes Intervention Program on a biannual basis 2. Measure weight loss of program participants on a biannual basis 3. Track the number of referrals made to community resources at each outreach event | | | |
| **PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:**  Personnel  Cash and in-kind financial resources (FY2020 and FY2021 budget to include program expenses) | | | |
| **COLLABORATIVE PARTNERS:**  National Kidney Foundation of Michigan  YMCA of Greater Grand Rapids | | | |

Adoption of Implementation Strategy

On October 31, 2018, the Board of Directors for Mercy Health Saint Mary's met to discuss the 2017 (Fiscal Years 2019-2021) Implementation Strategy for addressing the community health needs identified in the 2017 Community Health Needs Assessment. Upon review, the Board approved this Implementation Strategy.

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