

 Saint Luke's.

Saint Luke's East Hospital Community Health Needs Assessment Implementation Plan

2023

◆ Saint Luke's East Hospital



Saint Luke's East Hospital CHNA Implementation Strategy

Adopted by the Saint Luke's East Hospital Board of Directors on December 5, 2023

This implementation strategy describes how Saint Luke's East Hospital (SLE or the hospital) plans to address significant needs described in the Community Health Needs Assessment (CHNA) approved by the hospital on December 5, 2023. See the CHNA report at [Saint Luke's Hospital CHNAs and Implementation Strategies](#). SLE plans to implement the initiatives described herein during the calendar years 2024-2026.

Conducting the CHNA and developing this implementation strategy were undertaken by the hospital to assess and address significant health needs in the community served by SLE, and in accordance with Internal Revenue Service regulations in Section 501(r) of the Internal Revenue Code.

This implementation strategy addresses the significant community health needs described in the CHNA report. This document identifies the significant needs the hospital plans to address through various strategic initiatives and explains why the hospital does not intend to address certain other significant needs identified in the CHNA report.

This document contains the following information:

1. About SLE
2. Definition of the Community Assessed by SLE
3. Summary of Significant Community Health Needs
4. Implementation Strategy to Address Significant Health Needs
5. Significant Community Health Needs SLE Will Not Address
6. Adoption of the Implementation Strategy by SLE's Authorized Body

1. About SLE

Founded in 2006, Saint Luke's East Hospital is a 238-bed facility conveniently located in Lee's Summit, Missouri. Since the hospital's opening, Saint Luke's East has grown every year to ensure we continue to meet the needs of the community we serve. And with onsite primary care physician offices, we make getting exceptional health care as easy and convenient as possible for you.

In 2022, Saint Luke's East earned a five-star rating by the Centers for Medicare and Medicaid Services based on quality measures including safety, effectiveness, and patient experience. We have been recognized by U.S. News & World Report and received The Joint Commission's Advanced Certification for Total Hip and Knee Replacement. Saint Luke's East maternity care

was named in the Top 10% of hospitals in the nation by U.S. News & World Report. Additional information about Saint Luke's East Hospital is available at: [Saint Luke's East Hospital](#).

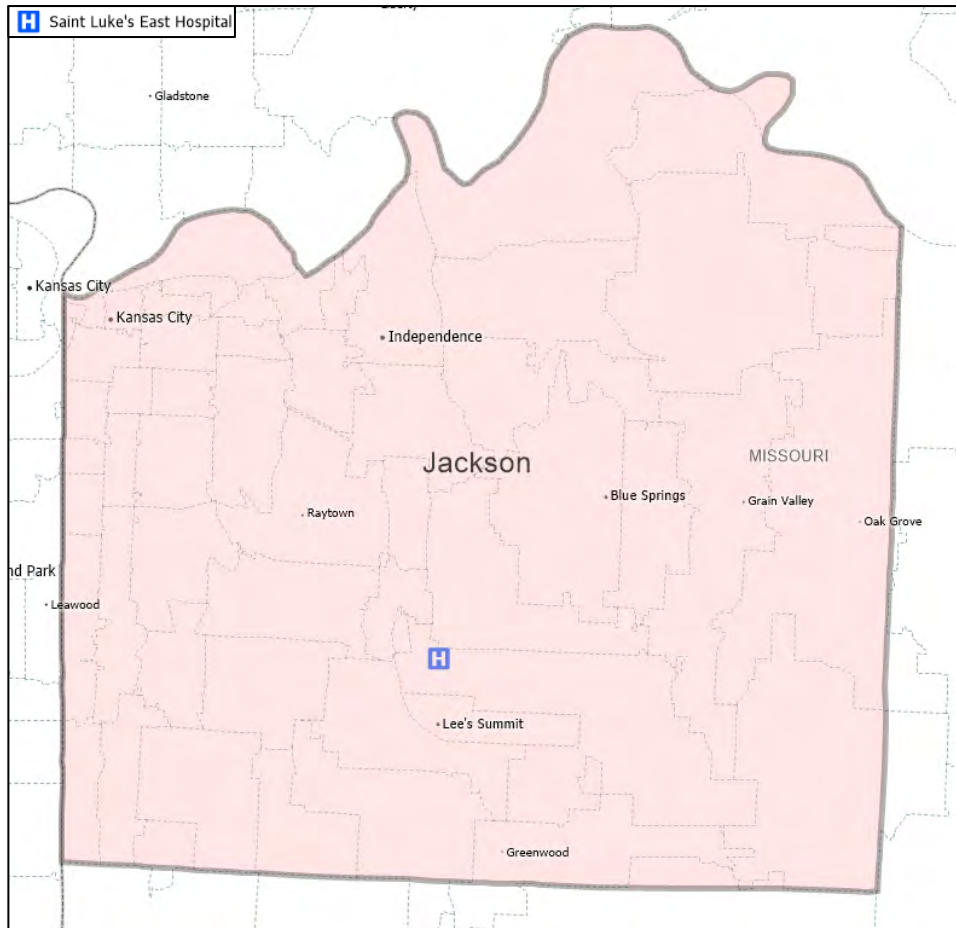
SLE is part of Saint Luke's Health System, which is a faith-based, not-for-profit health system committed to the highest levels of excellence in providing health care and health-related services in a caring environment. The system is dedicated to enhancing the physical, mental, and spiritual health of the diverse communities it serves. Saint Luke's Health System includes 14 hospitals and campuses across the Kansas City region, home care and hospice, behavioral health care, dozens of physician practices, a life care senior living community, and additional facilities and services. Additional information is available at: [About Saint Luke's](#).

2. Definition of the Community Assessed by SLE

For purposes of this CHNA, SLE's community is defined as Jackson County, Missouri. In the calendar year 2022, Jackson County accounted for approximately 74 percent of the hospital's inpatient volumes and 83 percent of emergency department visits.

The total population of the community in 2020 was 689,226.

The following map portrays the community served by SLE and the location of its main campus.



Source: Caliper Maptitude, 2023.

3. Summary of Significant Community Health Needs

As determined by the Community Health Needs Assessment, an overarching focus on advancing health equity has the best potential to improve community health. Within that context, significant health needs in the community served by Saint Luke's East Hospital are:

- Access to Care;
- Alcohol and Substance Use;
- Social Drivers of Health; and
- Transportation.

The CHNA report for SLE describes each of the above community health needs and why they were determined to be significant.

4. Implementation Strategy to Address Significant Health Needs

This implementation strategy describes how SLE plans to address the significant community health needs identified in the 2023 CHNA report. A committee comprised of SLE staff and SLE

leadership reviewed findings in the CHNA report and identified significant community health needs that the hospital intends and does not intend to address during calendar years 2024 through 2026.

As part of that decision-making process, the committee considered criteria such as:

- Whether the need is being addressed by other organizations;
- The extent to which the hospital has expertise or competencies to address the need;
- The availability of resources and evidence-based interventions needed to address the need effectively;
- The frequency with which stakeholders identified the need as a significant priority; and
- The potential for collaborations with other community organizations to help address the issue.

By applying these criteria, SLE determined that it will implement initiatives to address the following three significant community health needs identified by the CHNA process:

- Access to Care
- Social Drivers of Health
- Transportation

The following pages describe the actions SLE plans to implement to address the identified needs, the anticipated impact of those actions, the resources the hospital facility plans to commit to address the health needs, and planned collaborations between the hospital and other community organizations.

Cross-Cutting Initiatives

Recognizing that racism has yielded measurable health disparities, the SLE CHNA report indicates that an overarching focus on advancing health equity has the best potential to improve community health. Accordingly, SLE will continue to implement initiatives focused on advancing health equity in the SLHS Destination 2025 Strategic Plan and in the yearly SLE Operational Plan.

The SLHS Destination 2025 Strategic Plan includes goals and objectives focused on strengthening organizational culture and investing in the healthcare workforce by implementing programs for training on unconscious bias, health inequities, diversity, inclusivity, and belonging for leadership, staff, and medical staff. SLE will use data analytics to identify and reduce disparities in patient outcomes, patient satisfaction, readmission rates, approvals for financial assistance, and collections actions. In addition, SLE will advance health equity in the communities served by increasing access, providing equitable care, and partnering with community organizations.

SLE will develop community health baseline measures to monitor key indicators and assess the impact of this 2024-2026 implementation strategy.

Action Plans

The action plans below are based on prioritized needs from the hospital's 2023 CHNA. These strategies and objectives outline where the hospital intends to focus its efforts to address significant community health needs during the calendar years 2024-2026. In addition to the action plans described below, SLE will continue to offer an array of existing activities and programs that focus on addressing access to care and social drivers of health. The following existing activities and programs will continue to be provided by SLE in 2024-2026.

Access to Care

- Continue Hospital In Your Home program which provides innovative access to care in the comfort of the patient's home.
- Provide community and patient support for Medicaid enrollment.
- Provide education and training through community-based programs such as breastfeeding support group, diabetes education, and stroke and heart attack education.
- Advocate for and provide case management for vulnerable patients.
- Provide the Medication Assistance Access Program for patients who are underinsured or uninsured.
- Expand hiring programs that build pipelines for people of color and local hiring and workforce development programs.
- Expand programs to introduce school aged students to the health professions.

Needs of Older Adults

- Assist patients, aged 65 and older, to apply for benefits they are eligible for including Medicare, Medicaid, etc.
- Provide the Meds-to-Beds program, providing patients with access to medications prior to discharge, eliminating barriers to access.

Social Drivers of Health

- Expand screening of patients for social drivers of health issues.
- Provide social work services and complex case management to meet patients' social needs and promote health equity by connecting under resourced patients to social and medical services post discharge.
- Operate and support the Saint Luke's Community Resource Hub to expand patient, employee, and community awareness of available health and social services.
- Provide rideshare vouchers for patients in need post-discharge.

Priority Need: Access to Care
Goal: Improve access to care for chronic conditions management.
Strategy: Achieve equitable improvement of chronic conditions management.
Objectives By December 31, 2026, Saint Luke’s East Hospital will <ol style="list-style-type: none"> 1. Optimize partnerships to offer community-based education for chronic conditions. 2. Build community member trust by improving diversity and cultural competence of the healthcare workforce. 3. Explore initiatives to reduce hospital admissions and emergency department visits for ambulatory sensitive conditions, including but not limited to Remote Patient Monitoring and Transitions of Care programs.
Target Population <ul style="list-style-type: none"> ● Older adults with chronic conditions ● General population with chronic conditions ● Community members who face inequities based on race, ethnicity, sexual orientation, gender identity, age, physical abilities, geographic location, educational background, and economic status
Planned Collaborators <ul style="list-style-type: none"> ● Other SLHS Hospitals ● Community Senior Centers ● Assisted and Senior Living Facilities ● Community Based Organizations and Social Service Agencies
Hospital Resources <ul style="list-style-type: none"> ● Clinical and non-clinical staff time ● Resources and supplies to implement and coordinate educational programming. ● Marketing and education
Data and Evidence Based Support <ul style="list-style-type: none"> ● Centers for Disease Control and Prevention, 6/18 Initiative ● County Health Rankings & Roadmaps, Strategies ● Healthy People 2030, Older Adults ● Institute for Healthcare Improvement ● The Community Guide, The Community Services Preventive Task Force
Anticipated Outcomes
Implementation of evidence-based community education programs for adults with specified chronic conditions.
Develop and implement an action plan to address health care equity for chronic conditions.
The healthcare workforce will deliver compassionate, culturally appropriate care to all patients.
Reduced hospital admissions and emergency department visits for ambulatory sensitive conditions.
Action Steps
2024: Assign a liaison to build community partnerships.
2024: Identify health care disparities in patient populations by stratifying clinical outcomes measures for chronic conditions by sociodemographic characteristics and develop action plans to address health care equity.
2024: Identify and prioritize chronic conditions to focus on (based on stratification of clinical outcomes).
2024: Identify and build relationships with partners who will participate in community-based education.
2024: Develop a plan for execution of community-based education including curriculum, educators, schedule, evaluation, and collaborators.
2024: Establish a multidisciplinary taskforce and develop a strategic plan to improve diversity and cultural competence of the workforce. The strategic plan will include curriculum, educators, evaluation, and collaborators.

2024: Explore initiatives to reduce hospital admissions and emergency department visits for ambulatory sensitive conditions, including but not limited to Remote Patient Monitoring and Transitions of Care programs.
2025: Launch community education program with partners for chronic conditions management.
2025: Execute strategic plan for improving diversity and cultural competence training.
2026: Assess effectiveness of all initiatives and programming. Adjust as needed to reach target outcomes.

Priority Need: Social Drivers of Health
Goal: Reduce the medical impact of social isolation and loneliness.
Strategy: Integrate social connection into care and leverage interventions that provide psychosocial support to patients and families.
<p>Objectives</p> <p>By December 31, 2026, Saint Luke’s East Hospital will</p> <ol style="list-style-type: none"> 1. Provide health professionals with formal training and continuing education on the health and medical relevance of social connection, risks associated with social disconnection, and effective prevention and intervention strategies. 2. Establish an equitable program to fund and support community organizations providing evidence-based care for those who are at risk for or experiencing isolation or low social support.
<p>Target Population</p> <ul style="list-style-type: none"> • Community members who are at risk for or are experiencing social isolation. • Older adults • Care providers • Health professionals
<p>Planned Collaborators</p> <ul style="list-style-type: none"> • Other SLHS Hospitals • Community-based organizations • Behavioral health providers • Social support organizations
<p>Hospital Resources</p> <ul style="list-style-type: none"> • Clinical and non-clinical staff time • Funding for small grant program • Resources and supplies to implement small grant program. • Marketing and education
<p>Data and Evidence Based Support</p> <ul style="list-style-type: none"> • County Health Rankings & Roadmaps, Strategies • Healthy People 2030, Older Adults • Surgeon General’s Advisory on the Healing Effects of Social Connection and Community, 2023
Anticipated Outcomes
Health professionals will understand the medical relevance of social connection, risks associated with social disconnection, and will actively assess and offer effective interventions.
Provision of support and resources to community organizations providing evidence-based services for those who are at risk for, or are experiencing isolation, loneliness, or low social support.
Action Steps
2024: Identify a leader and assemble a committee focused on using evidence-based practice to advance social connection.
2024: Design, establish, and publicize an equitable program to fund (small grants) and support (volunteers, other resources) community organizations providing evidence-based care to adults who are at risk for or experiencing isolation or low social support. Focus areas include access to digital resources, health equity, provision of support groups or other events reducing the health and medical impact of social isolation.
2024: Utilizing the U.S. Surgeon General’s Advisory on the Healing Effects of Social Connection and Community , develop a comprehensive plan to educate and train health professionals on the health and medical relevance of social connection.
2024-2025: Implement education and training programs for health professionals.
2025: Market and launch small grant program.
2026: Assess effectiveness of all initiatives and programming. Adjust as needed to reach target outcomes.

Priority Need: Social Drivers of Health (including Transportation)
Goal: Improve health outcomes by improving the community’s connection to social support.
Strategy: Improve access to transportation and healthy food for patients seeking medical care and other healthcare services.
<p>Objectives</p> <p>By December 31, 2026, Saint Luke’s East Hospital will</p> <ol style="list-style-type: none"> 1. Strengthen community engagement to expand transportation options, reach, and reliability to increase patient access to medical care and other healthcare services. 2. Increase the proportion of patients screened for social drivers of health (SDOH) needs and connected to community resources. 3. Collaborate with community organizations to improve access to healthy food and food as medicine programs.
<p>Target Population</p> <ul style="list-style-type: none"> ● Community members with transportation barriers due to age, geographic location, physical abilities, economic status, or other factors. ● Patients with positive SDOH screenings
<p>Planned Collaborators</p> <ul style="list-style-type: none"> ● Other SLHS Hospitals ● Kansas City Area Transportation Authority ● Community-based organizations ● Area medical and non-medical transportation providers ● Payors
<p>Hospital Resources</p> <ul style="list-style-type: none"> ● Saint Luke’s Health System Transportation Committee ● Clinical and non-clinical staff time ● Funding ● Marketing and education
<p>Data and Evidence Based Support</p> <ul style="list-style-type: none"> ● Community Health Worker Tool Kit ● County Health Rankings & Roadmaps, Strategies ● Healthy People 2030, Nutrition and Healthy Eating/Transportation ● SDOH evidence-based resources
Anticipated Outcomes
Patients have reliable, affordable transportation options to access medical care and healthcare services.
Patients with SDOH needs are appropriately connected to community-based resources to receive support.
Improvement in chronic conditions management and outcomes such as diabetes, hypertension, and obesity through use of food as medicine programs.
Action Steps
2024: Develop a strategic plan for improving transportation to medical care and healthcare services that includes community partnerships and accountability metrics for transportation providers.
2024: Evaluate the use of community health workers as a resource to improve access and connection to community resources and meet SDOH needs for patients and improve community collaboration.
2024: Revise transportation policies, assess transportation vendors, review contracts with existing vendors, and develop new agreements to optimize costs and accountability metrics.
2024-2025: Design and establish an equitable program to fund (small grants) and support (volunteers, other resources) community organizations providing support for social drivers of health. Focus areas include access to digital resources, health equity, provision of support groups or other events reducing the health and medical impact of social drivers of health.
2026: Assess effectiveness of all initiatives and programming. Adjust as needed to reach target outcomes.

5. Needs SLE Will Not Address

SLE is committed to serving the community by adhering to its mission, using its skills and capabilities, and remaining a strong organization so that it can continue to provide a wide range of community benefits. Although SLE understands and acknowledges the importance of all the significant health needs identified in the 2023 CHNA, the hospital does not intend to address alcohol and substance use in this implementation strategy. The committee charged with developing this implementation strategy concluded, based on the criteria listed above, that alcohol and substance use was being addressed in the community by other organizations and providers with specialized services and expertise.

While SLE does not include alcohol and substance use in this plan, the hospital remains committed to work in this important area including having an active opioid stewardship committee that has been instrumental in ensuring provision of medication collection kiosks for patients to safely dispose of unused medications, tools for prescribers to review prescribing practices and monitor opioid use, and Narcan kit distribution throughout its retail pharmacies.

6. Implementation Strategy Adoption

The Saint Luke's East Hospital Board of Directors reviewed and adopted this implementation strategy at its December 5, 2023, board meeting.

◆ **Contact us**

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