Community Health Improvement Plan

Mercy Hospital South

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 South (MHS) completed a comprehensive Community Health Needs Assessment (CHNA) in partnership with other health systems in the region and represents one piece of the larger efforts towards a health St. Louis. The CHNA was adopted by the MHS Board of Directors in May 2025, and considered input from the county health department, community members, members of medically underserved, low-income and minority populations and various community organizations representing the broad interests of the MHS primary service area. Identified priorities for MHS for the next three years include: Access to Care, Behavioral Health, Nutrition/Food Insecurity, and Aging Services. The complete CHNA report is available electronically at mercy.net/about/community-benefits.

Mercy Hospital South is affiliated with Mercy, one of the largest Catholic health systems in the United States. Located in St. Louis, Missouri, MHS serves the southern portion of St. Louis County, the northern portion of Jefferson County, and parts of Illinois. This acute-care hospital has 767 licensed beds, includes 24-hour emergency care, and is a level II trauma center. Specialty hospital services include acute rehabilitation, cardiology, maternity services, oncology care, orthopedics, neurology/stroke, surgery, and emergency medicine.

Introduction *(continued)*

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 2025 CHNA and this resulting CHIP will provide the framework for Mercy Hospital South as it works in collaboration with community partners to advance the health and quality of life for the community members it serves.

Introduction *(continued)*

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

- Access to Care
- Behavioral Health
- Nutrition/Food Insecurity
- 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 4: 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
- Hancock Clinic
- Dispensary of Hope

Prioritized Need #1: Access to Care

Program 2 of 4: 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 South, a Family Engagement Specialist assists area families with children under 12 through crisis counseling, community referrals, home visitation, and parent education groups – helping strengthen families and promote healthy, safe homes. The program also provides essential items such as food, diapers, 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
- Parents as Teachers
- School Districts (School Social Workers and Counselors)
- St. Vincent De Paul

Prioritized Need #1: Access to Care

Program 3 of 4: 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: Hancock Clinic and FQHC Partners

Prioritized Need #1: Access to Care

Program 4 of 4: Hancock Clinic Partnership

PROGRAM DESCRIPTION:

The mission of iFM Community Medicine is to strengthen underserved communities, one patient at a time, to promote community health. iFM achieves this mission by reducing barriers to quality primary health care for economically disadvantaged people in the St. Louis metro area. After flood devastation, the Hancock Clinic was initiated by a partnership with iFM and the Hancock Place School District. Mercy Hospital South has continued to support the Hancock Clinic grow and much work has been done to serve patients of the clinic. Patients that visit Mercy South and are identified as being able to receive services from the Hancock Clinic are made an appointment prior to discharge from the hospital. Hancock Clinic serves residents from 63125, but also from 63123 on a referral basis from Mercy Hospital South. Many patients look to the Hancock Clinic as their medical home and primary source of care. Services provided include general services, women's health, basic labs, mental health, dietary/lifestyle education and STD testing for uninsured patients in this high need/high-risk population.

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

- Identify uninsured or at-risk community members who need primary care or other services and refer to the Hancock Clinic
- Connect patients with other community resources that help with health-related social needs

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Patients reached by the Hancock Clinic will demonstrate a 10% reduction in ED utilization over three years

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Funding to support Hancock Clinic operations
- Funding to support Hancock clinic initiatives

COLLABORATIVE PARTNERS:

- iFM Community Medicine
- Hancock Place School District

Prioritized Need #2: Behavioral Health

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 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:

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: Behavioral Health

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

Prioritized Need #2: Behavioral Health

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: Nutrition/Food Insecurity

GOAL:

To increase access to healthy food and nutrition education.

Prioritized Need #3: Nutrition/Food Insecurity

Program 1 of 1: CHF Shelf-Stable Food Bags Pilot

PROGRAM DESCRIPTION:

This pilot program will address food insecurity among persons with congestive heart failure (CHF) in Mercy Hospital South's service area. Operated in partnership with Food Outreach to create shelf-stable food bags for patients with CHF that are screened positive for being food insecure according to their dietary needs. Eligible patients will receive medically tailored ingredients and recipes for roughly 20 meals and 3 different snacks. If those receiving the shelf-stable bags follow serving sizes, the food would support them for about 10 days to allow for time to be connected to a food pantry or even an interim period as they navigate planning and budgeting for their dietary needs. CHF is not currently within the mission of Food Outreach, however as this and other programs develop, we hope this will turn into an area of focus for the organization and Mercy can further invest in supporting the available resources to support food access for those with CHF.

ACTIONS MERCY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

Mercy will integrate routine screening for food insecurity to better identify and address nutritional needs. Eligible patients with CHF will be given a bag of medically tailored food to support for the next 7-10 days. Mercy Nurse Navigators, Dieticians, and Community Health Workers will further support patients with CHF in accessing resources for food that supports the CHF diet, connection to other needed resources, and improved overall well-being.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

•Increase access to nutritious meals and improve dietary intake among those with CHF facing food insecurity
•Enhance health outcomes and reduces hospital readmissions
•Establish a sustainable Food Is Medicine model that strengthens nutrition support and can expand across Mercy service regions

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Dedicated storage and logistical support for shelf-stable bag distribution
- Clinical and operational support for those with CHF

COLLABORATIVE PARTNERS:

- Food Outreach
- Local and regional food pantries

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: MOSHIP Volunteer

PROGRAM DESCRIPTION:

Missouri's State Health Insurance Assistance Program (MOSHIP) receives funding to help Missourians have their Medicare questions answered through volunteer counselors trained by MOSHIP. MOSHIP is a nonprofit organization certified by the federal and state government to offer free, unbiased, and confidential services. The program can assist through open enrollment to help understand options, help Missourians afford life-saving medications/treatments, communicate with their insurance companies, and fully understand benefits available to them.

ACTIONS MERCY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

Mercy plans to recruit volunteers to support patients and community members with access to MOSHIP volunteers. Volunteers will be supported with access to MOSHIP training, continuing education, and space for MOSHIP counseling. Mercy will connect patients needing support through open enrollment and throughout the year with Medicare navigation. Mercy will also advertise MOSHIP volunteers as a resource to the community at large.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

•Enhance patient outcomes by providing personalized support through navigation services

•Improve cost savings to those receiving navigation services by finding plans that are affordable, cover medications, and reduce unnecessary readmissions

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Recruitment and on-site support of volunteers
- Office space for MOSHIP volunteers to meet with clients
- Indirect expenses to support the success of this program

COLLABORATIVE PARTNERS:

- MOSHIP
- Local volunteers and volunteer groups

Other Community Health Programs

Mercy South 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

In any case of prioritization, there will be some areas of needs that are identified that are not chosen as a priority. Because Mercy Hospital South has limited resources, not every community need will be addressed. Throughout the CHNA process, the following need arose as a community concern. However, it will not be addressed as a top priority because other organizations are more appropriate to address this need.

- **Culturally Competent Care**
  While this need listed will not be specifically addressed in our priorities, it will likely be impacted indirectly through the work in our other community outreach priorities.

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