Community Health Improvement Plan

Mercy Hospital Jefferson

Fiscal Year 2019 - 2021

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.

Table of Contents

I. Introduction

Mercy Hospital Jefferson (MHJ) completed a comprehensive Community Health Needs Assessment (CHNA) in partnership with Community Treatment Inc. (COMTREA), Jefferson County Community Partnership (JCCP), the Jefferson County Health Department (JCHD) and Jefferson Franklin Community Action Corps (JFCAC). The CHNA was adopted by the MHJ Board of Directors in April 2019, 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 community of Jefferson County. Identified priorities for MHJ for the next three years include: Access to Care, Mental Health and Substance Use. The complete CHNA report is available electronically at mercy.net/about/community-benefits.

MHJ is affiliated with Mercy, one of the largest Catholic health systems in the United States. Located in Festus, Missouri, MHJ serves the community of Jefferson County, the 6th most populous county in the state, spanning 20 municipalities and 15 zip codes. The acute-care hospital has 321 licensed beds, and includes 24-hour emergency care, acute rehabilitation, behavioral health services, cancer care, outpatient rehabilitation and cardiac catheterization. MHJ is the only full-service hospital in Jefferson County.

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 2019 CHNA and this resulting CHIP will provide the framework for MHJ as it works in collaboration with community partners to advance the health and quality of life for the community members it serves.

II. Implementation Plan by Prioritized Health Need

Prioritized Need #1: Access to Care

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

PROGRAM 1: **Community Health Worker Program**
PROGRAM DESCRIPTION: Community Health Workers (CHWs) serve as liaisons/links between health care and community and social services, screening for needs related to social determinants of health, and facilitating access to services and improving the quality and cultural competence of care. CHWs work one-on-one with at-risk patients and community members, acting as patient advocates, assisting patients in applying for Medicaid and financial assistance and connecting patients with community resources.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Identify uninsured and at-risk patients and community members in need of assistance in the emergency department (ED), inpatient settings, community events, and using reports and dashboards. 2. Assist uninsured patients with applying for Mercy financial assistance and Medicaid programs or other relevant programs. 3. In coordination with the Community Resource Coordinator (CRC), assist patients without an established primary care provider in establishing care with a primary care clinic or provider. 4. Screen patients for needs related to social determinants of health and connect patients to community resources to meet identified needs. 5. Connect patients with other community resources, including medication resources, as needed.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. The CHW will conduct outreach or connect with 10 patients/encounters per week. ***Medium-Term Outcomes:*** 1. By the end of each fiscal year for the next three years, the CHW will enroll 50 patients in Mercy financial assistance and help facilitate 20 Medicaid applications. 2. The CHW will assist at least 50 patients per quarter with community and medication assistance resources. ***Long-Term Outcomes:*** 1. Patients enrolling in CHW program will demonstrate a 10% reduction in ED utilization and a 10% reduction in inpatient admissions. 2. Patients enrolling in CHW program will demonstrate a 10% reduction in their total bad debt.
PLAN TO EVALUATE THE IMPACT: 1. Track number of new and ongoing encounters conducted by each CHW. (Output) 2. Track number of patients successfully enrolled in Mercy financial assistance and the number of Medicaid applications initiated or completed. (Short-term) 3. Log number of patients referred to CRC to establish a primary care home. (Short-term)

4. Record number of patients receiving community resources and medication assistance. (Short-term)
5. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing CHW services. (Long-term)
6. Analyze pre- and post- intervention bad debt for cohort of patients utilizing CHW services. (Long-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Salary and benefits for full-time CHW.
2. Office space and indirect expenses dedicated to CHW work.

COLLABORATIVE PARTNERS:

1. HEAL Healthcare Access Workgroup
2. Jefferson County Health Department
3. COMTREA
4. A Place for Mom

PROGRAM 2: Community Referral Program

PROGRAM DESCRIPTION:

The Community Referral Coordinator (CRC) Program uses CRCs to connect patients from the Inpatient Units and/or ED of the hospital with a primary care home for follow-up and preventative care. The program focuses on serving underinsured and uninsured patients; however, the CRCs will work with all patients in need of a medical home. The program focuses on assessing each patient's individual needs, current resources and available options for outpatient medical care. CRCs partner with patients to establish primary care medical homes at Federally Qualified Health Centers (FQHCs) or with independent Mercy providers. This program is supported by contracted services provided by the St. Louis Integrated Health Network (IHN). The IHN's CRC works full-time on-site at MHJ, collaborating closely and in an integrated way with hospital staff including medical providers, Care Coordinators and CHWs.

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

1. Identified patients (both in the ED and Inpatient Units) with NO PCP and a barrier to care, such as being uninsured or underinsured, receive CRC navigational supports to plan for outpatient care after discharge. This can include personalized referrals, appointment setting and assistance with exploring insurance options or financial assistance to obtain and maintain outpatient care.
2. CRC provides support for patients already established with a FQHC (predominately Comtrea in Jefferson County) to ensure coordinated outpatient care is received after discharge from the ED or Inpatient Unit.
3. For patients with identified social determinant of health needs, the CRC will connect patient with the CHW or Crisis Nursery Family Empowerment Social Worker for further assistance.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. The CRC will engage 10 new patients per working day.
2. The CRC will maintain a 50% encounter to referral ratio.

Medium-Term Outcomes:

1. The CRC will track and report 56% quarterly connection rates for all patients who were scheduled by the CRC.

Long-Term Outcomes:

1. Patients reached by the CRC program will demonstrate 10% reduction in ED utilization and 10% reduced inpatient admissions.
2. Patients enrolling in CRC program will demonstrate a 10% reduction in their total bad debt.

PLAN TO EVALUATE THE IMPACT:

1. IHN will track patient encounters, both in the ED and on the inpatient side, as well as clients referred as family or friends of a patient. (Short-term, Output)
2. IHN will track the number of patients encountered with or without an established primary care home. (Short-term, Output)
3. IHN will track how many encounters resulted in a scheduled appointment, what types of appointments are scheduled (Primary Care, Specialty, Behavioral Health, etc.), and where appointments are made. (Short-term)

4. IHN will track how many appointments are kept by patients, and at which facilities. (Medium-term)
5. IHN will work in partnership with Mercy Decision Support to conduct a yearly utilization analysis. IHN will provide a data set to Mercy Decision Support with 6 months of encounter data per Mercy site to measure utilization (ED and Inpatient) 6 months prior to the date of CRC encounter to 6 Months after. Financial impact of the change in utilization will also be computed in partnership with Mercy Finance Department. (Long-Term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Storage, work space and indirect expenses dedicated to supporting the work of the CRC.
2. Discretionary charitable funds to empower the CRC to address pressing social determinants of health without delay.
3. Contract / significant resource investment by the hospital.

COLLABORATIVE PARTNERS:

1. St. Louis Integrated Health Network (IHN)

PROGRAM 3: Crisis Nursery Outreach Center Partnership

PROGRAM DESCRIPTION:

The St. Louis Crisis Nursery provides short-term, safe havens for more than 7,200 children a year whose families are faced with an emergency or crisis. Through a Licensed Clinical Social Worker (LCSW), the Crisis Nursery Outreach Center at MHJ assists area families with under 12 with crisis counseling, community referrals, home visitation, and parent education groups to prevent child abuse and neglect and promote healthy families. The program also provides community families in need with donations of food bags, diapers, cleaning supplies and other needed household items.

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

1. LCSW will be integrated into the hospital by attending meetings and huddles to promote services.
2. Through the Family Empowerment Program (FEP), 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.
3. Provide trauma-informed parent education to families in need of social support and resources.
4. Offer crisis counseling through a LCSW, available at the hospital, at offices or in the community.
5. Support families in need through home visits with a LCSW.
6. Connect families with other community resources, including diapers, formula and clothing, as needed.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Increase referrals of patients, families, and community members to Crisis Nursery services, including the FEP, Parent Education Groups, and community resource assistance by 15% each year.
2. Increase referrals of Mercy coworkers to the Crisis Nursey services by 20% each year.

Medium-Term Outcomes:

1. Increase distribution of goods by 10% each year.
2. Families enrolled in the FEP will meet with LCSW at least one time per month throughout course of the year.

Long-Term Outcomes:

1. Improve scores on the Perceived Stress Scale by an average of 10% at the end of the FEP.
2. Improve scores on the Nurturing Skills Competency Scale by an average of 10% the end of the FEP.
3. Improve scores on the Family Protective Factors Survey by an average of 10% at the end of the FEP.

PLAN TO EVALUATE THE IMPACT:

1. Track number of home visits conducted by LCSW. (Output)
2. Track number of office visits conducted by LCSW. (Output)
3. Track number of field visits conducted by LCSW. (Output)
4. Track number of participating families in FEP. (Output)
5. Track number of Parent Education Group participants. (Output)

6. Record number of community members receiving community resource assistance for basic need items (food, diapers, clothing, etc.). (Short-term)
7. Record the number of referrals made to community resources. (Short-term)
8. Assess families enrolled in FEP with outcome rating scale, Perceived Stress Cale, Nurturing Skills Competency Scale, Family Protective Factors Survey and the Adult-Adolescent Parenting Inventory to assess any changes in stress level, knowledge, skills, attitudes, protective factors and general well-being. Assessments will be taken at pre-, mid- and post-intervention depending on survey tool in order to document change. (Long-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Storage and work space and indirect expenses dedicated to supporting the work of the Family Empowerment Social Worker.

COLLABORATIVE PARTNERS:

1. St. Louis Crisis Nursery
2. Birthright
3. Parents as Teachers
4. School Districts (School Social Workers and Counselors)
5. Parenting Network
6. Comtrea A Safe Place
7. Baby Ministry of DeSoto
8. St. Vincent de Paul
9. Selma American Baptist Church
10. New Hope United Methodist
11. Head Start
12. Jefferson Franklin Community Action Corporation

PROGRAM 4: Health Leads

PROGRAM DESCRIPTION:

Health Leads is a national health care organization that connects low-income patients with the resources they need to be healthy. Staff at Mercy Clinics utilize the Health Leads platform to implement a screening tool, which identifies social determinants that affect patients' medical care. If needs are identified, work is done to get patients the resources they need. Patients are then contacted weekly by phone to ensure resource connection and to address questions.

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

1. Identify at-risk patients in need of assistance in Mercy clinics through a targeted questionnaire at check-in.
2. Assist uninsured patients in applying for Mercy financial assistance, Medicaid programs and Marketplace insurance plans.
3. Assist patients without an established primary care provider in establishing care with a primary care clinic or provider.
4. Screen patients for needs related to social determinants of health and connect patients to community resources to meet identified needs.
5. Connect patients with other community resources, including medication resources, as needed.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Implement Health Leads at 20 primary care clinics in Mercy Clinic South by July 1, 2020.
2. Ensure clinics maintain a screening rate of at least 50% monthly.

Medium-Term Outcomes:

3. Ensure initial client contact within 1 week of screening.

Long-Term Outcomes:

4. Patients reached by the Health Leads program will demonstrate 10% reduction in ED utilization and 10% reduced inpatient admissions.
5. Patients enrolling in Health Leads program will demonstrate a 10% reduction in their total bad debt.
6. Patients enrolling in Health Leads program will demonstrate a 10% overall improvement towards the contribution margin.

PLAN TO EVALUATE THE IMPACT:

1. Track number of patients screened at participating clinics, and number of positive screenings. (Output)
2. Track number of patients successfully enrolled in Health Leads program. (Short-term)
3. Record number of patient needs that are successfully closed (successfully and equipped) versus the number closed unsuccessfully (disconnection/could not reach) and assess trends for establishing objectives for outcomes. (Medium-term)
4. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing Health Leads services. (Long-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Salary and benefits for two full-time Health Leads Program Managers.

2. Office space for Managers and Advocates and indirect expenses dedicated to Health Leads work.

COLLABORATIVE PARTNERS:

1. Health Leads USA
2. Jefferson College
3. Maryville University
4. STL Field Education Collaborative
5. Community resource organizations
6. Community volunteers

Prioritized Need #2: Mental Health

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

PROGRAM 1: Hospital Community Linkages: Emergency Room Enhancement (ERE)

PROGRAM DESCRIPTION: The Behavioral Health Network's (BHN) ERE project facilitates an integrated 24/7 region-wide approach that targets high utilizers of emergency rooms who present with behavioral health symptoms, with the primary goal of reducing preventable hospital readmissions. Patients identified through the ERE project are connected to community resources and inpatient and outpatient services. The program provides a peer support specialist, after-hours and weekend scheduling, as well as telephonic and mobile outreach crisis services for patients.

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

1. Community Health Leaders maintain ongoing relationship with BHN and other community partners, through participation in regional meetings and facilitation of data sharing and process improvement.
2. ED personnel facilitate referrals to ERE intervention partners.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Increase the number of referrals of high ED utilizers with mental health needs to the ERE program by 40% each year. (FY19=10)

Medium-Term Outcomes:

1. Increase the number of appointments scheduled by ERE intervention partners with community and hospital providers by 40% each year. (FY19=10)
2. Maintain at least an 80% cumulative engagement rate each year. (FY19=100%)

Long-Term Outcomes:

1. Patients reached by the ERE program will demonstrate a 10% reduction in ED utilization over 3 years.
2. Patients reached by the ERE program will demonstrate a 10% reduction in inpatient readmissions over 3 years.

PLAN TO EVALUATE THE IMPACT:

1. BHN will track number of program referrals. (Output)
2. BHN will track number of appointments scheduled. (Output)
3. BHN will track percent engagement rate. (Medium-term outcome)
4. Mercy will report on ED utilization rates and inpatient readmissions. (Long-term outcome)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Support and education for ED staff to identify and facilitate ERE referrals.
2. Staff time and indirect costs necessary to maintain ongoing partnership with BHN and community agencies.

COLLABORATIVE PARTNERS:

1. Behavioral Health Network of Greater St. Louis (BHN)
2. Behavioral Health Response (BHR)
3. Comtrea
4. Jefferson County Health Department

PROGRAM 2: Hospital Community Linkages (HCL) – Inpatient Project

PROGRAM DESCRIPTION: The HCL Inpatient project utilizes a designated liaison to identify and refer potential behavioral health consumers, facilitate referrals and ensure discharge documentation is transferred for continuity of care. The HCL program is part of an integrated 24/7 region-wide approach that targets high utilizers of inpatient settings, with the primary goal of reducing preventable hospital readmissions.

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

1. Community Health Leaders maintain an ongoing relationship with BHN and other community partners, through participation in regional meetings and facilitation of data sharing and process improvement.
2. Clinical staff facilitate referrals to HCL liaison.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Increase the number of referrals of potential behavioral health consumers to the HCL program by 20% each year. (FY19=37)

Medium-Term Outcomes:

1. Increase the number of appointments scheduled by HCL liaisons with community and hospital providers by 30% each year. (FY19=28)
2. Maintain at least an 85% kept appointment rate each year. (FY19=80%)

Long-Term Outcomes:

1. Patients reached by the HCL program will demonstrate a 10% reduction in ED utilization over 3 years.
2. Patients reached by the HCL program will demonstrate a 10% reduction in inpatient readmissions over 3 years.

PLAN TO EVALUATE THE IMPACT:

1. BHN will track number of program referrals. (Output)
2. BHN will track number of appointments scheduled. (Output)
3. BHN will track percent kept appointment rate. (Medium-term outcome)
4. Mercy will record ED utilization rates and inpatient readmissions. (Long-term outcome)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Support and education for clinical staff to identify and facilitate HCL referrals.
2. Staff time and indirect costs necessary to maintain ongoing partnership with BHN and community agencies.

COLLABORATIVE PARTNERS:

1. Behavioral Health Network of Greater St. Louis (BHN)
2. Behavioral Health Response (BHR)
3. Comtrea
4. Jefferson County Health Department

PROGRAM 3: Mental Health Services Inventory/Assessment/Pilot

PROGRAM DESCRIPTION: The hospital will collaborate with community partners to conduct a current assessment of behavioral health services offered, identify any existing gaps and pilot creative collaborative approaches to meet community behavioral health needs.

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

1. Conduct an internal inventory of existing Mercy behavioral health services (i.e. Inpatient, Outpatient, Intensive Outpatient Programs (IOP), Counseling Services, Classes, Support Groups, Regional Access Center services, Virtual Care Center (VCC) initiatives).
2. Conduct an external inventory of existing local community services offered by other health systems, non- profit and for-profit agencies.
3. Review data from any existing documents/community assessments, resource list inventories and focus group reports.
4. Identify gaps in service, explore Mercy VCC solutions and other best practice options (for example, intensive outpatient programs (IOPs)), and develop a plan to pilot a minimum of one initiative.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. By the end of FY20, the internal and external assessments will be completed.

Medium-Term Outcomes:

1. By the end of FY21, community need gaps will be identified and a plan, including funding support, will be presented for pilot initiative(s).

Long-Term Outcomes:

1. By the end of FY22, the pilot will be implemented and initial outcome data presented.

PLAN TO EVALUATE THE IMPACT:

Impact evaluation approach will be dependent on program piloted. Measurement tools will include, but are not limited to:

1. Number of internal behavioral health programs. (Short-term)
2. Numbers of patients and community members served. (Medium-term)
3. Analyses of available outcomes data, for example, utilization, readmission, and contribution margin. (Long-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Cost of coworker time.
2. Operational budgeted support as appropriate.
3. Philanthropy support as needed.

COLLABORATIVE PARTNERS (Align with Your Community – Examples here are St Louis):

1. St. Louis Behavioral Health Network (BHN)
2. National Alliance for Mental Illness

Prioritized Need #3: Substance Use

Goal: Increase prevention initiatives and substance use disorder treatment programs for uninsured and at-risk persons.

PROGRAM 1: Engaging Patients in Care Coordination (EPICC)

PROGRAM DESCRIPTION: The EPICC program, in partnership with the BHN, connects opioid overdose survivors treated in emergency rooms to recovery support and substance use treatment services, including Medication Assisted Treatment (MAT). Individuals must be over the age of 18 and meet diagnostic criteria for opioid dependence. Intensive referral and linkage services are provided by peer Recovery Coaches.

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

1. Facilitate referrals to BHN peer Recovery Coaches from the ED.
2. Increase availability of MAT by supporting buprenorphine waivers for Mercy clinicians.
3. Promote opioid overdose education and Narcan distribution in the community.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Increase the number of referrals of ED patients with opioid dependence to the EPICC program by 25% each year. (FY19=68)

Medium-Term Outcomes:

1. Increase the number of appointments scheduled by EPICC peer Recovery Coaches at hospital outreach by 30% each year. (FY19=28)
2. Maintain at least a 50% engagement rate at two-week follow-up each year. (FY19=47%)

Long-Term Outcomes:

1. Patients reached by the EPICC program will demonstrate a 10% reduction in ED utilization over 3 years.
2. Patients reached by the EPICC program will demonstrate a 10% reduction in inpatient readmissions over 3 years.
3. Reduce opioid-related deaths by 15% over 3 years. (52.7 per 100,000 population, 2017)

PLAN TO EVALUATE THE IMPACT:

1. BHN will track number of program referrals. (Output)
2. BHN will track number of appointments scheduled. (Output)
3. BHN will track percent engagement rate. (Short-term outcome)
4. Mercy will track the number of MAT waivered clinicians. (Medium-term outcome)
5. Mercy will report number of nonfatal overdoses in ED. (Long-term outcome)
6. Mercy will record ED utilization rates and inpatient readmissions. (Long-term outcome)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Support and education for ED staff to identify and facilitate EPICC referrals.
2. Staff time and indirect costs necessary to maintain ongoing partnership with BHN and community agencies, and to support MAT waivers for Mercy clinicians.

COLLABORATIVE PARTNERS:

1. Behavioral Health Network of Greater St. Louis
2. National Council on Alcoholism and Drug Abuse – St. Louis Area (NCADA)

PROGRAM 2: Substance Use Services Inventory/Assessment/Pilot

PROGRAM DESCRIPTION: The hospital will collaborate with the Ministry Controlled Substances Operational Task Force, local Mercy Behavioral Health teams and community partners to conduct a current assessment of services offered, identify any existing gaps and pilot creative collaborative approaches to meet community need.

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

1. Conduct an internal inventory of existing Mercy behavioral health services (i.e. Inpatient, Outpatient, Intensive Outpatient Programs (IOP), Counseling Services, Classes, Support Groups, Regional Access Center services, Virtual Care Center (VCC) initiatives).
2. Conduct an external inventory of existing local community services offered by other health systems, non- profit and for-profit agencies.
3. Review data from any existing documents/community assessments, resource list inventories and focus group reports.
4. Identify gaps in service, explore Mercy VCC solutions and other best practice options (Intensive Outpatient Program (IOP), Medication Assisted Treatment (MAT) and pilot a minimum of one initiative).
5. Promote and utilize the Prescription Drug Monitoring Program (PDMP). Explore integration into Epic.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. By the end of FY20, the internal and external assessments will be completed.

Medium-Term Outcomes:

1. By the end of FY21, community need gaps will be identified and a plan, including funding support, will be presented for pilot initiative(s).

Long-Term Outcomes:

1. By the end of FY22, the pilot will be implemented, and initial outcome data presented.

PLAN TO EVALUATE THE IMPACT:

Impact evaluation approach will be dependent on program piloted. Measurement tools will include, but are not limited to:

1. Number of internal substance use programs. (Short-term)
2. Program referrals and numbers of patients and community members served. (Output)
3. Appointments scheduled. (Output)
4. Engagement Rate at 2-week follow-up. (Medium-term)
5. Increase in number of Medication Assisted Treatment (MAT) providers as applicable. (Medium-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Ministry Controlled Substances Operational Task Force and Medical Marijuana Task Force.
2. Catherine's Fund support.
3. Community Health Leader research/project management support.
4. Operational budgeted support as appropriate.
5. Philanthropy support as needed.

COLLABORATIVE PARTNERS:

1. St. Louis Behavioral Health Network (BHN)

2. NCADA

III. 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 government burden to improve health. The need for these programs was identified through documentation of demonstrated community needs or a request from a public health agency or community group. Activities or programs that are carried out for the express purpose of improving community health and which involve an unrelated, collaborative tax-exempt or government organization as partners are also included. Although this is not an exhaustive list, many of these programs are listed below.

Community Benefit Category	**Program**	**Outcomes Tracked**
Community Health Improvement Services	Tobacco Cessation	Persons served
	Support Groups for Bariatrics, Diabetes, Grief Support, Suicide, Palliative Care and Stroke	Persons served
	Health Fairs, Presentations and Screenings	Persons served, cost of services
	Patient Benefit Advisors	Persons served
	Transportation Assistance Programs	Persons served, cost of services
Health Professions Education	Health professions student education – physical therapy, dietary, social work, pharmacy, nursing and other health professionals	Number of students
Financial and In-Kind Contributions	Blood Drives	Cost of services
	American Heart Association Heart Walk	Cost of services
	Sponsorship - National Alliance for Mental Illness	Cost of sponsorship
	Suicide Support Services – Hillsboro School District	Cost of services
	Meals on Wheels	Cost of services
	Blood Drives	Cost of services
Community Building Activities – Workforce	Disability Inclusion Task Force	Cost of services

& Economic Development		
	Twin City Chamber of Commerce	Cost of services
	Farmington Chamber of Commerce	Cost of services
Community Building Activities – Coalition Building & Board Membership	Jefferson County Drug Prevention Coalition	Cost of services
	Alive & Well Jefferson County	Cost of services
	Pony Bird Board of Directors	Cost of services
	Jefferson Foundation Board	Cost of services
	HEAL Healthcare Access Workgroup	Cost of services
	St. Pius X Board	Cost of services
	Enterprise Advisory Board	Cost of services
	Jefferson County Health Network	Cost of services
	Integrated Health Network Board	Cost of services

IV. Significant Health Needs Not Being Addressed

A complete description of the health needs prioritization process is available in the CHNA report. One health need identified in the 2019 CHNA process—environmental: air and water quality—was not chosen as a priority focus area. However, MHJ will continue its partnership with the Jefferson County Health Department (JCHD) and will collaborate with any environmental initiatives they develop. Mercy's Community Health Council (CHC) felt 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 should take precedence at this time.

NOTES:

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Your life is our life's work.