Community Health Improvement Plan

Mercy Hospital Jefferson

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

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Introduction

Mercy Hospital Jefferson, a 251-bed acute care facility in Festus, Missouri, completed a comprehensive Community Health Needs Assessment (CHNA) in collaboration with community partners, including the Jefferson County Health Department, COMPASS Health, Jefferson Franklin Community Action Corps, and others. The 2025 CHNA considered input from community members, organizations representing medically underserved and minority populations, and a wide range of stakeholders across Jefferson County. This process identified the top health priorities that will guide Mercy Hospital Jefferson's work over the next three years.

The resulting Community Health Improvement Plan (CHIP) outlines strategies and resources to address these priorities through evidence-based programs, expanded partnerships, and targeted interventions. The CHIP provides a framework for collaboration with local organizations and residents to improve health outcomes and enhance quality of life for the communities we serve.

Introduction *(continued)*

The CHNA identified five key health priorities and of the five, four were selected as focus areas for the Mercy Hospital Jefferson community. We will strive diligently to address these needs with a Health Equity lens over the next three years:

- Access to Care
- Behavioral Health/Substance Use
- Cancer
- Aging Services

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: Access to Care

GOAL:

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

Prioritized Need #1: Access to Care

Program 1 of 3: 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 to health-related social needs, such as transportation, housing, and financial instability, that impact access to care. 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:

Through personalized support, Mercy CHWs will 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.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Reduce 72-hour return rate
- Reducing readmission rates for focused populations

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:

- St. Louis Crisis Nursery
- Dispensary of Hope

Prioritized Need #1: Access to Care

Program 2 of 3: Crisis Nursery Outreach Partnership

PROGRAM DESCRIPTION:

The St. Louis Crisis Nursery serves more than 7,200 children each year through programs dedicated to preventing child abuse and neglect. At the Crisis Nursery Outreach Center at Mercy Hospital Jefferson, a Family Engagement Specialist supports families with children under 12 through crisis counseling, community referrals, home visits, and parent education groups—helping strengthen families and promote healthy, safe homes. The program also provides essential items such as food, diapers, and cleaning supplies to families in need.

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

Mercy will make referrals to the Family Empowerment Specialist who will provide families with children under 12 with services that help minimize stress, reduce isolation and empower families to achieve goals that ensure stability and safety.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- 90% of FEP participants will report reduced stress levels
- 90% of FEP participants will increase their Family Protective Factors in at least 3 of the 5 protective factor domains
- 85% of FEP participants will increase positive coping skills by graduation

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

Storage, workspace, and indirect expenses dedicated to supporting the work of the Family Engagement Specialist

COLLABORATIVE PARTNERS:

- St. Louis Crisis Nursery
- Mercy Hospital Jefferson Community Health Workers (CHWs)
- Mercy Hospital Jefferson Care Managers
- School Districts (School Social Workers and Counselors)

Prioritized Need #1: Access to Care

Program 3 of 3: Dispensary of Hope (DOH)

PROGRAM DESCRIPTION:

The Dispensary of Hope is a charitable medication distributor that delivers critical medicine donated by pharmaceutical manufacturers for free to the people who need it the most but cannot afford it. By partnering with Dispensary of Hope, Mercy Pharmacy can get access to their charitable formulary, connecting self-pay patients with the direst financial need to essential medicines across a range of drug classes, including insulins, anti-infectives, and psychotropics.

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

In contract with the Dispensary of Hope, Mercy Pharmacy will manage charitable formularies within participating pharmacies, including maintaining inventory and making weekly orders. Mercy will use attestation form to enroll qualifying patients in the Dispensary of Hope program and will promote the formulary.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Each year, will see a 10% reduction in ED visits
- Each year, will see a 10% reduction in total cost of care

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Annual contract fees to Dispensary of Hope for formulary access
- Pharmacist support for formulary management
- Marketing and communications support, in the form of flyers, rack cards, enrollment cards, etc.
- Training for caregivers to understand enrollment process for Dispensary of Hope

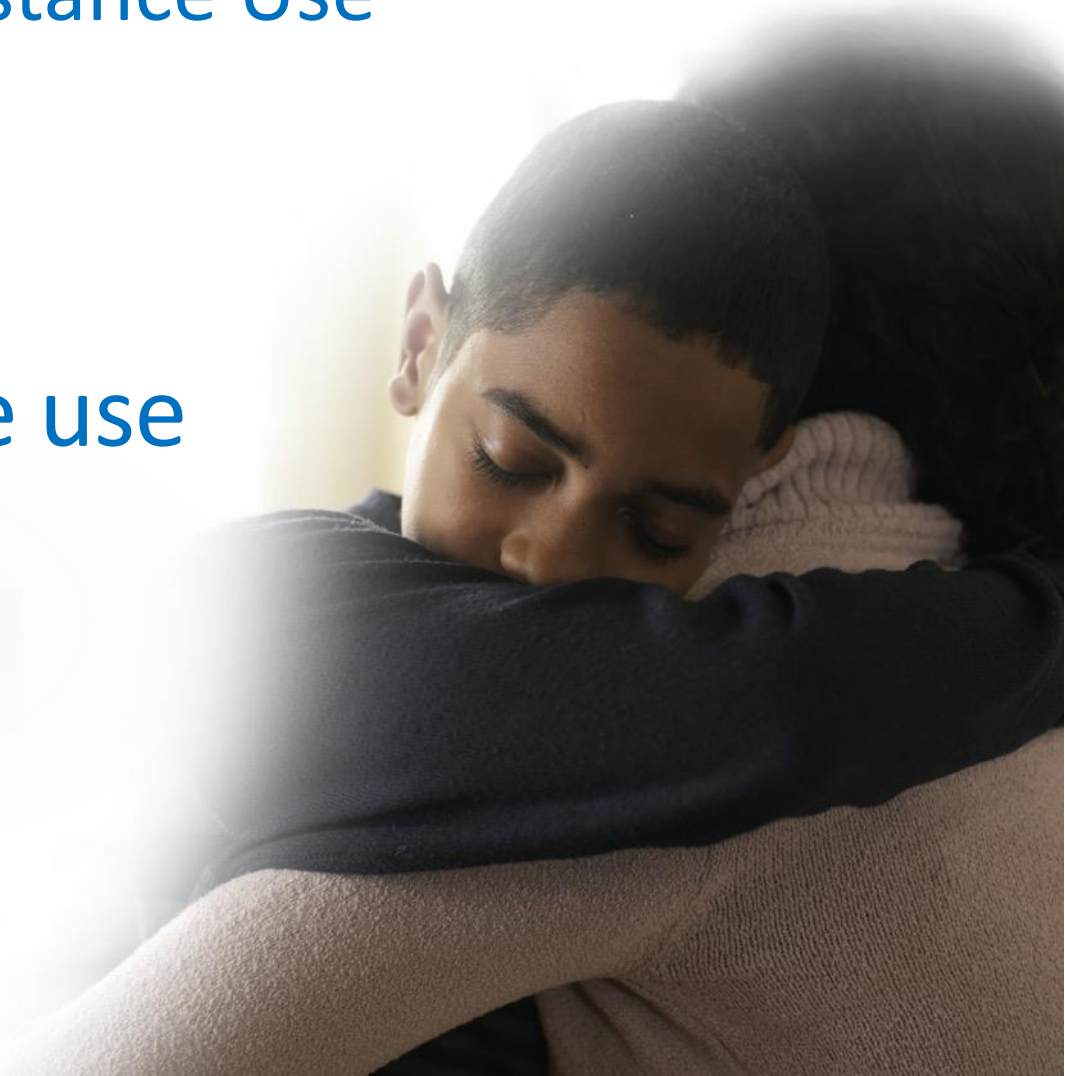
COLLABORATIVE PARTNERS:

- Dispensary of Hope
- Internal: Mercy Pharmacy, Integrated Health and Social Care, Care Management, Hospitalists, Mercy Clinics
- External providers: FQHC Partners

Prioritized Need #2: Behavioral Health and Substance Use

GOAL:

Increase access to mental health care and substance use treatment for uninsured and at-risk persons.



Prioritized Need #2: Behavioral Health

Program 1 of 4: 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 caregivers 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:

Mercy will 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. Mercy will also collaborate with external partners and behavioral health service providers to ensure a strong regional network for care coordination and social service navigation.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- 10% decrease in hospital readmissions and ED visits by FY28

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 #2: Behavioral Health

Program 2 of 4: 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:

Mercy will continue training and educating providers on the use of the care approach, identify gaps in care, and refer patients to Collaborative 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

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 #2: Substance Use

Program 3 of 4: Mercy StepOne Services

PROGRAM DESCRIPTION:

The StepOne Service™ is an inpatient, hospital-based acute withdrawal management service for adults requiring medical management of withdrawal symptoms from alcohol and/or opioids. Our personalized approach begins with a simple telephone pre-screening to develop a recovery plan best suited for each individual, allowing for planned admissions rather than unplanned ER visits. The service integrates into an existing med/surg unit, with 24-hour medical care provided over a 3–5 day period by the hospital's physicians and nurses. Comprehensive discharge planning helps patients transition to appropriate community-based addiction treatment that addresses the underlying causes of substance use disorder (SUD), with follow-up continuing for six months post-discharge.

ACTIONS MERCY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

Mercy will refer appropriate patients to the Mercy StepOne™ Care Coordinator. Mercy inpatient hospital beds will be provided for planned admissions to support medical supervision and management of withdrawal symptoms by Mercy physicians and nurses.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Increase new, local community partner relationships within three years
- Achieve and maintain community satisfaction with access at or above 85% within three years

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Workspace and indirect expenses dedicated to supporting the work of the Mercy StepOne Care Coordinator

COLLABORATIVE PARTNERS:

- Mercy Hospital Jefferson Leadership
- Mercy Hospital Jefferson Community Health Workers (CHWs)
- Mercy Hospital Jefferson Care Managers
- Substance Abuse Recovery Program (SURP)

Prioritized Need #2: Substance Use

Program 4 of 4: 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:

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.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- 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

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- SURP staff: providers, psychiatric consultant, and Licensed Clinical Social Workers
- Support and education 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 #3: Cancer

GOAL:

To increase access to cancer-related support, education, and resources that empower patients and families to make informed decisions and improve overall well-being.

Prioritized Need #3: Cancer

Program 1 of 1: Home-Based Palliative Care Program

PROGRAM DESCRIPTION:

The Mercy Home-Based Palliative Care Program will extend palliative care services to patients—particularly those living with cancer and other chronic illnesses—who are unable to access onsite support. Operated through the Mercy Palliative Care, the program will be RN-led, with nurses providing in-home visits to deliver symptom management, pain management, care coordination, and goals-of-care conversations. By bringing palliative services directly into the home, patients with advanced cancer and other serious illnesses can avoid unnecessary hospitalizations and focus on quality of life.

ACTIONS MERCY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

Mercy will enhance its Palliative Care Program by integrating a Registered Nurse to deliver in-home services focused on supporting cancer patients. This initiative will provide pain and symptom management for individuals facing barriers to accessing care, while facilitating goals-of-care discussions to ensure patients and families feel informed and supported. Virtual nurse practitioner consults will be incorporated to address complex oncology needs, and outcomes such as hospice referrals and hospital readmissions will be closely monitored to improve coordination and continuity of care.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Expand access to home-based palliative care for oncology patients, improving comfort and continuity of care
- Enhance quality of life by reducing unmanaged plain, supporting families in care decisions, and keeping patients within the Mercy system
- Decrease hospital readmissions and improve transitions to hospice through earlier, coordinated, and patient-centered care

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Dedicated RN position
- Integration of palliative care support into Mercy's oncology care pathway
- Support from Mercy oncology teams, NPs, and physicians

COLLABORATIVE PARTNERS:

- Mercy Palliative Care and Oncology Services
- Mercy hospitalists and primary care providers
- Community support agencies serving Jefferson, Washington, St. Francois, and Ste. Genevieve Counties

Prioritized Need #4: Aging Services

GOAL:

To increase supportive services and resources for older adults, to improve whole-person health.

Prioritized Need #4: Aging Services

Program 1 of 1: Network for Operationalizing Upstream Responses to Improve Systems and Health (NOURISH)

PROGRAM DESCRIPTION:

The NOURISH (Network for Operationalizing Upstream Responses to Improve Systems and Health) program will address food insecurity and malnutrition among older adults (65+) in Jefferson County through a Food is Medicine Hub. Operated in partnership with Washington University, Food Outreach, and Mercy Jefferson, the Hub will integrate medically tailored meals (MTMs) and expand nutrition services into clinical care for older adults. Eligible patients will receive medically tailored meals, groceries, and produce prescriptions, paired with dietician counseling, nutrition education, and community health worker support.

ACTIONS MERCY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

Mercy will integrate routine screening for food insecurity and malnutrition into care for older adults to better identify and address nutritional needs. Eligible patients aged 65 and older will be enrolled in a Medically Tailored Meal program providing monthly meal boxes with balanced, protein-rich foods and fresh produce. Nutrition education and counseling from registered dietitians and community health workers will further support healthy aging and improved overall well-being.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Increase access to nutritious meals and improve dietary intake among older adults facing food insecurity
- Enhance health outcomes, reduces hospital readmissions, and support independence for older adults living with or at risk of chronic disease
- Establish a sustainable Food Is Medicine model that strengthens nutrition support and can expand across Mercy service regions

PRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Integration of screening tools into Mercy Jefferson's 65 Prime+ Clinic workflow
- Clinical and operational support from Mercy dieticians, physicians, and community health workers
- Storage and logistical support for distribution of medically tailored meals

COLLABORATIVE PARTNERS:

- Washington University
- Food Outreach
- Regional farms and local producers

Other Community Health Programs

Mercy Hospital Jefferson 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.

Significant Health Needs Not Being Addressed

As with any prioritization process, not all identified health needs can be addressed directly. Mercy Hospital Jefferson must be thoughtful in how resources are allocated, focusing efforts where the greatest impact can be made. During the CHNA process, **obesity and maintaining a healthy lifestyle** emerged as a significant community concern. While this need was not selected as a top priority for the 2026–2028 CHIP, it will be influenced indirectly through Mercy Hospital Jefferson's work in other priority areas—particularly those that support improved access to care and community wellness. In this way, Mercy remains committed to creating an environment that promotes healthier choices and lifestyles.


Mercy
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