Community Health Improvement Plan

Mercy Hospital Southeast

Fiscal Year 2026

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.

Our Values

Dignity
Excellence
Justice
Service
Stewardship

Contents

Introduction

Mercy Southeast is committed to carrying out its mission to deliver compassionate care and exceptional service for all members of the communities it serves, with special attention to those who are marginalized, underserved, and most vulnerable. As part of this CHNA, Mercy convened a collaboration of area health care and non-profit partners to conduct a comprehensive community health survey and various focus group sessions. Available secondary health data was also obtained, and Southeast indicators were compared to those of Missouri and the United States.

Mercy Hospital Southeast is a 245-bed acute-care hospital located in Cape Girardeau, Missouri affiliated with Mercy, a large Catholic health system. Headquartered in St. Louis, Mercy serves millions of people each year in multiple states across the central United States. For the purposes of this Community Health Needs Assessment (CHNA), the community served by Mercy Southeast will be defined as the four-county Southeast region made up of Cape Girardeau, Bollinger, Scott and Stoddard Counties.

Mercy's mission is to deliver "compassionate care and exceptional service" to every community member. In dedication to this mission, our work includes the development of a Community Health Needs Assessment (CHNA) during the last year, in cooperation with stakeholders throughout the Southeast Missouri community.

Introduction *(continued)*

The CHNA identified ten top-priorities and of the ten, **three have been chosen as health needs for the Mercy Hospital Southeast community**. We will strive diligently to address these needs with a Health Equity lens over the next three years:

- Behavioral Health
- Transportation Access
- Healthcare Capacity

As always, we seek to develop a rich and rewarding network of partnerships with our neighbors. We welcome any thoughts you may have on ways to achieve our goal for a healthier community.

Improvement Plan by Prioritized Health Need

Prioritized Need #1: Behavioral Health

GOAL 1

Increase access to behavioral health care for uninsured and at-risk persons.

Prioritized Need #1: Behavioral Health

Program 1 of 3: Virtual Behavioral Health (vBH)

PROGRAM DESCRIPTION:

Mercy's Virtual Behavioral Health (vBH) program provides integrated, regional support for patients with behavioral health needs. Based out of local and centralized Ministry locations, vBH co-workers provide virtual and telephonic behavioral health assessments to establish patients' level of care, and facilitate referrals for inpatient, intensive outpatient (IOP), and outpatient services, as well as for basic social needs in their home communities. vBH also provides virtual psychiatric consults to help with medication stabilization related to the exacerbation of behavioral health conditions.

ACTIONS MERCY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

- Operate a hub-based model of virtual care, where clinical vBH co-workers respond to incoming referrals, conduct telephonic behavioral health assessments, and facilitate outgoing referrals for ongoing diagnosis, treatment, and support.
- Collaborate with external partners and behavioral health service providers to ensure a strong regional network for care coordination and social service navigation.
- Maintain internal coordination between relevant stakeholders, including Population Health, Behavioral Health, and Community Health, for ongoing assessment of community needs, assets, and barriers, and increased data and service integration for improved continuity of care and patient outcomes.
- Analyze true cost of care and return on investment analysis (ROI) for vBH patients and explore prospective for further developing complex care model

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

- Each year, the vBH program will increase the number of patient assessments completed by 10%.

Medium-Term Outcomes:

- Each year, the vBH program will increase the number of referrals made to IOP and Long-Acting Injection (LAI) Clinics by 10%.

Long-Term Outcomes:

- Over three-year period (FY26-FY28), patients who participated in vBH program will demonstrate a 10% decrease in hospital readmissions and ED visits. Commendable

Prioritized Need #1: Behavioral Health

Program 1 of 3: Virtual Behavioral Health (vBH) - continued

PLAN TO EVALUATE THE IMPACT:

- vBH will track assessments and consultations conducted
- vBH will track number of patients who are referred to BH resources and connected to appropriate treatment

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Cost of coworker and clinician time, including Regional Resource Behavioral Health RNs and LPNs and Patient RN Advocates.
- Operational budgeted support as appropriate.
- Indirect expenses related to EMR and clinic operations

COLLABORATIVE PARTNERS:

- Mercy Behavioral Health Service Line Leadership
- Mercy Virtual Behavioral Health (vBH)
- Substance Abuse Recovery Program (SURP) - EAST

Prioritized Need #1: Behavioral Health

Program 2 of 3: Collaborative Care

PROGRAM DESCRIPTION:

Supporting primary care providers (family medicine, internal medicine, obstetrics & gynecology, and pediatrics) in providing mental and behavioral health services to patients in need. The model provides a behavioral care manager to interact directly with patients, perform assessments, initiate treatment, and communicate and collaborate with primary care physicians. Collaborative Care provides a psychiatric consultant who meets with care managers regularly, reviews patient charts, and makes recommendations for medication and ongoing treatment.

ACTIONS MERCY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

- Continue training and educating providers on the use of the care approach.
- Identify gaps in care.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Increase patient referrals by 5% each year.
- Increase patient satisfaction assessment participation by 10% from previous CHIP cycle.

PLAN TO EVALUATE THE IMPACT:

- Track number of primary care physicians participating in program.
- Track number of referrals to Collaborative Care per month.
- Track percentage of patients referred to Collaborative Care who enroll in program (conversion rate).
- Track number of referrals of uninsured and Medicaid patients per month.

Prioritized Need #1: Behavioral Health

Program 2 of 3: Collaborative Care - continued

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Cost of coworker and clinician time, including Regional Resource Behavioral Health RNs and LPNs and Patient RN Advocates.
- Operational budgeted support as appropriate.
- Indirect expenses related to EMR and clinic operations

COLLABORATIVE PARTNERS:

- Mercy Behavioral Health Service Line Leadership
- Mercy Virtual Behavioral Health (vBH)
- Substance Abuse Recovery Program (SURP)

Prioritized Need #1: Substance Use

Program 3 of 3: Substance Use Recovery Program (SURP)

PROGRAM DESCRIPTION:

Mercy Substance Use Recovery Program (SURP) is an integrated, mission-driven, patient-centric approach to Opioid Use Disorder. SURP will ensure that any patient seeking care through Mercy will be connected to ongoing care for Opioid Use Disorder regardless of geography, clinical setting, or ability to pay. Through a virtual-first care experience, SURP provides Medication-Assisted Therapy (MAT), primarily through buprenorphine, for patients with Opioid Use Disorder. Patients who participate in SURP are also connected to support services, including counseling, behavioral therapies and general primary care, to implement a holistic harm-reduction care model. By offering proactive telephonic outreach and virtual treatment and support options, SURP can increase access to essential behavioral health services and facilitate continuity and ease of care for patients.

ACTIONS MERCY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

- Consistent with Mercy's care model, clinicians (primarily in the Emergency Department) will refer patients identified with Opioid Use Disorder to SURP.
- SURP LCSWs will outreach and engage with patients, providing necessary direct support as well as referrals and care coordination for treatment and primary care provision.
- SURP clinicians will facilitate MAT for patients, managing MAT medication prescription and adherence.
- Community Health Leaders will maintain an ongoing relationship with the SURP team and facilitate reporting of outcomes.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

- To increase the number of referrals of ED patients to SURP program by 10% each year
- To increase engagement rate through initiation of care by 10%
- Convert 35% of engaged patients (engaged for one month of treatment) from self-pay to Medicaid

Medium-Term Outcomes:

- Maintain engagement of 10% of patients that engage through a six-month period

Long-Term Outcomes:

- Patients reached by SURP will demonstrate a 20% reduction in ED utilization over three years.
- Patients reached by SURP will demonstrate a 10% reduction in inpatient readmission over three years.

Prioritized Need #1: Substance Use

Program 3 of 3: Substance Use Recovery Program (SURP) - continued

PLAN TO EVALUATE THE IMPACT:

- SURP will track program referrals.
- SURP will track number of patients who initiate care/engage with program.
- Mercy to track the number of MAT waivered clinicians.
- Mercy track ED utilization rates and readmissions.

PROGRAMS AND RESOURCES MERCY PLANS TO COMMIT:

- Funding for SURP staff, including 4 providers, 1 psychiatric consultant, and 2 Licensed Clinical Social Workers
- Support and education for clinicians in primary care, inpatient settings, OB/MFM and the ED to identify and facilitate patient referrals
- Staff time and indirect costs necessary to maintain ongoing partnership with BHN

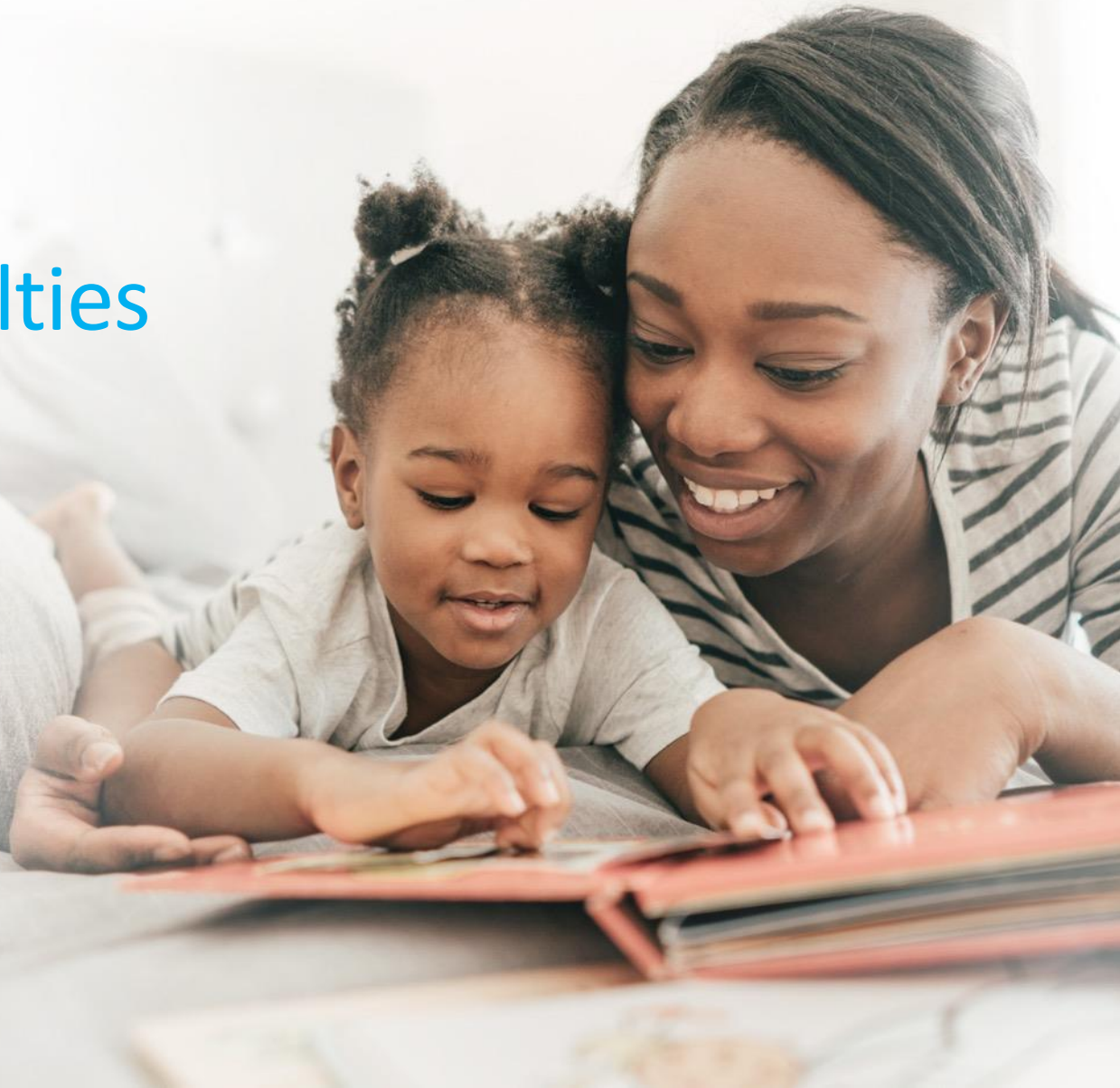
COLLABORATIVE PARTNERS:

- Behavioral Health Network of Greater St. Louis (BHN) – EPICC Program
- Behavioral Health Response (BHR)
- Mercy Virtual Behavioral Health (vBH)

Prioritized Need #2: Healthcare Capacity

GOAL 1

Increase access to specialties services (i.e. obstetrics, oncology) for wholistic clinical needs



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Prioritized Need #2: Access to Care

Program 1 of 1: Community Health Worker Program

PROGRAM DESCRIPTION:

The Community Health Worker (CHW) Initiative is dedicated to improving health care access and outcomes for underserved communities by bridging gaps between healthcare systems, social services, and the individuals they serve. CHWs engage directly with underserved communities to identify barriers related to social drivers of health, such as transportation, housing, and financial instability, that impact access to care. Through personalized support, CHWs help community members navigate healthcare services, assist with Medicaid and financial assistance enrollment, understanding health plan benefits, and connect individuals to vital community resources, including medication and social support programs. By fostering trust and cultural humility, this initiative aims to reduce disparities, enhance patient advocacy, and ensure equitable access to comprehensive health care for all community members.

ACTIONS MERCY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

- Review and confirm SDOH screening was completed for patients in the emergency department, inpatient, and clinic settings, to identify social risks factors.
- Provide outreach to patient population identified with social risk factors.
- Provide education and linkage to Medicaid and financial assistance, supporting screening and enrollment on an as needed basis.
- Educate underinsured patients on health plan benefits and resources aligned with chronic condition and/or social risk factors.
- Provide care navigation to Mercy services and referrals to community-based services, including medication assistance.
- Facilitating access to establish care with a Mercy primary care provider, as needed.
- Establish follow up plan for focused population(s).
- Provide closed-loop communication to referring provider

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Reduce 72-hour return rate (all payor).
- Reducing readmission rates for focused populations.

Prioritized Need #2: Access to Care

Program 1 of 1: Community Health Worker Program - continued

PLAN TO EVALUATE THE IMPACT:

- Track total patients screened for HRSNs.
- Track total patients screened positive for HRSNs.
- Track HRSN screening rate
- Track number of patients consults and referral orders to CHWs.
- Track turnaround time between referral received and CHW initial outreach
- Track number of unduplicated patients served
- Track number of patient encounters
- Track number of patients successfully enrolled in Mercy financial assistance and Medicaid.
- Track number of patients achieved access to community resource
- Track number of patients achieved access to medication assistance.

PROGRAMS AND RESOURCES MERCY PLANS TO COMMIT:

- Compensation and benefits for Community Health Workers.
- Mileage and travel expenses required for CHW work.
- Office space and indirect expenses dedicated to CHW work.
- CHW Training-Offered by Ministry (or through community partnership)

COLLABORATIVE PARTNERS:

- Cross Trails Health Centers
- Local Public Health Departments

Prioritized Need #3: Transportation Access

GOAL 1

Increase access to non-emergent medical transportation for underserved patients

Prioritized Need #3: Transportation Access

Program 1 of 1: Lyft Platform

PROGRAM DESCRIPTION:

The **Lyft Platform** is a comprehensive transportation solution designed to improve access to medical care by offering reliable, non-emergency medical transportation (NEMT) services. It leverages a web-based ride request portal to provide rides across the patient journey—from home to healthcare facilities and back. These requests can be in the moment or scheduled ahead of time, assisting with urgent transportation needs. Lyft drivers do not have any personal health information (PHI) besides their name and ride location details.

ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

- Partner with Lyft Healthcare to implement the Concierge platform.
- Train care coordinators and clinic staff to schedule rides via Lyft Concierge.
- Integrate ride scheduling into discharge planning and follow-up care.
- Promote the service through community outreach and healthcare providers.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Increase appointment attendance rates among Medicaid and Medicare beneficiaries.
- Reduce no-show appointments due to lack of transportation.
- Improve patient satisfaction with healthcare access.
- Support care coordination for vulnerable populations.

PLAN TO EVALUATE THE IMPACT:

- Number of rides
- Number of Users
- Transportation Mileage

Prioritized Need #3: Transportation Access

Program 1 of 1: Lyft Platform - continued

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Lyft Concierge platform access and training
- Funding for ride costs (grants, Medicaid reimbursements, etc.)
- Staff time for coordination and scheduling
- Data tracking tools for monitoring usage and outcomes

COLLABORATIVE PARTNERS:

- Lyft Health
- Mercy Inpatient Care Management
- Mercy Technology Services

Other Community Health Programs

Mercy Southeast 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: improve access to health care services, enhance the health of the community, advance medical or health care knowledge or 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.


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