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Community Health Improvement Plan

Mercy Hospital Lincoln

Fiscal Year 2019 – 2021

Mercy

Your life is our life's work.

Our Mission:

As the Sisters of Mercy before us, we bring to life the healing ministry of Jesus through our compassionate care and exceptional service.

Mercy

Watson Health
15 TOP HEALTH SYSTEMS
2019

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I. Introduction

Mercy Hospital Lincoln is a Catholic critical access hospital where the length of stay for inpatients is four days or less. Since 1953, it had operated as Lincoln County Memorial Hospital and, in 2015, it came under the sponsorship of Mercy. The facility was renamed Mercy Hospital Lincoln and is one of five hospitals comprising the Mercy East Community.

Mercy Hospital Lincoln (MHL) completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by its Board of Directors in May 2019. The report was compiled and completed with collaboration of Lincoln County Health Department (LCHD). Both organizations are in the city of Troy in Lincoln County, Missouri, which is a rural community located 55 miles northwest of St. Louis, MO. Together, they maintain an active partnership by collaborating on public health emergency planning and many forms of community health, safety and awareness.

The CHNA included input from the county health department, community members, members of medically underserved, low-income populations and various community organizations representing the broad interests of the community of Lincoln County. The CHNA identified four prioritized health needs the hospital plans to focus on addressing during the next three years:

1. Access to Care – Navigation
2. Access to Care – Transportation
3. Behavioral Health – Mental Health
4. Behavioral Health – Substance and Opioid Use.

The complete CHNA report is available electronically at mercy.net/about/community-benefits.

This three-year Community Health Improvement Plan (CHIP), aimed at addressing the prioritized health needs identified in the CHNA, will guide the coordination and targeting of resources, and the planning, implementation and evaluation of both new and existing programs and interventions. The 2019 CHNA and this resulting CHIP will provide the framework for Mercy Hospital Lincoln as it works in collaboration with community partners to advance the health and quality of life for the community members it serves.

II. Implementation Plan by Prioritized Health Need

Prioritized Need #1: Access to Care

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

PROGRAM 1: **Community Health Worker Program**
PROGRAM DESCRIPTION: Community Health Workers (CHWs) serve as liaisons/links between health care entities and other community and social services. CHWs screen patients for needs related to social determinants of health and facilitates access to these services to improve the quality and culture competence of care. CHWs work one-on-one with at-risk patients, acting as patient advocates, assisting patients in applying for health care coverage and government programs, such as Medicaid and disability, along with health care financial assistance and other community resources.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Continue Community Health Worker shared partnership with Lincoln County Health Department 2. Identify uninsured and at-risk patients and community members in need of assistance in Mercy Emergency Department, Mercy Urgent Care and through the use of reports and dashboards. 3. CHW will assist uninsured patients with applying for Mercy financial assistance, Medicaid programs and other mainstream government services. 4. CHW will assist patients without an established primary care provider in establishing care with a primary care clinic or provider. 5. CHW will screen patients for needs related to social determinants of health and connect patients to community resources to meet identified needs. 6. CHW will connect patients with other community resources, including medication resources, as needed.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. By the end of FY20, the CHW will enroll 10 patients in Mercy financial assistance, 5 in Medicaid, and 10 in mainstream government programs. 2. 35% of new patients referred to CHW without a primary care provider will establish care with a PCP at a Mercy clinic, FQHC, free clinic, or other clinic. 3. CHW will assist at least 10 patients with community and medication assistance resources. ***Medium-Term Outcomes:*** 1. Patients enrolling in CHW program will demonstrate a 10% reduction in ED utilization and reduced inpatient admissions. 2. Patients enrolling in CHW program will demonstrate a 10% reduction in their total bad debt.

Long-Term Outcomes:

1. Patients enrolling in CHW program will have improved health outcomes, improved well-being, and demonstrate improvement in measures of social determinants of health.

PLAN TO EVALUATE THE IMPACT:

1. Track number of new and ongoing encounters conducted by each CHW. (Output)
2. Track number of patients successfully enrolled in Mercy financial assistance, Medicaid and government mainstream services. (Short-term)
3. Measure number of patients successfully establishing a primary care home. (Short-term)
4. Record number of patients receiving community resource and medication assistance. (Short-term)
5. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing CHW services. (Medium-term)
6. Analyze pre and post intervention bad debt for cohort of patients utilizing CHW services. (Medium-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Mercy ED and UCC co-workers will continue relationship with CHW for smooth referral process
2. Salary and benefits for full-time Financial Assistance Representative.

COLLABORATIVE PARTNERS:

1. Lincoln County Health Department
2. Compass Health Network

Prioritized Need #1: Access to Care

Goal 2: Increase access to transportation services for uninsured and at-risk persons.

PROGRAM 1: Transportation Services Inventory/Assessment/Pilot
PROGRAM DESCRIPTION: The hospital will collaborate with community partners to conduct a current assessment of transportation services offered, identify any existing gaps and pilot creative collaborative approaches to meet transportation needs as it relates to accessing health services as well as other community needs.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Conduct an inventory of existing transportation services with a focus on low-cost programs 2. Conduct an internal and external inventory of existing transportation assistance offered by other health systems, non- profit and for-profit agencies. 3. Review data from any existing documents/community assessments, resource list inventories and focus group reports.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. By the end of FY20, the internal and external assessments will be completed. ***Medium-Term Outcomes:*** 1. By the end of FY21, community need gaps will be identified and a plan, including funding support, will be presented for pilot initiative(s). ***Long-Term Outcomes:*** 2. By the end of FY22, the pilot will be implemented and initial outcome data presented
PLAN TO EVALUATE THE IMPACT: Impact evaluation approach will be dependent on program piloted. Measurement tools will include, but are not limited to: 1. Number of transportation programs identified 2. Numbers of patients and community members served. 3. Analyses of available outcomes data, for example, missed appointments, ED utilization
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Cab Vouchers 2. Financial support for partnership in implementing a transportation dispatch software platform (Uber-like)
COLLABORATIVE PARTNERS: 1. Lincoln County Health Department 2. St. Charles County Cab

3. OATS/LINC
4. Logisticare
5. HealthTran
6. Civic leaders

Prioritized Need #2: Behavioral Health – Mental Health

Goal 1: Reduce patient visits of high utilizers of emergency rooms who present with behavioral health issues

PROGRAM 1: Emergency Room Enhancement (ERE)
PROGRAM DESCRIPTION: The Behavioral Health Network's ERE project facilitates an integrated 24/7 region-wide approach that targets high utilizers of emergency rooms who present with behavioral health symptoms, with the primary goal of reducing preventable hospital readmissions. Patients identified through the ERE program are connected to a peer-support specialist and community behavioral health resources. The program provides after-hours/weekend scheduling, as well as telephonic and mobile outreach crisis services for consumers referred to the ERE project.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Community Health Leaders maintain on-going relationships with BHN and other community partners through participation in regional meetings and facilitation of data sharing and process improvement. 2. Emergency Department staff facilitate referrals to ERE intervention partners.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. Increase the number of high utilizers in the Emergency Department with mental health needs referred to the ERE program by 50% each year (FY19=4) ***Medium-Term Outcomes:*** 1. Increase the number of appointments scheduled by ERE intervention partners with community and hospital providers by 50% each year. (FY19=3) 2. Maintain at least 60% cumulative engagement rate each year. ***Long-Term Outcomes:*** 1. Patients reached by the ERE program will demonstrate a 10% reduction in ED utilization over three years. 2. Patients reached by the ERE program will demonstrate a 10% reduction in inpatient readmissions over three years.
PLAN TO EVALUATE THE IMPACT: 1. BHN will track the number of ERE program referrals. (Output) 2. BHN will track number of ERE appointments scheduled. (Output) 3. BHN will track percent engagement rate. (medium-term outcome) 4. Mercy will track ED utilization rates and inpatient readmissions. (Long-term outcome)
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Support and educate ED staff to identify and facilitate ERE referrals 2. Staff time and indirect cost as necessary to maintain ongoing partnership with BHN and community agencies
COLLABORATIVE PARTNERS:

1. Behavioral Health Network of Greater St. Louis (BHN)
2. Compass Health Network
3. Preferred Family Health/Bridgeway

Prioritized Need #2: Behavioral Health – Mental Health

GOAL 2: Increase access to mental health care for uninsured and at-risk persons.

PROGRAM 2: Mental Health Services Inventory/Assessment/Pilot
PROGRAM DESCRIPTION: The hospital will collaborate with community partners to conduct a current assessment of behavioral health services offered, identify any existing gaps and pilot creative collaborative approaches to meet community behavioral health needs.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Conduct an internal inventory of existing Mercy behavioral health services (i.e. Inpatient, Outpatient, Intensive Outpatient Programs (IOP), Counseling Services, Classes, Support Groups, Regional Access Center services, Virtual Care Center (VCC) for Primary Care Integration. 2. Conduct an external inventory of existing local community services offered by other health systems, non- profit and for-profit agencies. 3. Review data from any existing documents/community assessments, resource list inventories and focus group reports. 4. Identify gaps in service, explore Mercy VCC solutions and other best practice options (for example, intensive outpatient programs (IOPs), and develop a plan to pilot a minimum of one initiative.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. By the end of FY20, the internal and external assessments will be completed. ***Medium-Term Outcomes:*** 1. By the end of FY21, community need gaps will be identified and a plan, including funding support, will be presented for pilot initiative(s). ***Long-Term Outcomes:*** 1. By the end of FY22, the pilot will be implemented and initial outcome data presented
PLAN TO EVALUATE THE IMPACT: Impact evaluation approach will be dependent on program piloted. Measurement tools will include, but are not limited to: 1. Number of Internal Behavioral Health Programs 2. Numbers of patients and community members served. 3. Analyses of available outcomes data, for example, utilization, readmission, and contribution margin.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Expand Access Providers NP, PA's, MAT, LCSW Counseling 2. Access Center Implementation and Phone Assessments – Promote to PCP's 3. Inpatient Virtual Consultation (Pilot) 4. Open IOP 5. Integrate with PCP 6. V Engagement/Consults with Schools

COLLABORATIVE PARTNERS:

1. Behavioral Health Network (BHN)
2. Catholic Family Counseling
3. Lincoln County Resource Board
4. Compass Health
5. Schools

Prioritized Need #2: Behavioral Health – Substance and Opioid Use

Goal 1: Increase prevention initiatives and substance use treatment programs for uninsured and at-risk persons

PROGRAM 1: Engaging Patients in Care Coordination (EPICC)
PROGRAM DESCRIPTION: The EPICC program, in partnership with the Behavioral Health Network of Greater St. Louis (BHN) connects opioid overdose survivors treated in emergency rooms to recovery support and substance use treatment services, including Medication Assisted Treatment (MAT). Individuals must be over the age of 18 and meet diagnostic criteria for opioid dependence. Intensive referral and linkage services are provided by peer Recovery Coaches.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Facilitate referrals to BHN peer Recovery Coaches from the Emergency Department. 2. Increase availability of medication assisted treatment (MAT) by supporting buprenorphine waivers for Mercy clinicians. 3. Promote opioid overdose education and Narcan distribution in the community.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. Increase the number of referrals of ED patients with opioid dependence to the EPICC program by 10% each year (FY19=6) ***Medium-Term Outcomes:*** 1. Increase the number of appointments scheduled by EPICC peer-recovery coaches at hospital outreach by 10% each year. (FY19=5) 2. Maintain at least a 50% engagement rate at 2-week follow-up each year. ***Long-Term Outcomes:*** 1. Patients reached by the EPICC program will demonstrate a 10% reduction in ED utilization over three years. 2. Patients reached by the EPICC program will demonstrate a 10% reduction in inpatient readmissions over three years. 3. Reduce opioid-related deaths by 10% over three years (2017 Lincoln County = 12)
PLAN TO EVALUATE THE IMPACT: 1. BHN will track number of program referrals. (Output) 2. BHN will track number of appointments scheduled. (Output) 3. BHN will track percent engagement rate. (Short-term outcome) 4. Mercy will track # of MAT waivered clinicians. (Medium-term outcome) 5. Mercy will record number of nonfatal overdoses in emergency department. (long-term outcome) 6. Mercy will record ED utilization rates and inpatient readmissions. (Long-term outcome)
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Support and educate ED staff to identify and facilitate EPICC referrals
2. Staff time and indirect cost as necessary to maintain ongoing partnership with BHN and community agencies
3. Mercy Clinic will continue to educate and promote clinicians to provide MAT

COLLABORATIVE PARTNERS:

1. Behavioral Health Network of Greater St. Louis
2. Compass Health Network
3. Preferred Family Health/Bridgeway

Prioritized Need #2: Behavioral Health – Substance and Opioid Use

GOAL 2: Increase prevention initiatives and substance abuse treatment programs for uninsured and at-risk persons.

PROGRAM 1: Substance Use Services Inventory/Assessment/Pilot
PROGRAM DESCRIPTION: The hospital will collaborate with the Ministry Controlled Substances Operational Task Force, local Mercy Behavioral Health teams and community partners to conduct a current assessment of services offered, identify any existing gaps and pilot creative collaborative approaches to meet community need.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Conduct an internal inventory of existing Mercy behavioral health services (i.e. Inpatient, Outpatient, Intensive Outpatient Programs (IOP), Counseling Services, Classes, Support Groups, Regional Access Center services, Virtual Care Center (VCC) initiatives). 2. Conduct an external inventory of existing local community services offered by other health systems, non- profit and for-profit agencies. 3. Review data from any existing documents/community assessments, resource list inventories and focus group reports. 4. Identify gaps in service, explore Mercy VCC solutions and other best practice options (Intensive Outpatient Program (IOP), Medication Assisted Treatment (MAT) and pilot a minimum of one initiative. 5. Promote and utilize the Prescription Drug Monitoring Program (PDMP). Explore integration into Epic.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. By the end of FY20, the internal and external assessments will be completed. ***Medium-Term Outcomes:*** 1. By the end of FY21, community need gaps will be identified and a plan, including funding support, will be presented for pilot initiative(s). ***Long-Term Outcomes:*** 1. By the end of FY22, the pilot will be implemented and initial outcome data presented
PLAN TO EVALUATE THE IMPACT: Impact evaluation approach will be dependent on program piloted. Measurement tools will include, but are not limited to: 1. Number of Internal Substance Use Programs 2. Program Referrals and numbers of patients and community members served 3. Appointments Scheduled 4. Engagement Rate at 2 week follow-up 5. Increase in number of Medication Assisted Treatment (MAT) providers as applicable.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Open MAT Clinic – Certified Providers
2. Improve EMT Referrals to MHL ED for OD's
    a. Narcan availability with First Responders
3. Educate Providers on Services
4. Implement Meds Disposal with Hospice and Homecare
    a. Lists of Drop-offs in MD Office
5. Ministry Controlled Substances Operational Task Force and Medical Marijuana Task Force
6. Catherine's Fund support
7. Community Health Leader research/project management support
8. Operational budgeted support as appropriate
9. Philanthropy support as needed

COLLABORATIVE PARTNERS:

1. Aviary
2. Behavioral Health Network (BHN) – EPICC
3. LC Core – Comm. Opioid Response Efforts
4. LC Drug Court Foundation
5. LC DART (Drug Alcohol Reduction Team)
6. Preferred Family/Bridgeway
7. Compass Health
8. NCADA

III. Other Community Health Programs

Mercy Hospital Lincoln conducts other community health programs not linked to a specific prioritized health need. These programs address a community health need and meet at least one of the following community benefit objectives:

1. Improve access to health care services
2. Enhance the health of the community
3. Advance medical or health care knowledge
4. Relieve or reduce government burden to improve health

The need for these programs was identified through documentation of demonstrated community need, a request from a public health agency or community group, or the involvement of an unrelated, collaborative tax-exempt or government organization as partners in the activity or program carried out for the express purpose of improving community health. Although this is not an exhaustive list, many of these programs are listed below.

Community Benefit Category	**Program**	**Outcomes Tracked FY19**
Community Health Improvement Services – Health Fairs	Pumpkin Patch Party Health Fair	300 served
	PBW Senior Fair	180 served
	DART Addiction Awareness Rally	100 served
Health Professions Education	PCMH Health Science (Med/Surg, ED, ACS)	18 served
	Med/Surg Student	1 served
	Pharmacy Student	2 served
	Lab Students	2 served
Donated Space	Alcoholics Anonymous	100 served
	4-H Meetings	85 served
	45th Circuit Children's Division	85 served
	Troy Rotary Meeting	25 served
	Amateur Radio Club Meetings	50 served

Community Building – Cash/In-Kind Donations	Lincoln County Council on Aging Trivia & Color Run	120 served
	Salvation Army Care packages	100 served
	Troy FFA Alumni Rodeo for Relay for Life	1,000 served
Community Building – Workforce Development	VFW Career Fair	31 served
	Career Days	525 served
	High School Career Day	80 served
	M*A*S*H Camp	17 served
Community Building – Coalition Building/Board Membership	United Way West Region Board Membership	
	Lincoln County Council on Aging Board Membership	
Community Building – Community Support	Shower of Love Baby Shower	50 served
	Mercy Lincoln ReStore	175 served

IV. Significant Health Needs Not Being Addressed

Mercy Hospital Lincoln (MHL) will continue to support, collaborate and partner with community agencies to address these additional top community needs, but not as part of our Community Health Improvement Plan.

- **Healthy Lifestyles: Heart Disease, High Blood Pressure, Obesity/Poor Nutrition/Physical Inactivity**

Mercy has prioritized improving healthy lifestyles among its 10,000+ co-workers in the East Community through the Healthification program. This is a robust initiative that provides comprehensive health evaluation, screening, education and incentives to increase healthy behaviors and improve health among Mercy co-workers. Mercy Clinic offers a variety of programs and services out in the community, such as nutrition and heart healthy education classes and screenings.

- **Accidental Injuries/Violence: Domestic, Elderly, Child Abuse, and Trafficking**

MHL works closely with domestic violence, sex trafficking and family services agencies, such as Bridgeway Behavioral Health Women's Shelter, Lincoln County Resource Board, Turning Point and local law enforcement to insure patients are given safe choices while in a hospital setting. Mercy provides safety awareness and educational campaigns along with a safety screening/referral question which cues up in each patient's Mercy's Electronic Medical Record (EMR).

- **Asthma & Lung Disease/Pneumonia & Influenza**

MHL will continue to donate unrestricted flu vaccine to Lincoln County Health Department in an effort to reach and protect more in our community. Community cancer screenings and education continue to be offered regionally. Efforts to address tobacco cessation will continue through Mercy's Certified Health and Wellness Coach/Mercy Road to Freedom program through Mercy's Cardiopulmonary Rehab area. Additionally, Mercy will continue to advocate around measures that promote tobacco cessation and raising the age to purchase tobacco products.

<u>Additional Needs Not Being Addressed and Why</u>

- **Physical Environment: Air/Water Quality & Housing**

MHL has chosen not to directly address Air/Water quality and Housing issues, but will continue to support industry, government, non-governmental organizations and the public in addressing these. Other Physical Environment issues, such as Transportation, Homelessness/Housing will be supported and addressed through community coalition work.

- **Maternal, Child & Infant Health**

MHL has limited Pediatric provider services, but will continue to support the efforts of Lincoln County Health Department and other Maternal, Child & Infant healthcare providers as appropriate.

NOTES:

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