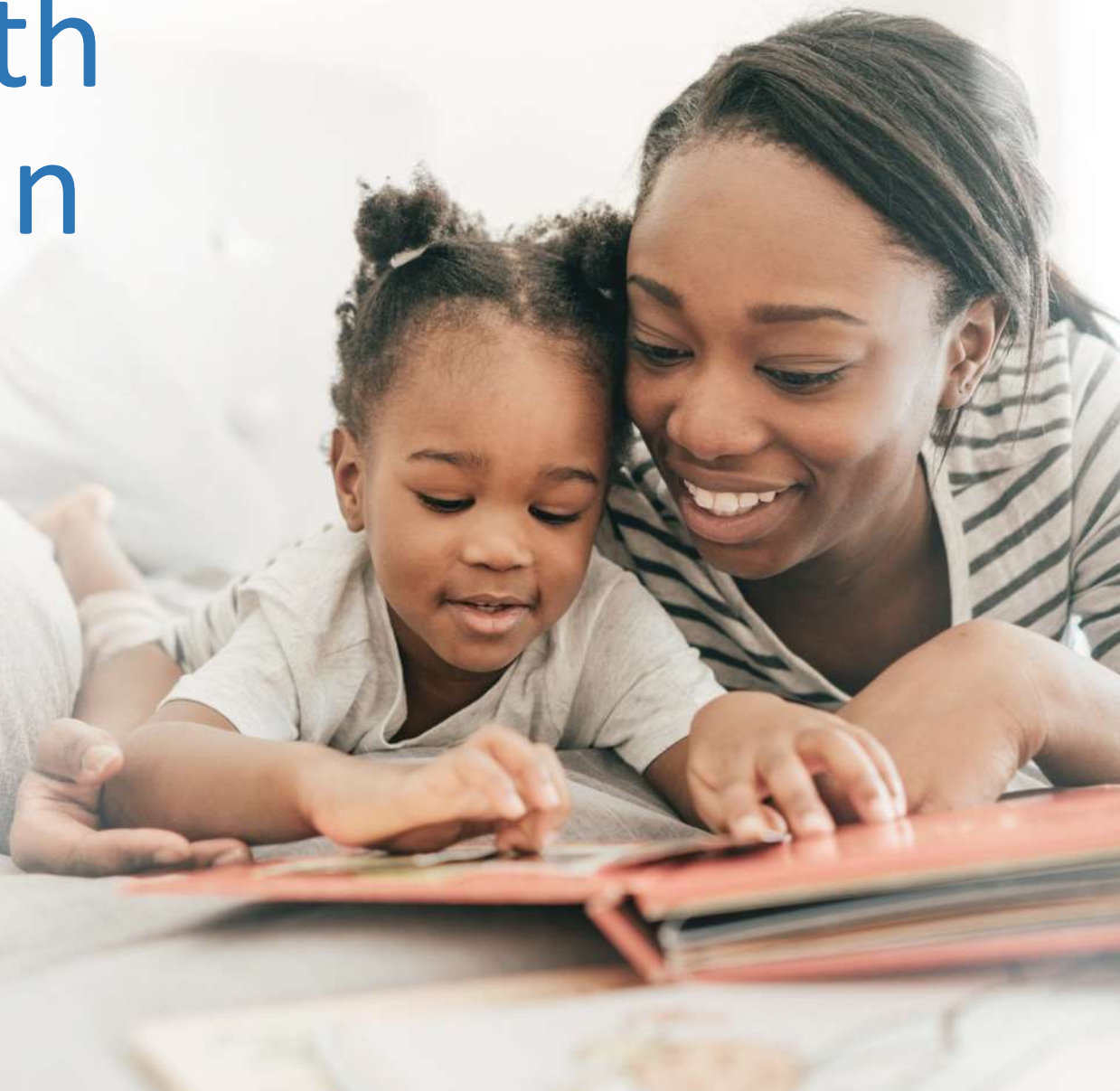
Community Health Improvement Plan

Mercy Hospital Cassville/Aurora

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 Cassville Aurora completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors in April 2019. Building upon the success of the 2016,2019 and 2022 regional health assessments, in 2024 partners again sought to better understand the health status, behaviors and needs of the populations served.

The resulting 2025 Regional Health Assessment (RHA) combines more than 200 hospital and community indicators, including feedback from stakeholders and citizens, across a 30-county region that includes southwest Missouri, southeast Kansas and northeast Oklahoma.
The CHNA identified three prioritized health needs the hospital plans to focus on addressing during the next three years: Diabetes, Mental Health and Heart Disease. The complete CHNA report is available electronically at mercy.net/about/community-benefits.

Mercy Cassville Aurora is affiliated with Mercy, one of the largest Catholic health systems in the United States. Located in the Monett community, Mercy Cassville and Aurora primary service area spans two counties across Southwest Missouri. The hospital has 25 licensed beds, includes comprehensive services.
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 Cassville Aurora as it works in collaboration with community partners to advance the health and quality of life for the community members it serves.

Implementation Plan by Prioritized Health Need

Prioritized Need #1: Diabetes

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

Prioritized Need #1: Diabetes

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 #1: Diabetes

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:

- MSU Care clinic
- CMAP Community Medication Access Program

Prioritized Need #1: Diabetes

Prescription Food Box

PROGRAM DESCRIPTION:

Missouri EATs welcomes Dade, Barry, Lawrence and Harrison counties to the program's 2025-2026 cohort. The Missouri EATs initiative, a program of University of Missouri Extension, is part of the Missouri Rural Food Access Partnership, a statewide collaboration dedicated to creating resilient and thriving food systems across Missouri. These new counties join Nodaway and Mississippi counties from the 2024-2025 cohort.
Communities involved in Missouri EATs (Engage, Act, Transform) collaborate with MU Extension on a comprehensive food system planning process, starting by assembling a team of leaders from within the community who identify key opportunities, such as supporting new food and farm businesses, expanding retail markets for local food, enhancing nutrition and cooking education or reducing food waste,

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 #1: Diabetes

Prescription Food Boxes(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
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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:

MU Extension
Mercy Clinics

Prioritized Need #2: Mental Health

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

Prioritized Need #2: Behavioral Health

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. Concert Health 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 #2: Behavioral Health

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 #2: Behavioral Health

Program : 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.

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 #3: Heart Disease

Increase access to Heart Disease prescriptions for uninsured and at-risk persons.

Prioritized Need #3: Heart Disease

CMAP (Community Medication Access Program)

PROGRAM DESCRIPTION:

CMAP is a department at Mercy that delivers critical medicine donated by pharmaceutical manufacturers for free to the people who need it the most but cannot afford it. By assisting patients connect with these companies, Mercy 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:

- Mercy will use enrollment form to assist qualifying patients in the program and will promote the assistance with Mercy providers and co-workers across relevant departments, including Hospitalists and ED physicians, Care Management, Diabetes Education, Behavioral Health, and Mercy Clinic.
- Mercy will communicate with community partners, including other healthcare providers, to promote the use of CMAP for patients in need.
- Mercy will work to connect qualifying patients with Mercy Financial Assistance and Medicaid and Medicare as applicable.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

- Maintain the number 30-day prescriptions filled /month
- Maintain the number of patients served / month
- Maintain the number of patient encounters / month

Medium-Term Outcomes:

- Maintain the dollars saved for patients monthly

Long-Term Outcomes:

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

Prioritized Need #3: Heart Disease

CMAP (Community Medication Access Program)

PLAN TO EVALUATE THE IMPACT:

- Track number of patients served
- Track number of prescriptions filled
- Track estimated cost savings to patient
- Conduct a yearly utilization analysis to understand program impact, patient readmissions, ED utilization, and total cost of care

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Salaries for CMAP Caregivers.
- 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 CMAP

COLLABORATIVE PARTNERS:

- CMAP
- Internal: Mercy Pharmacy, Integrated Health and Social Care, Care Management, Hospitalists, Mercy Clinics
- External providers: Pharmaceutical companies

Other Community Health Program

Mercy Cassville/Aurora 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 MHSL 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.

- **Communicable Diseases**

  Communicable diseases spread from person to person, including respiratory illnesses. The severity of some of these illnesses can be reduced through vaccination.
- **Sexually Transmitted Infections**

  Sexually transmitted infections (STIs) are spread through sexual contact. They are preventable and treatable.
- **Vector-borne illness**

  Engagement with the Monett Community's abundant outdoor resources comes with increased need for awareness and prevention of illnesses from insects, particularly Alpha-gal Syndrome (AGS), Lyme disease and ehrlichiosis.

Significant Health Needs Not Being Addressed

- **Cancer**
  In the Springfield Community, cancer is the second leading cause of death.
- **Lung health**
  Chronic lung conditions including chronic obstructive pulmonary disease (COPD) and asthma are incurable and cause mild to severe breathing difficulties.

Next Steps

After carefully reviewing the data and mapping existing resources, MHS is developing an implementation plan with evidence-based strategies. The plan will be submitted to a committee of appointed members from Mercy Hospital Cassville/Aurora, for their approval. The final version of the CHNA and Implementation Plan will be available to the public on the Mercy Hospital website, **www.mercy.net/communitybenefits**.

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