MERCYHEALTH

2022 Community Health Needs Assessment – Implementation Plan

Mercy Health — St. Rita's Medical Center, LLC

2023 – 2025 Community Health Needs Assessment – Implementation Plan

Mercy Health – St. Rita's Medical Center, LLC

Adopted by the Mercy Health- St. Rita's Medical Center Board of Trustees, April 27, 2023

Mercy Health has been committed to the communities it serves for nearly two centuries. This long-standing commitment has evolved intentionally, based on our communities' most pressing health needs.

The following document is a detailed Community Health Implementation Plan for St. Rita's Medical Center, LLC. As a system, Mercy Health is dedicated to our Mission of extending the compassionate ministry of Jesus by improving the health and well-being of our communities and bringing good help to those in need, especially people who are poor, dying and underserved. We strive to create effective strategies to meet the health needs of our community.

Having identified the greatest needs in our community, the Community Health Implementation Plan ensures our resources for outreach, prevention, education, and wellness are directed towards opportunities where the greatest impact can be realized.

Mercy Health — St. Rita's Medical Center

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Introduction

Mercy Health- St. Rita's Medical Center, LLC ("Mercy Health Lima") serves a 10-county region throughout west central Ohio, providing comprehensive, high-quality medical services, including the Henry and Beverly Hawk Vascular & Heart Center at St. Rita's, St. Rita's Orthopedic Care Center, the Neuroscience Institute, trauma and emergency, comprehensive cancer treatment, women's health, maternity, pediatrics, sports medicine and rehabilitation, behavioral health services, home care, and hospice. Mercy Health- St. Rita's Medical Center has 407 registered beds, has more than 15,000 discharges per year, provides over 51,000 emergency department admissions and is a joint venture with the Institute for Orthopedic Surgery. Other health care delivery facilities include one-free standing emergency department, 1 ambulatory surgery center and 29 physician practice sites. St. Rita's Medical Center is an affiliated hospital with The Ohio State University Comprehensive Cancer Center-Arthur G. James Cancer Hospital and Richard J. Solove Research Institute's (OSUCCC-James).

The detailed process, participants, and results are available in Mercy Health Lima Community Health Needs Assessment, which is available at Mercy.com

This Community Health Needs Assessment Implementation Plan will address the prioritized significant community health needs through the CHNA. The Plan indicates which needs Mercy Health Lima will address and how, as well as which needs Mercy Health Lima won't address and why.

Beyond programs and strategies outlined in the plan, Mercy Health Lima will address the health care needs of the community by continuing to operate in accordance with its mission to extend the healing ministry of Jesus by improving the health of its communities with emphasis on the poor and underserved. This includes providing care for all individuals regardless of their ability to pay.

The strategies in this Implementation Plan will provide the foundation for addressing the community's significant needs between 2023 – 2025. However, Mercy Health Lima, anticipates that some strategies, and even the needs identified, will evolve over that period. Mercy Health Lima plans a flexible approach to addressing the significant community needs that will allow for adaption to changes and collaboration with other community agencies.

Community Served by the Hospital
The community served by this hospital is defined as the counties within the primary service area containing the residential address for equal to or greater than 75% of the patients discharged during the most recently completed calendar year for which data is available at the beginning of the community health needs assessment process.

Geographic Identifiers: Allen County, Auglaize County, and Putnam County, Ohio. Community served by the hospital was defined as the primary service area: Allen County, Auglaize County, and Putnam County. Patient data indicates that 80% of persons served at Mercy Health Lima reside in the primary service area, based on the county of residence of discharged inpatients during 2020.

The population size of Allen County is 102,808 residents, Auglaize County has a population of 45,709 residents, and Putnam County has a population of 33,836 residents. The median age of the Allen County population is 39.4 years of age, median age for Auglaize County is 40.4 years of age, and median age for Putnam County is 40.2 years of age.

Our Mission

As a system Mercy Health is dedicated to extending the compassionate ministry of Jesus by improving the health and well-being of our communities and bring good help to those in need, especially people who are poor, dying and underserved.

Our Vision

Inspired by God's hope for the world, we will be a ministry where associates want to work, clinicians want to practice, people seek wellness and communities thrive.

Our Values

Human Dignity

We commit to upholding the sacredness of life
and being respectful and inclusive of everyone.

Integrity

We commit to acting ethically and modeling right relationships
in all of our individual and organizational encounters.

Compassion

We commit to accompanying those we serve with mercy and
tenderness, recognizing that "being with" is as important as "doing for."

Stewardship

We commit to promoting the responsible use of all human
and financial resources, including Earth itself.

Service

We commit to providing the highest quality in every dimension of our ministry.

Executive Summary

Background and Process

Mercy Health Lima identified the significant needs of its community by participating in a collaborative effort across key stakeholders from Allen, Auglaize, and Putnam counties. Mercy Health Lima utilized data from three large, comprehensive county documents that included primary and secondary data from multiple sources and combined such data with the results from a written survey of adults and youth in the community. Input from the community was obtained through various methods as outlined in Mercy Health Lima's CHNA.

Key stakeholders from Mercy Health Lima, including but not limited to clinical leaders, physicians, administration, and community agency representatives from Allen, Auglaize, and Putnam counties, participated in the CHNA prioritization for Mercy Health Lima on March 30, 2022. Based on the data presented (attached in CHNA Appendix), over 50+ stakeholders identified 15 significant health needs (Chronic Disease Management, Substance Abuse, Mental Health, Maternal/Infant Health, Diabetes, Housing, Provider Access, Preventive Screenings, Transportation, Smoking, Tobacco Cessation, Medication Access, K-12 Readiness/Success, Obesity, Cancer, Food Access/Insecurity).

Identifying Significant Needs

The 50+ key stakeholders ranked all 15 significant health needs by magnitude, the seriousness of the consequence, and the feasibility of correcting the problem. This method of ranking allows for health needs to be ranked as objectively as possible based on the data.
After the ranking, the committee voted and determined the top seven health issues that may be addressed through hospital-wide efforts as identified in the prioritized health needs.

Implementation Plan

Mercy Health Lima is committed to addressing the prioritized significant health needs of the community through the strategies described in this Implementation Plan.

Prioritized Significant Health Needs

The table below lists the prioritized significant health needs that were identified through the CHNA and specifies which needs Mercy Health Lima will address.

Prioritized Significant Health Needs	Hospital Addressing Need
Chronic Disease Management	Yes
Substance Abuse	Yes
Mental Health	Yes
Maternal & Infant Health	Yes
Access	Yes
Healthy Behaviors	Yes
Housing & Community Conditions	Yes

Prioritized Significant Social Determinant of Health Needs Implementation Strategies:

Housing & Community Conditions

Description
As detailed in the hospital's Community Health Needs Assessment Report:

Many groups in the region have conducted various housing studies to gain greater understanding of the region's housing stock, gaps, and opportunities. The issues of a lack of affordable workforce housing, poor quality rental homes, a lack of housing stock and older housing continue to rise. A deep dive into the neighborhood just north of the hospital details these poor living conditions.

Goal 1:
Identify communities with high lead exposures and improve their overall health outcomes.

Expected impact
Increase lead screenings with ambulatory practice and referrals to appropriate community resources for high-risk populations.

Targeted populations
Children (0-5 years old), Individuals with poor housing and a lack of access to local providers.

Strategy 1.1:
Partner with Mercy Health Lima Physicians, WOCAP, and other community partners to reduce lead exposures locally with a focus on communities with disparities and promote environmental justice.

- **Year 1**- Collaborate with Mercy Health Lima ambulatory care practices to collect baseline data on the number of children receiving lead screenings and baseline data for the # of referrals for services. Identify internal team members, local lead abatement contracts, develop resources, and increase capacity to effectively address.
- **Year 2** - Continue efforts from Year 1, increase lead screenings by 5% and 5% increase in referrals from baseline.
- **Year 3** - Continue efforts from Year 2, increase lead screenings by 10% and 10% increase in referrals from baseline.

Strategic measure 1.1:
Increase Mercy Health Lima Primary Care lead screenings for children ages 0-5 by 10% and increase referrals to community resources by 10% from baseline by December 31, 2025.

- **Strategic Measure:** Lead screenings performed by Mercy Health Lima ambulatory care; # of positive screens and # of referrals to community resources.
- **Baseline #'s:** Need to identify baseline number for screenings and referrals.

Community collaborations

- Project 129, LLC., Mercy Health Physicians- Lima, WOCAP.

Community resources available

The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- WOCAP, Mercy Health- Lima, City of Lima, Project 129 LLC.

Goal 2:

Increase access to safe and stable housing for new parents and decrease infant mortality.

Expected impact

Development of referral and triage program for new parents that will decrease infant mortality.

Targeted populations

New mothers, low or disrupted incomes with unstable housing, Single parents (specifically in Census Tracts 129, 124 and 141 within Lima)

Strategy 2.1:

Partner with Help Me Grow, City of Lima, and WOCAP to ensure safe and stable housing for new parents.

- **Year 1** - Identify needs, develop a referral and triage program, and establish a baseline for the # of new parents counseled and # of referrals.
- **Year 2** - Continue efforts from Year 1, implement program and increase new parents counseled by 6% from baseline.
- **Year 3** - Continue efforts from Year 2, increase new parents counseled by 12% from baseline.

Strategic measure 2.1:

By December 31, 2025, develop a referral and triage program to increase the # of new parents that are counseled on safe housing needs and referred to a community navigator/liaison by 12% from baseline.

- **Strategic Measure:** Development of referral and triage program, # of new parents counseled and # of referrals to community navigator/liaison.
- **Baseline #:** Need to establish baseline # for new parents counseled and # of referrals.

Community collaborations

- Currently working collaboratively with the Maternal & Infant Task Force and our Housing priority group to develop and map out the process of implementing a triage program.

Community resources available

The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- WOCAP, Help Me Grow, Heartbeat of Lima, Health Partners of Western Ohio, Mercy Health- Lima, City of Lima, Project 129 LLC., Habitat for Humanity.

Goal 3:
Increase childcare options that are available within the community.

Expected impact
Establish three new childcare options within Allen, Auglaize, and Putnam counties to support medical employees and increase childcare slots by 10%.

Targeted populations
Medical associates and working parents

Strategy 3.1:
Actively support and/or develop additional childcare options in Allen, Auglaize, and Putnam counties.

- **Year 1** - Identify three new potential areas for potential childcare options from baseline, establish baseline measure for # of childcare slots and # of childcare facilities that provide food. Begin to provide land to Putnam County, renovate and establish Allen County, and explore feasibility of options in Wapakoneta, with goal of opening one in Year 2.
- **Year 2** - Continue efforts from Year 1 and open one location (Allen County). Support ongoing process to identify, renovate and establish potential sites of care in Auglaize and Putnam County and increase available childcare slots by 5% from baseline.
- **Year 3** - Continue efforts from Year 2 and increase the # of available childcare slots by 10% and establish childcare slots by 5% from baseline.

Strategic measure 3.1:
Help to partner and/or establish three childcare options within Allen, Auglaize, and Putnam County to help support medical employees and other working parents by increasing available childcare slots by 10% and the number of childcare facilities that provide food by 10% by December 31, 2025.

- **Strategic Measure:** # of childcare facilities available to serve medical associates and # of childcare slots available, # of childcare facilities that provide food.
- **Baseline #:** Need to establish baseline # for childcare slots and # of childcare facilities that provide food.

Community collaborations

- Currently working and exploring three potential locations that could house childcare options in Allen, Auglaize, and Putnam counties.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Local childcare facilities, Children's Hunger Alliance, West Ohio Food Bank, Local YMCA's, Activate Allen County.

Goal 4:
Support and provide a safe and inviting environment for surrounding community members.

Expected impact
Establish three new pocket parks in Census Tracts 129, 134 and 141 in Lima, Ohio.

Targeted populations
Residents in Lima Census Tracts 129, 134, 141

Strategy 4.1:
Collaborating and partnering with local neighborhoods to establish and open three new pocket parks in underserved identified census tracts/neighborhoods by December 31, 2025.

- **Year 1** - Identify three new potential sites for pocket parks from baseline. Establish new pocket park in Census Tract 129.
- **Year 2** - Continue efforts from Year 1 and expand to two pocket parks from baseline in Census Tracts 129 and 134.
- **Year 3** - Continue efforts from Year 2 and expand to three pocket parks from baseline in Census Tracts: 129, 134 and 141.

Strategic measure 4.1:
Partner with local neighborhoods to establish and open three new pocket parks in underserved identified census tracts/neighborhoods by December 31, 2025.

- **Strategic Measure:** # of pocket parks in Census Tracts 129, 134 and 141.
- **Baseline #:** 0 pocket parks currently.

Community collaborations

- Hospital is currently involved in the OHIZ (Ohio Health Improvement Zone) grant through ODH, in which we are actively working to increase access to services in Census Tracts 129, 134 and 141 in conjunction with a community navigator and local neighborhood associations.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- WOCAP, Mercy Health- Lima, City of Lima, Project 129 LLC, SAFY, Activate Allen County, Allen County Public Health Department.

Goal 5:
Decrease housing blight and improve housing stability.

Expected impact
That a landlord registry will be created and developed to help improve housing affordability and stability for residents in Lima, Ohio.

Targeted populations
Children (0-5 years old), Individuals with poor housing and a lack of access to local providers.

Strategy 5.1:
Improve the number of rental stock options in the City of Lima.

- **Year 1** - Explore the feasibility with partners on creating a landlord registry.
- **Year 2** - Continue efforts from Year 1, update feasibility and explore potential census tracts to implement landlord registry.
- **Year 3** - Continue efforts from Year 2.

Strategic measure 5.1:
Partner with the City of Lima to explore the feasibility of developing and implementing a landlord registry by December 31, 2025.

- **Strategic Measure:** Develop a landlord registry for Lima, Ohio.
- **Baseline #:** currently, a landlord registry does not exist.

Community collaborations

- Have been working with the City of Lima, their City Council and newly formed Community Improvement Corporation (CIC) to start the development of a landlord registry for Lima, Ohio.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- WOCAP, Mercy Health- Lima, City of Lima, Project 129 LLC.

Goal 6:
Increase home ownership in Census Tract 129 in the City of Lima.

Expected impact
To increase homeownership in Census Tract 129 to 315 homes, decrease rent burden to 55% and increase homeownership/financial engagements to 15 individuals.

Targeted populations
Residents in Census Tract 129, and those affected with rent burden.

Strategy 6.1:
Increase homeownership in Census Tract 129, while decreasing rent burden and increasing financial literacy.

- **Year 1** - Collaborate with partners, implement Project 129 for Census Tract 129. Establish process and methods.
- **Year 2** - Continue efforts from Year 1 and increase homeownership by 2.5%, decrease rent burden by 1.5% and increase homeownership/financial education class engagement by 5% from baseline.
- **Year 3** - Continue efforts from Year 2 and increase homeownership by 5%, decrease rent burden by 5% and increase homeownership/financial education class engagement by 10% from baseline.

Strategic measure 6.1:
By December 31, 2025, partner with Project 129 LLC., WOCAP, Habitat for Humanity, and local financial institutions to increase homeownership by 5%, decrease rent burden by 5% and increase engagement in homeownership/financial education classes by 10% in Census Tract 129.

- **Strategic Measure:** # of homes owned in Census Tract 129; % of those who are rent burden and the # of individuals who complete a homeownership/financial education class.
- **Baseline #:** 300 homes are owned, rent burden is 61%, and homeownership/financial education classes is currently 0.

Community collaborations

- Currently collaboratively working with the community resources identified below as part of our Direct Community Investment fund for the work within Census Tract 129.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- WOCAP, Mercy Health- Lima, City of Lima, Project 129 LLC., Superior Credit Union, Premiere Bank, Greater Lima Region, Inc.

Mental Health

Description
As detailed in the hospital's Community Health Needs Assessment Report:

Mercy Health- Lima's primary service area shows a concern in mental health needs in both adult and adolescent populations. Depression, anxiety, bullying, social isolation, and suicide ideation have been identified as high-priority focus areas to address.

Goal 1:
Address, educate, and provide resources to adolescents facing mental health challenges.

Expected impact
Increase capacity for youth mental health programming.

Targeted populations
Adolescents with Behavioral Health Needs

Strategy 1.1:
Screen for mental health problems among youth and connect them with needed resources to address these issues and expand the number of mental health programs available.

- **Year 1** - Expand mental health screening programs targeted to youth by increasing youth screenings by establishing baseline measure for number of programs provided to youth and number of youth screenings. Develop inventory of school behavioral health services to review with school.
- **Year 2** - Continue efforts from Year 1 and increase youth programs by 3% and increase screenings by 5% from baseline. Update inventory of resources to review with school.
- **Year 3** - Continue efforts from Year 2 and increase youth programs by 5% and increase screenings by 10% from baseline. Update inventory of resources to review with school.

Strategic measure 1.1:
Expand mental health screening programs targeted for youth by 5% and increase screenings by 10% of current baseline screenings by December 31, 2025.

- **Strategic Measure:** # of mental health programs available for youth, # of youth mental health screenings, # of suicide attempts (149 in 2022) and # of drug overdoses (103 in 2022).
    - Youth that considered suicide: 15% of Allen County youth, 18% of Auglaize County youth.
    - Youth that have felt sad or hopeless for almost every day for 2 or more weeks in a row:
    - 27% for Allen County, 27% for Auglaize County. Youth who had attempted suicide in the past year:
        - 7% for Allen County, 4% for Auglaize County.
    - Poor self-reported mental health (% of adults, so not a good representation): 25.7% for Census Tract 127 and 25.6%,18.8% for Census Tract 403, and 17% for Census Tract 30.

Community collaborations

- Currently working with the Mental Health & Recovery Services Board of Allen, Auglaize, Hardin counties; Putnam ADAMHS Board, local schools, Mercy Health Behavioral Health.

Community resources available

The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Mental Health & Recovery Services Board of Allen, Auglaize, Hardin counties; Putnam ADAMHS Board, Mercy Health Behavioral Health, SAFY, Behavioral Health providers, School Navigators.

Goal 2:

Maximize the reach and efficiency of mental health clinicians.

Expected impact

Increase access and reach of current telehealth capabilities at Mercy Health Primary Care Practices and align to local community resources.

Targeted populations

Adolescents with Behavioral Health Needs

Strategy 2.1:

Using telehealth, extend the reach and efficiency of current mental health clinicians that are currently insufficient in size to address community health needs.

- **Year 1** - Explore capabilities and opportunities to expand the mental health telehealth capabilities and access and establish the baseline number of patients who are currently utilizing telehealth services.
- **Year 2** - Continue efforts from Year 1 and increase patients who currently utilize telehealth services by 5% from baseline.
- **Year 3** - Continue efforts from Year 2 and increase patients who currently utilize telehealth services by 10% from baseline.

Strategic measure 2.1:

Explore the capabilities and opportunities to expand the mental health telehealth capabilities and access with Mercy Health, Mental Health Boards, local providers, and community organizations, and increase the number of patients who currently utilize telehealth services by 10% by December 31, 2025.

- **Strategic Measure:** Expanded access to telehealth services to address behavioral and mental health within Lima Primary Care practices, # of patients who currently utilize telehealth services.
- **Baseline=** 0 practices leveraging telehealth as mental health option,
    - Poor Self-reported mental health: 25.9% for Census Tract 136, 18.8% for Census Tract 403, and 17% for Census Tract 301
    - Depression: 24.2% for Census Tract 129 and Census Tract 127, 23.7% for Census Tract 403, 20.30% for Census Tract 302.

Community collaborations

- Mercy Health - Lima Ambulatory Practices.

Community resources available

The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Mental Health & Recovery Services Board of Allen, Auglaize, Hardin counties; Putnam ADAMHS Board, Mercy Health Behavioral Health, SAFY, Behavioral Health providers, School Navigators.

Goal 3:

Increase access to mental health services.

Expected impact

Develop a local dashboard highlighting local and available mental health resources.

Targeted populations

Adolescents with Behavioral Health Needs

Strategy 3.1:

Create dashboard/webpage increasing local awareness of available mental health services.

- **Year 1** - Explore feasibility of creating and developing a mental health webpage and establish a baseline to calculate # of engagements.
- **Year 2** - Create awareness of this service through hospital/other partners and increase engagement by 5% from baseline.
- **Year 3** - Continue efforts from Year 2 and increase engagement by 10% from baseline.

Strategic measure 3.1:

Create a mental health webpage (with map) that shows all mental health services/where they are/if telehealth options available and get 10% engagement by December 31, 2025.

- **Strategic Measure:** Development of a dashboard and increased engagements in dashboard by 10%.
- **Baseline:** currently, no dashboard exists, need to establish baseline for total # of engagements.
    - Percent Depressed (Baseline: 24.10% for Tract 136, 23.70% for Tract 403, 20.20% for Tract 302).
    - Poor self-reported mental health (Baseline: 25.90% for Tract 136, 18.80% for Tract 403, 17% for Tract 302).

Community collaborations

- Currently leverage Allen County Health Atlas and stakeholders that consists of Activate Allen County, Lima/Allen Chamber of Commerce, Allen County Public Health, Mental Health & Recovery Services Board of Allen, Auglaize, and Hardin counties, City of Lima, Regional Planning Commission, United Way.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Mental Health & Recovery Services Board of Allen, Auglaize, Hardin counties; Putnam ADAMHS Board, Mercy Health Behavioral Health, SAFY, Behavioral Health providers, School Navigators.

Goal 4:
Decrease poverty level and hardship index.

Expected impact
Develop two adult vocational training programs in underserved census tracts to offer training and employment opportunities to decrease poverty and positively influence mental health.

Targeted populations
Adolescents with Behavioral Health Needs

Strategy 4.1:
Design employment program opportunities to positively influence mental health.

- **Year 1** - Explore feasibility and develop options for training courses Mercy Health could partner with or aid in (Pharmacy techs, electrical technicians, construction, etc.).
- **Year 2** - Continue efforts from Year 1, begin implementation of programs and get target market aware of the opportunity/enrolled.
- **Year 3** - Continue efforts from Year 2, help those in the program with the job search afterwards to help get them employed.

Strategic measure 4.1:
Implement two adult vocational training programs and decrease poverty rate by 2% of baseline by December 31, 2025.

- **Strategic Measure:** # of vocational training programs developed and decreased poverty rate.
- **Baseline #:** 0 vocational training programs
    - **Poverty Rate** (Baseline: 40.67% for Tract 136, 12.82%
    - for Tract 402, 12.13% for Tract 301).
    - **Labor Force Participation**
    - (Baseline: 63.39% for Tract 136, 62.67% for Tract 402, 61.94% Tract 301).
    - **Hardship Index** (Baseline:91.6 for Tract 136, 92.8 for Tract 402,93.5 for Tract 301).
    - **Unemployment Rate** (Baseline: 14.36% for Tract 136, 6.30% for Tract 402,4.89% for Tract 301).

Community collaborations

- Central District of Lima, Apollo Career Center, Ohio Means Jobs.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- WOCAP, Mercy Health- Lima, City of Lima, Project 129 LLC., Ohio Means Jobs, Mental Health Boards.

Goal 5:
Increase support for school personnel to better assist youth.

Expected impact
Identify, develop, implement, and deploy well-being and resiliency programming to better support school personnel by facilitating local focus groups to be understand how to support school personnel to build and develop resiliency.

Targeted populations
Adolescents with Behavioral Health Needs

Strategy 5.1:
Increasing resiliency of school personnel to better assist youth.

- **Year 1** - Facilitate focus groups with school personnel to determine 3 main stressors regarding mental health and establish baseline # of youth programs and # of youth screenings.
- **Year 2** - Continue efforts from Year 1, develop a plan to address and begin implementation, increase screening programs by 2.5% and youth screenings by 5% from baseline.
- **Year 3** - Continue efforts from Year 2, review plan and reassess with school personnel to identify if new barriers and/or challenges exists that need to be addressed. Increase screening programs by 5% and youth screenings by 10% from baseline.

Strategic measure 5.1:
Expand mental health screening programs targeted for youth by 5% and increase screenings by 10% of current baseline screenings by December 31, 2025.

- **Strategic Measure:** # of focus groups and the # of program implemented (currently both at 0).
- **Baseline Measure:** Need to identify baseline measure for # of programs and # of screenings.

Community collaborations

- Currently working with the Mental Health Boards to effectively address with the school navigators.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Mental Health & Recovery Services Board of Allen, Auglaize, Hardin counties; Putnam ADAMHS Board, Mercy Health Behavioral Health, SAFY, Behavioral Health providers, School Navigators.

Access

Description
As detailed in the hospital's Community Health Needs Assessment Report:

Many factors influence health outcomes, such as access to health care, social determinants of health, public health systems and prevention, and health equity. Mercy Health Lima has chosen to focus on a multitude of access issues that negatively impact one's health. Committee members have identified a variety of these barriers to access including access to providers, access to medication, access to transportation, access to food and access to employment. Preventing access to any one of these can have negative impacts on an individual's health.

Goal 1:
Increase access to healthcare services in underserved census tracts within Allen, Auglaize, and Putnam counties.

Expected impact
Increase access to healthcare services in underserved areas by providing 15 health education events that provide primary care services to individuals where access may be a barrier.

Targeted populations
Underserved populations, Place-based Economic Hardship, Black/African American's

Strategy 1.1:
Partner with St. Rita's Residency Programs, Ohio Northern University HealthWise Mobile Clinic, Fire and EMS to increase opportunities to obtain medical services in underserved areas.

- **Year 1** - Identify underserved areas, medical services that are needed most and collaborate to set up five new events from baseline.
- **Year 2** - Continue efforts from Year 1 and increase number of events to 10 from baseline.
- **Year** 3 - Continue efforts from Year 2 and increase total number of events to 15 from baseline.

Strategic measure 1.1:
Complete 15 new health education events in identified underserved census tracts by December 31, 2025.

- **Strategic Measure:** # of health education events in underserved areas; baseline is currently 0.
    - Percent of adults who visited a doctor for routine check-up within last year (Baseline: 71% for Allen County; 77.5% for Putnam County; and 59% for Auglaize County.

Community collaborations

- Mercy Health Lima is currently working with Ohio Northern University and the St. Rita's Graduate Medical Education residents and other community providers to effectively address gaps in care and to appropriate address through the Mobile Clinic.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- WOCAP, Mercy Health- Lima, City of Lima, Project 129 LLC/

Strategy 1.2:
Administer the 419 Place-based Disparities program to provide community needs assessments to help identify barriers of care, provide follow-up to residents 3 months post event, and provide appropriate referrals to community resources.

- **Year 1** - Identify high-need census tracts, complete 250 needs assessments, 70% follow-up and 1.5% increase in referrals from baseline.
- **Year 2** - Continue efforts from Year 1 and increase needs assessments to 500, 80% follow-up and 3% increase in referrals from baseline.
- **Year 3** - Continue efforts from Year 2 and increase needs assessments to 750, 90% follow-up and 5% increase in referrals from baseline.

Strategic measure 1.2:
Complete 750 needs assessments in identified census tracts and provide follow-up for 90% of event attendees to assess engagement, and 5% increase in the number of referrals by December 31, 2025.

- **Strategic Measure:** # of health needs assessments completed (2022= 250); % of attendees provided post-event follow-up (2022=75%), 35 referrals.

Community collaborations

- Currently Mercy Health-Lima has employed a Community Navigator who is working with local organizations and community resources to effectively address any barriers to care and to refer out to the most appropriate resource to help address.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Mercy Health- Lima provides services to ensure access to primary care providers and health insurance coverage. Other service providers in the community included Lima Memorial Health System, Bluffton Hospital, Health Partners of Western Ohio, Joint Township District Memorial Hospital, Mental Health and Recovery Services, Ohio Northern University, primary care, and specialty providers.

Goal 2:
Increase access to healthy food and vegetables on a regular basis to food-insecure individuals in underserved Census Tracts (CT's).

Expected impact
Decrease food insecurity to school youth by implementing 9 onsite food pantries and weekend meal programs to schools serving a high % of food insecure youth.

Targeted populations
Food insecure adolescents

Strategy 2.1:
Partner with the West Ohio Food Bank (WOFB) and Children's Hunger Alliance (CHA) to establish on-site school pantries and implement weekend meal packs through the Adopt-A-School program.

- **Year 1** - Identify three new distribution areas for weekend food kits and/or establish new school pantries from baseline.
- **Year 2** - Continue efforts from Year 1 and expand to six new distribution areas for weekend food kits and/or establish new school pantries from baseline.
- **Year 3** - Continue efforts from Year 2 and expand to nine new distribution areas for weekend food kits and/or establish new school pantries from baseline.

Strategic measure 2.1:
Increase the number of on-site school pantries and/or weekend meal pack sites by 9 implementations sites by December 31, 2025.

- **Strategic Measure:** # of on-site schools implanting an onsite pantry and/or weekend meal program (2022=2)
    - Percent of residents who experience food insecurity (Baseline: 14% for Allen County; 10% for Auglaize County; and 9% for Putnam County.
    - 25% of Allen County youth reported not eating breakfast any of the days of the week.
    - 10% of Allen County adults had to choose between paying bills and buying food.

Community collaborations

- Mercy Health Lima is currently collaborating with the West Ohio Food Bank and Children's Hunger Alliance to provide strategic food delivery options where access and food insecurity remains a concern for youth with our local schools.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- West Ohio Food Bank, Churches United Pantry, St. Vincent De Paul Food Pantry, Our Daily Bread Soup Kitchen, Downtown Farmers Market, Community Gardens.

Strategy 2.2:
Partner with Activate Allen County (AAC) and the West Ohio Food Bank (WOFB) to expand the Green Prescription (Rx) program to Specialty Practices and increase the number of referrals from Mercy Health providers.

- **Year 1** - Identify two new specialty practices for Green Rx implementation and increase provider referrals by 2.5% from baseline.
- **Year 2** - Continue efforts from Year 1 and identify four new specialty practices for Green Rx implementation and increase provider referrals by 5% from baseline.
- **Year 3** - Continue efforts from Year 2 and identify 6 new specialty practices for Green Rx implementation and increase provider referrals by 7.5% from baseline.

Strategic measure 2.2:
Expand access to the Green Prescription (Rx) program to six new specialty practices per year and increase Mercy Health provider referrals by 7.5% by December 31, 2025.

- **Strategic Measure:** # of specialty practices that have implemented the Green Prescription program, % of provider referrals.
- **Baseline:** is 0 (2022); provider referrals = 2022 (25).

Community collaborations

- Mercy Health Lima is currently partnering with Activate Allen County and the West Ohio Food Bank to implement the Green Prescription program to all Mercy Health Lima Primary Care practices.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Mercy Health Lima primary care, specialty care, Activate Allen County, West Ohio Food Bank, local food pantries, community gardens, downtown Farmer's Market, Children's Hunger Alliance.

Goal 3:
Increase access to transportation and high dollar medication.

Expected impact
Improve access to transportation for provider visits by increasing Mercy Express program service delivery area to underserved areas by increasing patients served by 10%.

Targeted populations
Individuals who identify transportation and medication as a barrier to care

Strategy 3.1:
Explore the feasibility of expanding the Mercy Express transportation program.

- **Year 1** - Explore the feasibility of expanding Mercy Express program and identifying potential funding partners and/or opportunities from baseline.
- **Year 2** - Continue efforts from Year 1, update feasibility and explore potential grant opportunities for transportation alignment from baseline.
- **Year 3** - Continue efforts from Year 2, update feasibility and explore potential grant opportunities for transportation alignment from baseline.

Strategic measure 3.1:
Explore the feasibility of increasing hours and the distance of service area to increase access opportunities for individuals who identify transportation as a barrier by December 31, 2025.

- **Strategic Measure:** # of patients served by Mercy Express.
- **Baseline:** (2022=3,582 transports).

Community collaborations

- Currently work with Mercy Express, Black and White Cab, Lima Regional Transit Authority to effectively address transportation issues for patients who lack transportation.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Mercy Express, Public Transportation, Transportation Services.

Strategy 3.2:
Expand the access of the Prescription Assistance Program. Educate teams on overall availability.

- **Year 1** - Educate providers about available services. Increase access to Prescription Assistance Programs by collaborating with local physician office and St. Rita's Care Coordinators. Establish baseline number.
- **Year 2** - Continue efforts from Year 1. Increase referrals by 10% from baseline (an additional pharmacy technician may be needed to achieve this goal).
- **Year 3** - Continue efforts from Year 2. Increase referrals by 15% from baseline.

Strategic measure 3.2:
Expand referrals by 15% over baseline by December 31, 2025.

- **Strategic Measure:** # of referrals to Prescription Assistance
- **Baseline Measure:** Need to establish baseline measure

Community collaborations

- Currently work across all practices and specialties to identify patients lack access to medication and are unable to afford, through our Mercy Action program and leveraging our Pharmacy Patient Tech Navigator.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Mercy Health-Lima, Dispensary of Hope, Mercy Action, Lima Memorial Health System, Bluffton Hospital, Health Partners of Western Ohio, Joint Township District Memorial Hospital, Mental Health & Recovery Services, primary care, specialty care practices and outpatient pharmacy.

Prioritized Significant Social Health Needs Implementation Strategies:

Substance Abuse

Description
As detailed in the hospital's Community Health Needs Assessment Report:

Mercy Health Lima's primary service area shows a concern in substance abuse in both adult and youth populations. Drug use and overdose deaths have been identified as high priority focus areas to address. For instance, 13% of Allen County youth had used marijuana in the past 30 days and 13.9% of Putnam County youth have used illicit drugs in the past year. In Allen County, 17% of adults currently binge drink and 4.3% of all Putnam County residents have been diagnosed with an alcohol/substance abuse/dependence by a medical professional.

Goal 1:
Reduce and prevent unintentional drug overdose deaths.

Expected impact
Reduce and prevent unintentional drug overdose by increasing Naloxone dispensing efforts to 275 doses throughout St. Rita's Medical Center.

Targeted populations
Individuals affected by opioid use disorder or those affected by the opioid epidemic. Mental health patients and the unemployed population.

Strategy 1.1:
Provide naloxone to those in need to decrease the risk of death due to opioid overdose.

- **Year 1** - Increase YoY naloxone dispensing by 10% throughout the hospital and Family Medicine Clinic from baseline.
- **Year 2** - Continue efforts from Year 1 with a stretch goal of increasing by 15% from baseline.
- **Year 3** - Continue efforts from Year 2 with a stretch goal of increasing by 20% from baseline.

Strategic measure 1.1:
Increase year over year naloxone dispensing hospital-wide and within the Family Medicine clinic by 20% of baseline by December 31, 2025.

- **Strategic Measure:** # of naloxone doses dispensed.
- **Baseline:** 128 total doses of naloxone dispensed by Mercy Health- St. Rita's Outpatient Pharmacy (2022); 100 doses of naloxone dispensed through Emergency Department (2022).

Community collaborations
Currently working with all local and area providers through task force.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Mental Health & Recovery Services Board, UMADOP, Coleman Professional Services, Family Resource Center, Health Partners of Western Ohio, Allen County Health Department, Central Ohio Poison Center, Joint Township District Memorial Health, primary and specialty care providers.

Goal 2:
Prevent drug abuse and/or misuse.

Expected impact
Decrease drug abuse and/or misuse by increasing the number of Emergency Department Providers that are waivered for buprenorphine to 90%.

Targeted populations
Emergency Department Physicians, Residents, Physician Assistants, and Nurse Practitioners.

Strategy 2.1:
Increase the % of Emergency Department providers with a waiver for buprenorphine for Medication-Assisted Treatment (MAT).

- **Year 1** - Increase the number of ED providers waivered by 50% from baseline (increase to 46% of providers)
- **Year 2** - Continue efforts from Year 1 and increase ED providers waivered by 75% from baseline.
- **Year 3** - Continue efforts from Year 2 and increase ED providers waivered by 90% from baseline.

Strategic measure 2.1:
Increase the number of Emergency Department Providers that waivered for buprenorphine 90% of baseline by December 31, 2025.

- **Strategic Measure:** # of Emergency Department providers that are waivered.
- **Baseline:** Currently 9 of 29 (31%) ED providers are waivered.

Community Collaborations
Currently working with local substance abuse providers through collaborative efforts to aligns efforts and resources.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Mental Health & Recovery Services Board, UMADOP, Coleman Professional Services, Family Resource Center, Health Partners of Western Ohio, Allen County Health Department, Central Ohio Poison Center, Joint Township District Memorial Health, primary and specialty care providers.

Goal 3:
Decrease cigarette and tobacco use for adult smokers in Allen, Auglaize, and Putnam Counties.

Expected impact
Decrease cigarette and tobacco use for adult smokers in Allen, Auglaize, and Putnam Counties by increasing provider referrals to St. Rita's Smoking Cessation Clinic up to 230 total referrals.

Targeted populations
Adult smokers, low income, poor housing, and individuals presenting with behavioral health needs.

Strategy 3.1:
Partner with Activate Allen County, Allen County Public Health Department, Mercy Health Physicians, community organizations and local providers to increase referrals to St. Rita's Smoking Cessation Clinic.

- **Year 1** - Increase referrals by 5% from baseline.
- **Year 2** - Continue efforts from Year 1 and increase referrals by 10% from baseline.
- **Year 3** - Continue efforts from Year 2 and increase referrals by 12% from baseline.

Strategic measure 3.1:
Increase referrals to St. Rita's Smoking Cessation Clinic by 12% from baseline by December 31, 2025.

- **Strategic Measure:** # of provider referrals.
- **Baseline:** 207 provider referrals in 2022.

Community collaborations

- Currently working Activate Allen County, Allen County Public Health Department, Mercy Health Primary Care and Specialty Practices.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Activate Allen County, St. Rita's Medical Center, Ohio Department of Health State Quit Line, Blanchard Valley Health System- Bluffton Hospital.

Strategy 3.2:
Partner with Activate Allen County, Allen County Public Health Department, Mercy Health Physicians, community organizations and local providers to increase enrollment into Ohio Department of Health Tobacco Quit Line.

- **Year 1** - Conduct outreach and training to service providers servicing 3% of adults to increase referrals for enrollment into Ohio Tobacco Quit Line by .25%% of adult smokers from baseline. Complete cessation related community outreach and engagement activities. Support and expand the reach of state level media cessation mass media campaign.
- **Year 2** - Continue efforts from Year 1 and increase referrals for enrollment into Ohio Tobacco Quit Line by .5% of adult smokers from baseline.
- **Year 3** - Continue efforts from Year 2 and increase referrals for enrollment into Ohio Tobacco Quit Line by 1% of adult smokers from baseline.

Strategic measure 3.1:
By December 31, 2025, document enrollment to Ohio Tobacco Quit Line for 1% of adult's smokers in Allen County.

- **Strategic Measure:** # of adult Allen County smokers enrolled.
- **Baseline #:** 1% of adult smokers is 192 adults enrolled in State Quit Line.

Community collaborations

- Working with Activate Allen County and Allen County Public Health Department on the Tobacco Use & Prevention grant through Ohio Department of Health to increase enrollment into the state tobacco quit line for users in Allen County.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

Activate Allen County, Allen County Public Health Department, Mercy Health Physicians, community organizations and local providers.

Healthy Behaviors

Description
As detailed in the hospital's Community Health Needs Assessment Report:

Healthy behaviors are a prioritized health need for Mercy Health- Lima's primary service area. Smoking, alcohol, binge drinking, drug use, lack of exercise, poor nutrition, and high weight status have been identified as a high priority focus area to address.

Goal 1:
Decrease cigarette, tobacco, and vaping use for adult and youth smokers in Allen, Auglaize, and Putnam Counties. Provide education regarding harmful effects of tobacco/vaping. Provide resources for tobacco cessation programs/Ohio Tobacco Quit Line.

Expected impact
Decrease youth nicotine use and the # of adult smokers by increasing the # of tobacco/vaping education events to 15 for youth and aligning referrals to the St. Rita's Tobacco Cessation program from the Allen County Schools wellness programming.

Targeted populations
Adults, teen smokers, families

Strategy 1.1:
Partner with Allen County Public Schools wellness programming and local schools to provide tobacco cessation education to staff and students and increase enrollment into the Ohio Tobacco Quit Line.

- **Year 1** - Complete five school education events, increase referrals by 1.5% and OTQL enrollment by 1% from baseline.
- **Year 2-** -Continue efforts from Year 1 and complete ten school education events, increase referrals by 3% and OTQL enrollment by 2% from baseline.
- **Year 3** - Continue efforts from Year 2 and complete fifteen school education events, increase referrals by 5% and OTQL enrollment by 3% from baseline.

Strategic measure 1.1:
Complete 15 student tobacco/vaping school education events, increase referrals to St. Rita's Tobacco Cessation Program by 5% and increase referrals for enrollment into Ohio Tobacco Quit Line by 1% of adult smokers from baseline.

- **Strategic Measure:** # of school education events focused on tobacco/vaping; # of referrals to tobacco cessation program; # enrolled in Ohio Tobacco Quit Line for Allen County.
- **Baseline #:** school education events = 5 (2022); total referrals from schools= 5, Baseline measure for Ohio Tobacco Quit Line enrollment= 10, 1% of Adult Smokers is 192 adults enrolled in State Quit Line.

Community collaborations

- Working with Activate Allen County and Allen County Public Health Department on the Tobacco Use & Prevention grant through Ohio Department of Health to increase enrollment into the state tobacco quit line for users in Allen County.

Community resources available

The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

Activate Allen County, Allen County Public Health Department, Mercy Health Physicians, community organizations and local providers.

Goal 2:

Increase adult physical activity.

Expected impact

Increase adult physical activity by providing 15 Walk with a Doc events, providing 70% post event follow-up to participants, and increasing provider referrals to the program by 5%.

Targeted populations

Inactive adults in Census Tracts 129, 134 and 141

Strategy 2.1:

Partner with the St. Rita's Family Medicine Residents, Lima YMCA, and the City of Lima to expand the Walk with a Doc program to underserved census tracts within Allen County to increase adult physical activity.

- **Year 1** - Identify high-need census tracts, complete 5 Walk with a Doc events, and establish baseline numbers for % of follow-up with attendees and # of referrals.
- **Year 2** - Continue efforts from Year 1 and complete 10 Walk with a Doc events, 60% follow-up with attendees and a 3% increase in referrals from baseline.
- **Year 3** - Continue efforts from Year 2 and complete 15 Walk with a Doc events, 70% follow-up with attendees and a 5% increase in referrals from baseline.

Strategic measure 2.1:

Complete 15 Walk with a Doc program events in identified census tracts within Lima, provide follow-up to 70% of attendees to assess engagement, and a 5% increase in referrals by December 31, 2025.

- **Strategic Measure:** # of Walk with a Doc program events; % of follow-up provided to attendees, # of provider referrals to program.
- **Baseline:** Establish baseline number for # of walk with a doc event, % of follow-up provided to attendees, # of provider referrals to program.

Community collaborations

- Currently collaborating with the Lima YMCA, St. Rita's Medical Center Family Medicine Residents, Activate Allen County, and residents in Census Tracts 129, 134 and 141.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Local YMCAs, City of Lima, Mercy Health Lima, Local fitness centers, St. Rita's providers and community providers.

Strategy 2.2:
Partner with Activate Allen County and other community organizations to develop and implement an Activated Business Challenge to increase adult physical activity.

- **Year 1** - Explore the feasibility of developing and implementing an Activated Business Challenge. Implement assessment rubric/framework with local partners.
- **Year 2** - Continue efforts from Year 1 and have 10 businesses engaged and awarded from baseline.
- **Year 3-** -Continue efforts from Year 2 and have 15 businesses engaged and awarded from baseline.

Strategic measure 2.2:
Partner with Activate Allen County and other community organizations, to explore the feasibility of developing an Activated Business Challenge program with the goal of awarding 15 businesses from baseline by December 31, 2025.

- **Strategic Measure:** # of businesses awarded the Activated Business Challenge.
- **Baseline:** 0 currently in 2022.

Community collaborations

- Currently in the process of revisiting the framework to deploy through Activate Allen County.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Activate Allen County, Lima/Allen County Chamber of Commerce, Greater Lima Region, Inc., Allen Economic Development Group, local and community businesses.

Strategy 2.3:
Develop an Exercise Prescription program through the Family Medicine Resident Clinic and UNOH Family Medicine Center.

- **Year 1** - Explore the feasibility of developing an Exercise Prescription (Ex Rx) program in conjunction with the Family Medicine Resident Clinic and UNOH Family Medicine. Establish a baseline measure for # of referrals.
- **Year 2** - Continue efforts from Year 1 and pilot the program with increasing referrals by 5% from baseline.
- **Year 3** - Continue efforts from Year 2 with expanding to 2 primary care practices with increasing referrals by 10% from baseline.

Strategic measure 2.2:
Partner with Mercy Health Family Medicine Physicians, local YMCAs and other community fitness centers to explore the feasibility of developing an Exercise Prescription (Ex Rx) program with the goal of increasing referrals by 10% from baseline by December 31, 2025.

- **Strategic Measure:** Development and Implement an Exercise Prescription program; # of provider referrals.
- **Baseline:** Establish baseline measures for # of referrals in Year 1.

Community collaborations

- Working to pilot at UNOH Family Medicine practice in conjunction with Activate Allen County and the Lima Family YMCA.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

Activate Allen County, Mercy Health family medicine practices, Local YMCAs, Local community and fitness center, Mercy Health Lima residents, Parks & Recreation.

Goal 3:
To support physical, mental, spiritual health and wellness.

Expected impact
Support physical, mental, spiritual health and wellness by providing 15 community-based health events in underserved communities.

Targeted populations
Adults and youth within Allen, Auglaize, and Putnam counties.

Strategy 3.1:
Community-based health events.

- **Year 1** - Complete 5 community-based health events from baseline.
- **Year 2** - Continue efforts from Year 1 and complete 10 community-based health events from baseline.
- **Year 3** - Continue efforts from Year 2 and complete 15 community-based health events from baseline.

Strategic measure 3.1:
Partner with Activate Allen County to provide 15 Neighborhood Block parties and/or Healthy Family Expos by providing health resources and screenings to underserved census tracts within Allen County by December 31, 2025.

- **Strategic Measure:** # of community health events held.
- **Baseline:** 3 community health events (2022).

Community collaborations

- Work with Activate Allen County towards their development of the Neighborhood Block Parties to help bring community health and local resources to areas that lack access to resources.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Local churches, local community organizations, Activate Allen County, local non-profits, local government, local health care providers

Goal 4:
Increase youth physical activity and nutritional access.

Expected impact
Expand school-based nutrition and physical activity programming to 41,250 total youth engagements.

Targeted populations
Youth (K-12)

Strategy 4.1:
School-based nutrition and physical activity programs.

- **Year 1** - Expand programming to support a 5% increase in youth programming engagements that encourage healthy nutrition and physical activity from baseline.
- **Year 2** - Continue efforts from Year 1 and increase programming efforts by 7% from baseline.
- **Year 3** - Continue efforts from Year 2 and increase programming efforts by 10% from baseline.

Strategic measure 4.1:
Expand school-based nutrition and physical activity programming, such as GoNoodle, Activated School Challenges and Healthy Nutrition education workshops, to increase youth programming engagements by 10% from baseline by December 31, 2025.

- **Strategic Measure:** # of individuals engaged in school-based nutrition and physical activity programming.
- **Baseline:** 37,500 total unique youth engagements (2022).

Community collaborations

- Plan to offer GoNoodle and health and nutrition workshops at local affiliated community schools to increase awareness around prevention and encourage healthy eating and exercise. Will also support the Activated School Challenges through Activate Allen County.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

Activate Allen County, GoNoodle, Mental Health & Recovery Services Board, Local schools, St. Rita’s Medical Center Weight Management.

Strategy 4.2:
Community-based nutrition and physical activity programs.

- **Year 1** - Expand programming to support a 1.5% increase in youth programming engagements that encourage healthy nutrition and physical activity from baseline.
- **Year 2** - Continue efforts from Year 1 and increasing programming efforts by 3% from baseline.
- **Year 3** - Continue efforts from Year 2 and increase programming efforts by 5% from baseline.

Strategic measure 4.2:
Expand community-based nutrition and physical activity programming, such as Wapakoneta Healthy Kids Day, Bridging the Gap screenings and Farm & Safety Day events, to increase youth programming engagements by 5% from baseline by December 31, 2025.

- **Strategic Measure:** # of youth programming engagements.
- **Baseline #:** 500 total youth programming engagements.

Community collaborations

- Currently, partner with community organizations to plan for the Bridging the Gap event, which is an event that is intended for minority health screenings and health services. Aligning with our school partners to implement school-based programming form a variety of services lines.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

Mercy Health, Lima Memorial Health System, Health Partners of Western Ohio, local community organizations, area schools, Bradfield Community Center, Activate Allen County.

Strategy 4.3:
Implement a childcare challenge program.

- **Year 1** -Expand programming to support an increase in youth programming engagements and childcare facilities and establish baseline measure for # of program engagements.
- **Year 2** - Continue efforts from Year 1 and increase programming efforts by 6% and increase by 9 childcare facilities from baseline.
- **Year 3** - Continue efforts from Year 2 and increase programming efforts by 10% and increase by 12 childcare facilities from baseline.

Strategic measure 4.3:
Partner with Activate Allen County to expand childcare based nutrition and physical activity programming, through the Activated Child Care Challenge to increase youth programming engagements by 10% and increase to 12 childcare facilities from baseline by December 31, 2025.

- **Strategic Measure:** # of youth programming engagements; # of childcare facilities.
- **Baseline Measure:** Establish baseline measure for # of programming engagements; # of childcare facilities is 3 (2022).

Community collaborations

- Currently working with Activate Allen County in support of their Activated Child Care Challenge

Community resources available

The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:
Mercy Health St. Rita's Medical Center, Activate Allen County, local childcare, and community centers

Prioritized Significant Clinical Health Needs Implementation Strategies:

Chronic Disease Management:

Description
As detailed in the hospital's Community Health Needs Assessment Report:

Adult and youth obesity are a prioritized health need for Mercy Health- Lima's primary service area. Chronic illnesses such as heart disease, diabetes, and cancer can be directly correlated with a lack of exercise, poor nutrition, high weight status and a lack of access to preventive screenings.

Goal 1:
Reduce the complications of diabetes.

Expected impact
Reduce the complications of diabetes for patients who are food insecure by increasing total enrollments into Green Prescription program.

Targeted populations
Diabetic patients with SDOH of Food Insecurity

Strategy 1.1:
Increase access to healthy food prescription program to reduce food insecurity and improve diet quality.

- **Year 1** - Connect patients with food resources through the Green Prescription program and increase enrollments by 2% from baseline.
- **Year 2** - Continue efforts from Year 1 and increase patient enrollments into the Green Prescription program by 15% from baseline.
- **Year 3** - Continue efforts from Year 2 and increase patient enrollments into the Green Prescription program by % from baseline.

Strategic measure 1.1:
Increase the number of enrolled patients by 20% for the Green Prescription (Rx) program with an emphasis on reducing disparities by December 31, 2025.

- **Strategic Measure:** # of diabetic patients enrolled in the Green Prescription program.
- **Baseline #:** Establish baseline measurement in 2023.

Community collaborations

- Partnership with Activate Allen County, West Ohio Food Bank and Mercy Health in delivering the Green Prescription program.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- St. Rita's Diabetes Clinic, West Ohio Food Bank, Activate Allen County, local food pantries, Health Partners of Western Ohio, farmers markets, community gardens.

Strategy 1.2:
Keeping pre-diabetes and diabetes under control through effective disease management and proactive referrals.

- **Year 1** - Increase provider referrals to the Diabetes Management Clinic And establish baseline measurement for # of referrals.
- **Year 2** - Increase provider referrals to the Diabetes Management Clinic by 5% from baseline.
- **Year 3** - Continue efforts from Year 2 and increase provider referrals to the Diabetes Management Clinic by 10% from baseline.

Strategic measure 1.2:
Increase the number of referrals by 10% for Diabetes Clinic with an emphasis on reducing disparities by December 31, 2025.

- **Strategic Measure:** # of provider referrals.
- **Baseline #:** establish baseline measure for # of referrals in 2023.
- Percent of adults who have been told by a health professional that they have diabetes (Baseline: 12% for Allen County; 11% for Auglaize County; 18% for Putnam County. Source: 2021 CHNA.).

Community collaborations

- Currently working with providers and population health to increase referrals to the Diabetes Management Clinic.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Mercy Health St. Rita's Medical Center, Health Partners of Western Ohio, area providers, Lima Memorial, local specialty clinics.

Strategy 1.3:
Increase the % of primary care patients meeting HbA1c Control through the MaGiCQ Core Measures.

- **Year 1** - Decrease the number of patients with HbA1c>9 by 1% from baseline.
- **Year 2** - Continue efforts from Year 1 and decrease number of patients with HbA1c>9 by 2% from baseline.
- **Year 3** - Continue efforts from Year 2 and decrease number of patients with HbA1c>9 by 3% from baseline.

Strategic measure 1.3:
Decrease the number of patients with HbA1c>9 by 3% with an emphasis on reducing disparities by December 31, 2025

- **Strategic Measure:** # of patients with a HbA1c>9
- **Baseline #:** Current performance for HbA1c>9 is at 15% of patients non-adherent due to value or time (2022).

Community collaborations

- Currently working with Mercy Health Lima Ambulatory Care Practices to effectively address when screening patients.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Mercy Health- Lima Ambulatory Care Practices, Care Coordination, Community Initiatives Addressing Exercise and Healthy Eating, Comprehensive Oral Health Program w/ Health Partners of Western Ohio.

Goal 2:
Reduce Cancer Mortality.

Expected impact
To decrease cancer mortality by increasing the # of referrals captured in Epic for high-risk preventive cancer screenings by 5% from baseline.

Targeted populations
Patients with high risk factors for developing cancer, especially those patients without access to primary care providers; Black/African Americans

Strategy 2.1:
Increase the number of cancer screenings reported by community events and primary care patients through MaGiCQ Core Measures.

- **Year 1** - Continue cancer awareness, outreach, and screening efforts focused on breast, colon, cervical and lung cancers. Work in conjunction with Cancer Center for their CoC (Commission on Cancer) requirements of screening, education, and disparities. Establish baseline measure for # of referrals for mammograms, colonoscopies, low dose CT lung cancer screenings and Pap tests.
- **Year 2** - Continue efforts from Year 1 and increase referrals by 2.5% from baseline.
- **Year 3** - Continue efforts from Year 2 and increase referrals by 5% from baseline.

Strategic measure 2.1:
Increase the number of referrals by 5% for breast, prostate, cervical and lung cancer with emphasis on reducing disparities by December 31, 2025.

- **Strategic Measure:** # of referrals for preventive cancer screenings and MaGiCQ Core Measures
- **Baseline:** Need to establish baseline measures for # of referrals for mammograms, colonoscopies, low dose CT lung cancer screenings and Pap Tests. Current MaGiCQ Core Measures; Breast Cancer 75%, Colorectal Cancer 71%, Cervical Cancer 37% (Mercy Health Lima)
    - Ever had cancer (Metopio):
        - Allen County- Census Tracts 116 (9%), 120 (6%)
        - Auglaize County- Census Tracts 402 (8%), 412 (12%)
        - Putnam County- Census Tracts 304 (8.2%)

Community collaborations

- Currently working across all service lines and in conjunction with our Place-based disparities program to appropriately address high-need areas within Allen, Auglaize, Putnam Counties

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

Goal 3:
Reduce Chronic Disease Mortality.

Expected impact
Decrease chronic disease mortality by aligning high-risk patients to Outpatient Palliative Care Program by increasing referrals by 5% from baseline.

Targeted populations
Chronic Disease patients with COPD, Cancer, DM, CHF, CAD

Strategy 3.1:
Align at-risk patients to Outpatient Palliative Care Program.

- **Year 1** - Ensure at risk patients are aligned to PCP, hospice and/or palliative care services. Establish baseline measure for # of referrals.
- **Year 2** - Continue efforts from Year 1 and increase by 2.5% of baseline.
- **Year 3** - Continue efforts from Year 2 and increase referrals by 5% of baseline.

Strategic measure 3.1:
Increase the number of referrals by 5% for Outpatient Palliative Care program with an emphasis on reducing disparities by December 31, 2025.

- **Strategic Measure:** # of referrals to Outpatient Palliative Care Program
- **Baseline:** Establish baseline measure for # of referrals.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

Mercy Health St. Rita's Medical Center, Mercy Health Lima Primary Care, Mercy Health Hospice and Palliative Care.

Goal 4:
Increase equity and reduce health disparities.

Expected impact
Increase access to Cardiovascular services among African Americans by increasing the # of referrals from 2021 baseline and establishing 9 outreach events to increase awareness and education for African American residents.

Targeted populations
African Americans, Patients with COPD, Heart Failure and Obesity

Strategy 4.1:
Identify health care disparities in patient populations by stratifying quality, safety and clinical data using sociodemographic characteristics of Mercy Health Lima patients.

- **Year 1** - Reducing health disparities among African Americans by creating 3 outreach events from baseline to increase public health awareness in the community. Increase the use of cardiovascular services among African Americans by 1.5% from 2021 baseline.
- **Year 2** - Increase the use of cardiovascular services among African Americans by 3% from 2021 baseline. Reducing health disparities among African Americans by creating 6 outreach events from baseline to increase public health awareness in the community.
- **Year 3** - Increase the use of cardiovascular services among African Americans by 5% from 2021 baseline. Reducing health disparities among African Americans by creating 9 outreach events from baseline.

Strategic measure 4.1:
Increase the number of referrals by 5% for Isolated Coronary Artery Bypass Surgery among African Americans, establish 9 outreach activities by December 31, 2025, to increase public health awareness in efforts to reduce health disparities among African Americans and other community members.

Strategic Measure: # of Mercy Health Isolated CABG Procedures/Cases, # of community health outreach events

Baseline #: # of cases 50 (2019), 44 (2020), 56 (2021), 11 (1Q ’22); Currently 0 community health outreach events, need to establish baseline measure

Race:
2019: Caucasian- 92%, Black- 8%
2020: Caucasian- 95.45%, Black- 2.27%, Pacific Islander- 2.27%
2021: Caucasian- 98.21%, Black- 1.78%
2022 (through Mar. 2022): Caucasian- 100%
Like Group 2022: Caucasian- 80.22%, Black- 6.65%, Asian- 4.01%, Native American- 0.54%, Pacific Islander- 0.30%

As you can see from the data above, majority of cardiovascular services are administered to people of Caucasian race. There was a significant drop in cardiovascular services from 8%-0% among the African American community from 2019-2022. When compared to Like Groups, there is a significant difference in the baseline use of cardiovascular services. (Source: The Society of Thoracic Surgeons, 2022).

Community collaborations

- Currently working the Black Ministerial Alliance and other minority community organizations in conjunction with Mercy Health Lima to measure as Joint Commission Equity and Disparity Standard of Care.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

Local community organizations and predominantly minority organizations, faith-based community, Mercy Health Lima Cardiovascular Services.

Maternal & Infant Health:

Description
As detailed in the hospital's Community Health Needs Assessment Report:

Adult and youth obesity are a prioritized health need for Mercy Health- Lima's primary service area. Chronic illnesses such as heart disease, diabetes, and cancer can be directly correlated with a lack of exercise, poor nutrition, high weight status and a lack of access to preventive screenings.

Goal 1:
Decrease infant mortality.

Expected impact
Decrease infant mortality by implementing a Mom's Quit for 2 program.

Targeted populations
Expecting mothers who currently smoke and/or use tobacco.

Strategy 1.1:
Explore the feasibility of expanding and offering the Mom's Quit for 2 program to Allen County by December 31, 2025.

- **Year 1** - Explore the feasibility of expanding and offering the Mom's Quit for 2 program.
- **Year 2** - Continue efforts from Year 1 and continue efforts and/or apply for grant if applicable.
- **Year 3** - Continue efforts from Year 2, expand and build upon efforts in conjunction with Tobacco Cessation grant currently available.

Strategic measure 1.1:
Explore the feasibility of expanding the Mom's Quit for 2 program to Allen County by December 31, 2025.

- **Strategic Measure:** Establish and implement the Mom's Quit for 2 program in Allen County.
- **Baseline #:** program currently not implemented.

Community collaborations

- Currently working with Activate Allen County, Allen County Public Health Department and Help Me Grow on increasing enrollment into state tobacco quit line.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Activate Allen County, St. Rita's Tobacco Cessation Program, WIC, Allen County Public Health Department, OBGYN Specialist of Lima, Heartbeat of Lima, Help Me Grown, St. Rita's Mom & Baby.

Goal 2:
Reduce births to women without fathers present.

Expected impact
Decrease infant mortality by implementing a Mom's Quit for 2 program.

Targeted populations
Single expecting mothers

Strategy 2.1:
Explore the feasibility of adding a father's program to Mom's Quit for 2 program.

- **Year 1** - Explore the feasibility of adding father's program to Mom's Quit for 2 program.
- **Year 2** - Continue efforts from Year 1.
- **Year 3** - Continue efforts from Year 2.

Strategic measure 2.1:
Explore the feasibility of expanding the Mom's Quit for 2 program to Allen County by December 31, 2025.

- **Strategic Measure:** establishing and implementing the Mom's Quit for 2 program in Allen County, with an option and curriculum for father's.
- **Baseline #:** program currently not implemented.

Community collaborations

- Currently working with Activate Allen County, Allen County Public Health Department and Help Me Grow on increasing enrollment into state tobacco quit line.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Activate Allen County, St. Rita's Tobacco Cessation Program, WIC, Allen County Public Health Department, OBGYN Specialist of Lima, Heartbeat of Lima, Help Me Grown, St. Rita's Mom & Baby.

Goal 3:
Decrease infant mortality.

Expected impact
Decreasing infant mortality by improving education provided to new mothers at St. Rita's Medical Center educating on the appropriate safe sleep techniques for newborns.

Targeted populations
First time parents

Strategy 3.1:
Create new modern safe sleep video option.

- **Year 1** - Identify, create, and develop video in collaboration with community partners. Establish baseline measurements for # of video engagements.
- **Year 2** - Continue efforts from Year 1 and increase engagements with video by 6% from baseline.
- **Year 3** - Continue efforts from Year 2 and increase engagements with video by 12% from baseline.

Strategic measure 3.1:
Create a new safe sleep video option via social media that is more modern and engaging and increase engagements with video by 12% by December 31, 2025.

- **Strategic Measure:** video developed; # of engagements with video
- **Baseline #:** 0, currently not video or engagements created and/or established.

Community collaborations

- Allen County Maternal Infant Task Force.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Activate Allen County, St. Rita's Tobacco Cessation Program, WIC, Allen County Public Health Department, OBGYN Specialist of Lima, Heartbeat of Lima, Help Me Grown, St. Rita's Mom & Baby.

Goal 4:
Decrease infant mortality.

Expected impact
Decrease infant mortality by increasing health equity and decreasing health disparities by improving referrals for at-risk first-time mothers from OBGYN Specialists of Lima to appropriate community resources.

Targeted populations
First time parents

Strategy 4.1:
Increase health equity and decrease health disparities for mothers who are at high-risk.

- **Year 1** - Identify high-risk mothers in collaboration with partners and, while in outreach, increase referrals by 2.5% from baseline.
- **Year 2** - Continue efforts from Year 1 and increase referrals by 5% from baseline.
- **Year 3** - Continue efforts from Year 2 and increase referrals by 10% from baseline.

Strategic measure 4.1:
By December 31, 2025, administer the 419 Place-based Disparities program in collaboration with Help Me Grow and OBGYN Specialists of Lima to mothers in high-risk census tracts, increasing coordination and referrals to available community resources by 10%.

- **Strategic Measure:** # of referrals from OBGYN Specialist for high-risk mothers to community resources.
- **Baseline #:** 0, currently establishing new process in alignment with the 419 Place-based Disparities program.

Community collaborations

- Allen County Maternal Infant Task Force.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Activate Allen County, St. Rita's Tobacco Cessation Program, WIC, Allen County Public Health Department, OBGYN Specialist of Lima, Heartbeat of Lima, Help Me Grown, St. Rita's Mom & Baby.

Goal 5:
Improve infant health.

Expected impact
Improve infant mortality by improving access to education resources for first time parents and connecting to community resources.

Targeted populations
First time parents

Strategy 5.1:
Increase awareness to education and training apps and social media platforms to new mothers.

- **Year 1** - Create awareness campaign on Yo-Mingo app and increase active learners by 20% from baseline. Provide new child-birth education materials.
- **Year 2** - Continue efforts from Year 1, increase Yo-Mingo active learners by 30% from baseline.
- **Year 3** - Continue efforts from Year 2, increase Yo-Mingo active learners by 40% from baseline.

Strategic measure 5.1:
Increase Yo-Mingo active learners by 40% for all pregnant mothers by December 31, 2025.

- **Strategic Measure:** # of engagements on Yo-Mingo platform.
- **Baseline #:** 48 active learners currently enrolled.

Community collaborations

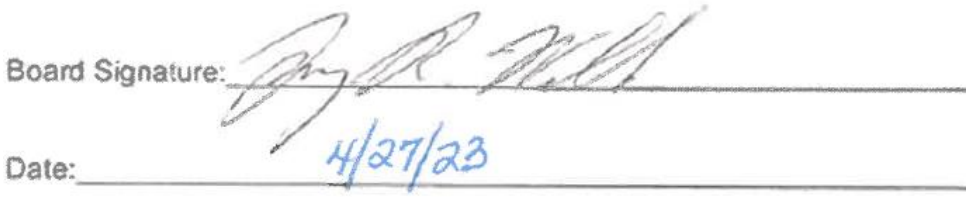
- Allen County Maternal Infant Task Force.

Community resources available
The existing healthcare facilities and other resources in the community that are available to meet the prioritized need include:

- Activate Allen County, St. Rita's Tobacco Cessation Program, WIC, Allen County Public Health Department, OBGYN Specialist of Lima, Heartbeat of Lima, Help Me Grown, St. Rita's Mom & Baby.

Board Approval

The Mercy Health- St. Rita's Medical Center LLC, 2023 Community Health Improvement Plan was approved by the St. Rita's Medical Center LLC, Governing Board of Trustees on April 27, 2023.



For further information or to obtain a hard copy of this CHIP please contact: Tyler Smith, tssmith1@mercy.com.

Mercy Health CHIP Website: https://www.mercy.com/about-us/mission/giving-back/community-health-needs-assessment