An IRS-mandated Community Health Needs Assessment (CHNA) was recently completed for each hospital within the Mercy East Community:

- Mercy Hospital Jefferson
- Mercy Hospital Saint Louis
- Mercy Hospital Washington
- Mercy Hospital Lincoln

The CHNA reports for each hospital may be accessed at: [https://www.mercy.net/about/community-benefits](https://www.mercy.net/about/community-benefits).

Upon completion of these assessments, the IRS requires hospitals to implement a three-year plan to improve the community’s health through strategies that address a significant community health need, as identified through the CHNA. The Community Health Improvement Plan (CHIP) must:

1. Describe the actions that the hospital intends to take to address the health need, the anticipated impact of these actions, and the plan to evaluate such impact
2. Identify the programs and resources that the hospital plans to commit to address the health need
3. Describe any planned collaboration between the hospital and other agencies in addressing the health need.

Attached is the CHIP for Mercy Hospital Jefferson (MHJ). The health needs that have been prioritized in this CHIP are:

- Access to Care
  - Navigation
  - Transportation
  - Health Insurance Coverage
- Mental Health
- Substance Use

The Community Health Council for Mercy Hospital Jefferson will oversee the Community Health Improvement Plan and monitor its progress.
Priority Area/Community Need: ACCESS TO CARE

Narrative: As outlined in the 2016 MHJ Community Health Needs Assessment (CHNA), accessing health care is a challenge for many Jefferson County residents. Jefferson County has far less providers per capita than the state of Missouri, as well as the national average. The shortage encompasses primary care, dental/oral care, and mental health services. Additionally, cost of care and unmet health-related social needs contribute to access challenges, for example, lack of reliable transportation can result in missed medical appointments.

MHJ implements targeted initiatives, which align with the goals of the Jefferson County Health Department (JCHD), the Missouri Foundation for Health (MFH), Healthy People 2020, and the Center for Medicare & Medicaid Services, to remove barriers to health care access.

Goal #1: NAVIGATION – Increase the number of patients who receive follow-up and preventive care from a healthcare provider, with emphasis on the uninsured and underinsured

Objective: The Community Referral Coordinator (CRC) program at Mercy Hospital St. Louis will be expanded to the MHJ emergency department (ED) and will provide patients without a medical home assistance in finding a primary care or specialty care provider, along with social service support, as appropriate.

- Activity: Secure Mercy Caritas grant for program expansion
- Activity: Hire a CRC for MHJ ED
- Activity: Develop a community plan to inform patients on how and why to contact a CRC; include on ED patient discharge paperwork

Objective: CRC patient encounters will result in scheduled appointments

- Activity: Strengthen transition of care processes by developing a communication plan to enhance relationships with key Mercy hospital and clinic leaders/co-workers
- Activity: Refer uninsured and underinsured ED patients to the CRC prior to these patients’ discharge to facilitate face-to-face CRC patient encounters
• **Activity:** Monitor/report patient encounters and scheduled appointments

**Objective:** Patients will keep the CRC-scheduled appointments (show rates will improve from that of baseline data)

• **Activity:** Provide social service support in collaboration with Health Leads, as appropriate, to patients to address needs that may impede their ability to keep a medical appointment

• **Activity:** Monitor/report show rates and encounter types

**Leaders/Departments Involved:** Care Management, Emergency Department, Mercy Clinic, Finance/Eligibility Services, and Community Health

**Community Partners:** Saint Louis Integrated Health Network (IHN); Health Leads; Deaconess Faith Community Ministries; Jefferson County Health Department (JCHD); Community Treatment Inc (COMTREA)

**Evaluation Plan for Goal:**

CRC team will establish **baseline data and 3-year measurable outcomes** to include:

**Outputs:**
- Referrals to CRC
- CRC patient encounters
- Referrals for patients to receive follow-up/preventive care
- Referrals for patients to address health-related social needs

**Short-Term Outcomes:** *(Data Source: IHN)*
- CRC patient encounters with an emphasis on increasing “in person” encounters
- CRC encounters resulting in scheduled appointment
- Show-rates for CRC scheduled appointments

**Long-Term Outcomes:**
- Reduced ED utilization for non-emergent care
- Reduced inpatient utilization with emphasis on patients with chronic conditions

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**Goal #2:** NAVIGATION – Increase the number of Mercy Clinic Jefferson patients who
receive social service resource assistance using the Health Leads model

**Objective:** Mercy Clinic Jefferson will implement Health Leads program in order to assist patients with health-related social needs through resource referral.

- **Activity:** Hire a new FTE who will oversee and begin to develop a detailed program design and implementation plan

- **Activity:** Develop a comprehensive resource directory using the Health Leads Reach tool

- **Activity:** Train co-workers from Mercy Clinic Jefferson on administering the Health Leads questionnaire and appropriate follow-up

- **Activity:** Recruit a student volunteer workforce to assist with patient resource and referral

- **Activity:** Train dedicated staff and volunteers on how to access and use the community resource inventory

**Objective:** Patients’ identified health-related social needs will be addressed, following the Health Leads model

- **Activity:** Screen all Mercy Clinic Jefferson patients using predesigned questionnaire. Core screening areas will include: housing instability and quality, food insecurity, utility needs, interpersonal violence, and transportation needs beyond medical transportation.

- **Activity:** Provide community referrals and follow-up to all patients determined to have unmet health-related social needs

**Objective:** Mercy Clinic Jefferson will evaluate whether increasing patients’ awareness of and access to community services impacts total health care costs and recipients’ health outcomes

- **Activity:** Collect and review data regarding screenings, referrals and follow-up
- **Activity:** Identify gaps in resources available

- **Activity:** Evaluate the Mercy Neighborhood Ministry (MNM) emergency assistance program and MHJ's Chaplain Fund for opportunities to support the Health Leads model and fill resource gaps

**Leaders/Departments Involved:** Care Management, Mercy Clinic Jefferson, Community Health

**Community Partners:** Health Leads, local colleges, social service agencies

**Evaluation Plan for Goal:**
The Health Leads Team will establish **baseline data and 3-year measureable outcomes**

**Outputs:**
- New FTE Health Leads project lead
- Patient screening/questionnaire
- Community Resource Database
- Co-worker trainings on administering questionnaire to patients
- Development of volunteer base
- Individualized community referrals
- Health Leads reporting

**Short-Term Outcomes:** *(Data Source: Mercy)*
- Mercy Clinic Jefferson patients in need receive referrals and navigation assistance with health-related social needs

**Long-Term Outcomes:** *(Data Sources: Mercy)*
- Reduced cost of care, ED visits and admissions for uninsured patients and high-risk Medicare and Medicaid beneficiaries
- Improved health and quality of care
- Gaps in local resources are identified and addressed internally/externally
**Goal #3: TRANSPORTATION** – Decrease non-emergent transportation barriers for individuals/families accessing primary and specialty care

**Objective:** Decrease the number of missed medical appointments due to transportation issues for patients of Mercy Clinic site TBD

- **Activity:** Track reasons for missed appointments at targeted Mercy Clinic (first 30-60 days for baseline)
- **Activity:** Inventory fees and requirements of current transportation providers in area
- **Activity:** Evaluate contractual relationships with transportation providers, such as OATS, JeffCo Express and Safe Rides
- **Activity:** Develop and promote improved patient transportation assistance to improve access for patients in need

**Leaders/Departments Involved:** Mercy Jefferson Transportation, Mercy Clinic Jefferson, Community Health, Length of Stay Task Force Team #4

**Community Partners:** OATS, JeffCo Express, Safe Rides

**Evaluation Plan for Goal:**
The Mercy Jefferson Transportation Team will establish **baseline data and 3-year measureable outcomes**

**Outputs:**
- Number of patients receiving transportation assistance
- Number of appointments missed due to transportation issues
- Number of Mercy Clinic patient missed appointments due to transportation

**Short-Term Outcomes: (Data Source: Mercy)**
- Areas of transportation expansion are identified

**Long-Term Outcomes: (Data Sources: Mercy)**
- Reduced missed appointments due to transportation barriers
Goal #4: COVERAGE – Increase the percentage of Missouri lives, aged 0-64, that are covered by quality, affordable health insurance

Objective: Mercy Certified Application Counselors (CACs) will assist 225 uninsured individuals within the Mercy East Community with acquiring health insurance through the Missouri Health Insurance Marketplace

- **Activity:** Train and certify Mercy CACs
- **Activity:** Educate 10,000 Missourians on health insurance coverage options and obligations through participation in 200 health insurance awareness/education events

Objective: Missouri will expand Medicaid, making insurance coverage a possibility for a greater number of Missouri residents

- **Activity:** Mercy Advocacy Team leads strategies, such as engaging with state and local legislative officials, in support of Missouri Medicaid expansion

  **Activity:** Actively participate in the Catholic Charities Advocacy Council

Leaders/Departments Involved: Finance/Eligibility Services and Advocacy

Community Partners: Missouri Foundation for Health and Missouri Coverage Assistance Program (MCAP) partners

Evaluation Plan for Goal

MCAP team will establish **baseline data and report 2-year measureable outcomes**, as outlined in the MFH application to include:

Outputs:
- Certified CACs
- Education/awareness events
- Co-worker training on referring to CACs

Short-Term Outcomes: *(Data Source: Mercy CAC Program)*
- Enrollments

Long-Term Outcomes: *(Data Source: Missouri Foundation for Health)*
- The percent of uninsured Missouri residents under the age of 65 falls to 5%.
**Priority Area/Community Need: MENTAL HEALTH/SUBSTANCE USE**

**Narrative:** As outlined in the 2016 MHJ Community Health Needs Assessment (CHNA), mental health and substance use are considered to be significant health concerns within Jefferson County community. The rate of inpatient hospitalizations due to mental health disorders is higher than state the average and suicide was identified as a top 10 cause of death within the county. Additionally, the reported number of incidents involving methamphetamines is higher for Jefferson County than that for 36 states, and prescription drug use is a major concern, exacerbated by Missouri being the only state in the nation to lack a Prescription Drug Monitoring Program (PDMP).

Due to a shortage of behavioral health providers, behavioral health access must be addressed on a regional level. Mercy will implement regional strategies, building on the services of its hospitals and clinics in the Mercy East Community (Jefferson, St. Louis, Washington, and Lincoln), and other community partners to address mental health and substance use needs. These strategies will be in alignment with the behavioral health goals of the Jefferson County Health Department (JCHD), the St. Louis Behavioral Health Network (BHN), the Centers for Disease Control, the Missouri and United States Departments of Health and Human Services, and Healthy People 2020.

**Goal #1:** SUBSTANCE USE – Reduce and manage patients’ pain without increasing their risk of addiction to prescription opioid/opiates

**Objective:** The opioid/opiate prescribing rates within MHSL and Mercy Clinics will decrease

- **Activity:** Partner with Mercy’s Opiate Rx Task Force to implement risk mitigation strategies for prescription opioid addiction and diversion

- **Activity:** Review and incorporate, as feasible, the current Centers for Disease Control opioid/opiate prescribing guidelines

- **Activity:** Investigate employing alternative pain management practices, such as non-pharmacologic treatments and non-opiate/opioid pain medications

- **Activity:** Acquire data on the volume of opiates prescribed by physician and the number of adverse opioid-related events to establish benchmarks for individual physician metrics

- **Activity:** Educate and promote informed choices and best practices in pain therapies among Mercy
Objective: Missouri will implement a state-wide Prescription Drug Monitoring Program

- Activity: Participate in the expanded St. Louis County/City Prescription Drug Monitoring Program and collect data to illustrate its benefit

- Activity: Mercy’s Opiate Rx Task Force member(s) advocate for the implementation of a state-wide Prescription Drug Monitoring Program

Leaders/Departments Involved: Behavioral Health, Mercy Clinics, Quality, Pharmacy, Advocacy and Community Health

Community Partners: JCHD, National Council on Alcoholism and Drug Abuse (NCADA), COMTREA, Catholic Family Services, Behavioral Health Network (BHN). Behavioral Health Response (BHR), National Alliance on Mental Illness (NAMI), Alive & Well STL

Evaluation Plan for Goal
Regional CHIP Behavioral Health team will establish baseline data and report 3-year measurable outcomes to include:

Outputs:
- Risk mitigation strategies, such as patient urine screenings, prescribing algorithms and guidelines, or medication management agreements
- Data on volume of opioids/opiates prescribed by physician
- Number of advocacy events/activities

Short-Term Outcomes: (Data Source: Mercy)
- Pain management practices improve

Long-Term Outcomes: (Data Source: Mercy)
- Reduced opioid/opiate prescribing rates
Goal #2:  SUBSTANCE USE – Increase the number of Mercy East Community members able to access appropriate, quality substance use treatment

Objective: Substance use treatment services in the Mercy East Community will expand and/or be enhanced

- Activity: Implement and develop the Psychiatric Nurse Liaison program for hospitalized patients with addiction disorders
- Activity: Evaluate implementing Medication-Assisted Treatments (Vivitrol, Suboxone) with patients, as appropriate
- Activity: Explore potential partnerships, particularly with agencies that have residential detoxification programs, to enhance transitions of care/recovery outcomes (Preferred, C-Star, Harris House, Aviary Recovery Center, Queen of Peace)
- Activity: Improve the clinical competency of behavioral health providers in the area of addiction treatment

Objective: The number of low income/uninsured patients able to access substance use treatment will increase

- Activity: Improve the process for expedited Charity Care applications for patients with substance use disorders

Leaders/Departments Involved: Behavioral Health, Mercy Clinic, Pain Management Specialists, Holistic Health, Quality, Pharmacy, and Community Health

Community Partners: JCHD, National Council on Alcoholism and Drug Abuse (NCADA), COMTREA

Evaluation Plan for Goal
Regional CHIP Behavioral Health team will establish baseline data and report 3-year measurable outcomes to include:

Outputs:
- Number of patients referred/served
- Number of Psychiatric Nurse Liaisons
- Number of co-workers trained on Medication-Assisted Treatments
- Number of behavioral health providers who participate in professional development

Short-Term Outcomes: (Data Source: Mercy)
• Number of Partnerships Developed

**Long-Term Outcomes:** *(Data Source: TBD)*
• Addiction & Death rates from substance use decrease

**Goal #3:**  **MENTAL HEALTH** – Increase the number of Mercy East Community members able to **access** appropriate, quality mental health treatment

**Objective:** Services to address mental health needs in the Mercy East Community will expand and/or be enhanced

• **Activity:** Collaborate with community partners to identify the mental health service gaps in the region

• **Activity:** Engage in strategic planning regarding where to add resources/partner in order to serve more people (Mental Health Navigators in primary care offices, Advanced Practice Registered Nurse (APRN) in targeted locations)

• **Activity:** Open new adult psychiatry clinic at MHSL

• **Activity:** Expand the Psychiatric Nurse Liaison program for hospitalized patients with mental health needs

• **Activity:** Recruit new mental health providers, including Psychiatrists, Counselors, Nurse Practitioners, and Psychiatric Pharmacists

• **Activity:** Expand Intensive Outpatient Programs and clinic services at Mercy Hospital Washington and Mercy Hospital Jefferson

• **Activity:** Implement the Columbia Suicide Severity Rating Scale (CSSRS) as an evidence-based suicide screening tool in EPIC

• **Activity:** Remain involved in Alive & Well STL Health Collaborative

• **Activity:** Advocate for legislation to improve mental health service delivery through continued participation in the Behavioral Health Network’s Board of Directors

**Objective:** The number of low income/uninsured patients able to access
mental health treatment will increase

• **Activity:** Improve the process for expedited Charity Care applications for patients with substance use disorders

**Leaders/Departments Involved:** Behavioral Health, Mercy Clinic, Virtual Care, Finance, and Community Health

**Community Partners:** JCHD, NCADA, COMTREA, Catholic Family Services, Behavioral Health Network (BHN). Behavioral Health Response (BHR), National Alliance on Mental Illness (NAMI), Alive & Well STL

**Evaluation Plan for Goal**

Regional CHIP Behavioral Health team will establish **baseline data and report 3-year measurable outcomes** to include:

**Outputs:**
- Inventory of mental health services currently available
- Number of resources added/partnerships formed
- Number of patients served
- Number of mental health providers recruited

**Short-Term Outcomes:** *(Data Source:)*
- TBD

**Long-Term Outcomes:** *(Data Source:)*
- TBD
**Additional Needs Being Addressed**

1. **Violence: Domestic, Elderly, Child Abuse, and Trafficking**

   Mercy will continue its collaboration and involvement with A Safe Place, a local domestic violence shelter, as well as the awareness and education campaigns it has begun with restroom resource posters, a training video, and the incorporation of a screening question/referral process in Mercy’s Electronic Medical Record (EMR).

   MHSL and Alternatives to Living in Violent Environments (ALIVE), a St. Louis based domestic violence agency, have implemented Project HOPE, the only program in the St. Louis area that allows domestic violence survivors to file for, and potentially have granted, orders of protection while still in a hospital setting. Inpatient care management is currently looking into expanding this resource to MHJ.

1. **Cancer: Lung/Tobacco Use**

   Efforts to address tobacco cessation will continue through Mercy’s Certified Health and Wellness Coach/Mercy Road to Freedom program though Mercy’s Cardiopulmonary Rehab area. Additionally, Mercy will continue to advocate around measures that promote tobacco cessation. For example, Tobacco 21, a bill introduced by a MHSL physician in 2016 to raise the tobacco products purchase age to 21 in St. Louis County, was recently passed and will go into effect on December 1, 2016. MHJ will look for opportunities to collaborate with MHSL and potentially expand legislation to Jefferson County.

1. **Obesity/Poor Nutrition/Physical Inactivity**

   Although MHJ did not choose healthy lifestyles as a priority community health need to be addressed, Mercy has focused on its own coworkers, 10,000+ in the St Louis region, as a start to addressing this need. A robust
initiative, Mercy’s Healthification program, provides comprehensive health evaluation, screening, education, and incentives to increase healthy behaviors and improve health among Mercy coworkers.

1. Chronic Conditions: Heart Disease, Diabetes, or Asthma and Allergies

MHJ continues to provide education and support to those patients and community members with chronic conditions. In addition to having a Deaconess Faith Community Nurse and Mercy home health team, who provide patients with chronic disease management and education, a specialized congestive heart failure clinic was just established within the cardiology clinic in Jefferson. Clinic operations are also currently partnering with Novo Nordisk to provide Diabetic Academy, a 6 week free course focused on diabetes management.

Additional Needs Not Being Addressed and Why

1. Environmental: Air/Water Quality

MHJ will continue its partnership with the Jefferson County Health Department (JCHD) and will collaborate with any environmental initiatives they develop.

However, it was felt by Mercy’s Community Health Council (CHC) that while continued attention to this issue was important, Mercy’s focus remains on providing quality healthcare. Therefore, the issues of access, and the community’s crisis with behavioral health and addiction demanded Mercy’s focus at this time.
Community Health Council
Mercy Jefferson

Leadership
LEADERS
Eric Ammons – President
Jared Bryson – VP, Mission Services

MEMBERS
Stacy Blankenship – Chief Nursing Officer
Dawn Brandenberg – Supervisor, Mercy Clinic Care Management
Jared Bryson – VP, Mission
Donna Easter – Community Relations Specialist, Integrated Marketing
Dan Eckenfels – VP, Finance
Ron Finnan – Manager of Operations, Mercy Clinic Jefferson
Rick Fischer – Community and Government Relations Advocate
Madeline Gemoules – Outreach Coordinator, Mercy Neighborhood Ministry
Rich Hadley – Manager, Pastoral Services
Andrew Held – Director, Development
Terry Herbert – Exec. Dir. Community Relations, Integrated Marketing
Ken Joyce – Director, Mission
Jack King – Board Member
Patricia Lael – Manager, Inpatient Care Management
Michelle Meyer – VP Operations
Patty Morrow – Exec. Dir, Behavioral Health
Sharon Neumeister – Dir, Mercy Neighborhood Ministry
Erin Poniewaz – Supervisor of Counseling, Behavioral Health
Jill Randal – Faith Community Nurse, Deaconess
Annette Richardson-Latham – Regional Director, Inpatient Care Management
Ray Weick – VP, Physician Growth and Business Development
Responsibilities

1. Completes:
   a. Community Health Needs Assessment every three years
   b. Annual written Community Health Implementation Plan
   c. Annual community impact plan
2. Develops & manages a Community Benefit budget
   a. Annual Community Benefit amount falls between 5-8%
3. Assures Community Benefit activities:
   a. Meet a prioritized community health need
   b. Make a measurable impact on a community health indicator
   c. Involve collaboration/partnership with key community stakeholders and advocacy with key legislators
   d. Connect programs to service line and community master planning strategies
   e. Develop innovative programs/medical management of charity & Medicaid populations
4. Reports:
   a. Community Benefit activities accurately and thoroughly
   b. Information for 990H/990, especially narrative questions
   c. Community Benefit activities quarterly to local boards and ministry oversight group

To comply with IRS guidelines, the following timeline will guide Community Benefit program development and reporting:

2. Community Health Implementation Plans written and approved by local boards – 11/15/2016
3. FY13 tax return prepared and submitted – 5/15/2016

The local Community Health Council is accountable for ensuring Community Benefit meets mission, compliance and IRS guidelines.