



Community Health Improvement Plan

Mercy Hospital South

Fiscal Year 2023 - 2025



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.

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I. Introduction

Mercy Hospital South (MHS) completed a comprehensive Community Health Needs Assessment (CHNA) in partnership with many others in our region and represents one piece of the larger effort towards a healthier St. Louis, led by the St. Louis Partnership for a Healthy Community (STLPHC). The STLPHC is comprised of a broad range of stakeholders representing the wide variety of entities that impact health – it includes both the City of St. Louis Department of Health and the St. Louis County Department of Health, area hospital systems, government, academic institutions, agencies/departments, coordinated care organizations, community-based organizations, and business partners in St. Louis City and County. The CHNA was adopted by the MHS Board of Directors in May 2022, 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 south St. Louis County. Identified priorities for MHS for the next three years include: Access to Care, Behavioral Health & Substance Use, and Diabetes. The complete CHNA report is available electronically at mercy.net/about/community-benefits.

MHS is a part of 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. This acute-care hospital has 767 licensed beds and is the only designated Level II Trauma Center in South St. Louis County. Specialty hospital services include acute rehabilitation, cardiology, maternity services, oncology care, orthopedics, neurology/stroke, surgery, and emergency medicine.

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 2022 CHNA and this resulting CHIP will provide the framework for MHS 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: Mercy's Community Health Worker (CHW) Program, implemented through Community Health and Access, seeks to address the social needs of uninsured and underserved patients in Mercy's communities. Community Health Workers (CHWs) serve as liaisons between health care and community and social services, screening for needs related to social determinants of health, 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 and medication assistance.

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

- Identify uninsured and at-risk patients and community members in need of assistance in the emergency department (ED), community events, and using reports and dashboards.
- Assist uninsured patients with applying for Mercy financial assistance and Medicaid programs or other relevant programs.
- 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.
- Screen patients for needs related to social determinants of health and connect patients to community resources to meet identified needs.
- Connect patients with other community resources, including medication resources, as needed.

HP2030 ALIGNMENT

- Objective AHS-01: [Increase the proportion of people with health insurance](#)
- Objective AHS-R03: [Reduce the proportion of people under 65 years who are underinsured](#)
- Objective AHS-04: [Reduce the proportion of people who can't get medical care when they need it](#)
- Objective AHS-06: [Reduce the proportion of people who can't get prescription medicines when they need them](#)
- Objective AHS-07: [Increase the proportion of people with a usual primary care provider](#)
- Objective AHS-09: [Reduce the proportion of emergency department visits with a longer wait time than recommended](#)

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

- The CHW will conduct outreach or connect with 20 patients in 30 encounters per week.

Medium-Term Outcomes:

- By the end of each fiscal year for the next three years, the CHW will enroll 100 patients in Mercy financial assistance and help facilitate 100 Medicaid applications.

- Each CHW will assist at least 100 patients per year with community and medication assistance resources.

Long-Term Outcomes:

- Each year, patients enrolled in CHW program will demonstrate a 20% reduction ED utilization.
- Each year, patients enrolled in CHW program will demonstrate a 20% reduction in their total cost of care.

PLAN TO EVALUATE THE IMPACT:

- Track number of new and ongoing encounters conducted by each CHW.
- Track number of patients successfully enrolled in Mercy financial assistance and Medicaid.
- Track number of patients receiving community resource and medication assistance.
- Analyze ED utilization clinic no-show rates for patients enrolled in CHW program.
- Analyze total cost of care for patients enrolled in CHW program.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Compensation and benefits for full-time CHW.
- Mileage and travel expenses required for CHW work.
- Office space and indirect expenses dedicated to CHW work.

COLLABORATIVE PARTNERS:

- St. Louis Crisis Nursery
- Integrated Health Network (IHN)Community Referral Coordinator (CRC) Program
- HEAL Partnership

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 MHS, 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:

- 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.
- CRC provides support for patients already established with health clinic/FQHC (predominately Hancock Clinic in 63125 or South County Health Center) to ensure coordinated outpatient care is received after discharge from the ED or Inpatient Unit.
- 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.

HP2030 ALIGNMENT

- Objective AHS-07: [Increase the proportion of people with a usual primary care provider](#)

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

- The CRC will engage 8- 10 new patients per working day.
- The CRC will maintain a 50% encounter to referral ratio.

Medium-Term Outcomes:

- The CRC will track and report 60% quarterly connection rates for all patients who were scheduled by the CRC.

Long-Term Outcomes:

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

PLAN TO EVALUATE THE IMPACT:

- 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.
- IHN will track the number of patients encountered with or without an established primary care home.

- 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.
- IHN will track how many appointments are kept by patients, and at which facilities.
- 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.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

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

COLLABORATIVE PARTNERS:

- St. Louis Integrated Health Network (IHN)
- Mercy Primary Care and Specialty Physicians
- Hancock Clinic, South County Health Center and other FQHC partners

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 family engagement specialist, the Crisis Nursery Outreach Center at MHS 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:

- LCSW will be integrated into the hospital by attending meetings and huddles to promote services.
- 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.
- Provide trauma-informed parent education to families in need of social support and resources.
- Offer crisis counseling through a Family Engagement Specialist, available at the hospital, at offices or in the community.
- Support families in need through home visits with a Family Engagement Specialist.
- Connect families with other community resources, including diapers, formula and clothing, as needed.

HP2030 ALIGNMENT

- Objective ECBP-D07: [Increase the number of community organizations that provide prevention services](#)

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

- Maintain consistent level of referrals of patients, families, and community members to Crisis Nursery services, including the FEP, Parent Education Groups, and community resource assistance.
- Continue referrals of Mercy coworkers to the Crisis Nursey services at the current level.

Medium-Term Outcomes:

- The Crisis Nursery will continue to provide concrete support to families through distribution of critically needed supplies at the current level.
- Families enrolled in the FEP will meet with a Family Engagement Specialist at least one time per month throughout course of the year.

Long-Term Outcomes:

- 90% of FEP participants will reduce their stress levels, as indicated by a decrease in stress score from pre to post intervention on the In-Session Stress Scale.
- 90% of FEP participants will increase their Family Protective Factors by completion of FEP participation, as indicated by new skills in at least 3 of the 5 protective factor domains.
- 85% of FEP participants will increase positive coping skills by graduation, as indicated by an increase in positive coping score on the Brief COPE Assessment from pre to post.

PLAN TO EVALUATE THE IMPACT:

- Track number of home visits conducted by Family Engagement Specialist.
- Track number of office visits conducted by Family Engagement Specialist.
- Track number of field visits conducted by Family Engagement Specialist.
- Track number of participating families in FEP.
- Track number of Parent Education events held.
- Record number of community members receiving community resource assistance for basic need items (food, diapers, clothing, etc.).
- Record the number of referrals made to community resources.
- Assess families enrolled in FEP with outcome rating scale, Perceived Stress Scale, 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.

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

PROGRAM: Hancock Clinic Partnership

PROGRAM DESCRIPTION:

The Hancock School Based Community Clinic serves students and staff of the Hancock School District as well as any verified residents of the 63123 and 63125 ZIP code at no out-of-pocket expense to patients (the majority of which are uninsured). The Hancock Clinic serves all residents of the Lemay/63125 area which is an economically depressed area. Hancock Clinic also serves residents from 63123 on a referral basis from Mercy Hospital South. 100% of the students in the school district qualify for free/reduced lunches. The clinic serves all ages in the community with over half of the patients being adult/19+. 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 PROGRAM INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. Identify uninsured or at-risk community members in need of primary care
2. Provide needed basic health care services to families, students and staff in the 63125 community without charge
3. Establish Mercy Hospital South dedicated appointments to funnel patients from 63123 and 63125 seen by MHS CRC in ED to establish primary care home
4. Connect patients with other community resources that help with health and social needs

HP2030 ALIGNMENT

Objective AHS-07: [Increase the proportion of people with a usual primary care provider — AHS-07 - Healthy People 2030 | health.gov](#)

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Maintain consistent level of referrals to Hancock Clinic
2. Increase spectrum of services provided to address the whole patient
3. Ensure better continuity of care between Hancock Clinic and the Mercy system to ensure access to specialty services for higher-needs patients

Medium-Term Outcomes:

4. Increase patients that repeat for an annual visit and follow-up after initial visit

Long-Term Outcomes:

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

PLAN TO EVALUATE THE IMPACT:

- Hancock Clinic will track all patient encounters, broken out by patient zip code
- Hancock Clinic will track how many appointments are kept by patients that are referred from Mercy
- Hancock Clinic will track the number of patients encountered that come from Mercy
- Hancock Clinic will track how many encounters resulted in a scheduled specialist appointment with Mercy, what types of appointments are scheduled (Specialty, Behavioral Health, etc.)
- Hancock Clinic will track spectrum of services provided to all patients

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Funding to support Hancock Clinic Initiatives
2. CRC support to funnel patients from 63125 and 63123 in need of a primary care home

COLLABORATIVE PARTNERS:

iFM Community Medicine
Hancock School District

PROGRAM 4: Health Leads
<p>PROGRAM DESCRIPTION:</p> <p>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.</p>
<p>ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ul style="list-style-type: none"> • Identify at-risk patients in need of assistance in Mercy clinics through a targeted questionnaire at check-in. • Assist uninsured patients in applying for Mercy financial assistance, Medicaid programs and Marketplace insurance plans. • Screen patients for needs related to social determinants of health and connect patients to community resources to meet identified needs. • Connect patients with other community resources, including medication resources, as needed.
<p>HP2030 ALIGNMENT</p> <ul style="list-style-type: none"> • Objective AHS-04: Reduce the proportion of people who can't get medical care when they need it • Objective AHS-07: Increase the proportion of people with a usual primary care provider
<p>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</p> <p>Short-Term Outcomes:</p> <ul style="list-style-type: none"> • Continue to implement Health Leads in all Jefferson and South clinics. • Ensure clinics maintain a screening rate of at least 50% monthly. <p>Medium-Term Outcomes:</p> <ul style="list-style-type: none"> • Ensure initial client contact within 1 week of screening. <p>Long-Term Outcomes:</p> <ul style="list-style-type: none"> • Patients reached by the Health Leads program will demonstrate 10% reduction in ED utilization and 10% reduced inpatient admissions. • Patients enrolling in Health Leads program will demonstrate a 10% reduction in their total bad debt. • Patients enrolling in Health Leads program will demonstrate a 10% overall improvement towards the contribution margin.
<p>PLAN TO EVALUATE THE IMPACT:</p> <ul style="list-style-type: none"> • Track number of patients screened at participating clinics, and number of positive screenings. • Track number of patients successfully enrolled in Health Leads program. • 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. • Analyze ED utilization and inpatient admissions data for cohort of patients utilizing Health Leads services.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Salary and benefits for two full-time Health Leads Program Managers.
- Office space for Managers and Advocates and indirect expenses dedicated to Health Leads work.

COLLABORATIVE PARTNERS:

- Community resource organizations
- Community volunteers

<p>PROGRAM 1: Dispensary of Hope</p>
<p>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 most dire financial need to essential medicines across a range of drug classes, including insulins, anti-infectives, and psychotropics.</p>
<p>ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ul style="list-style-type: none"> • 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 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 the formulary for patients in need. • Mercy will work to connect qualifying patients with Mercy Financial Assistance and Medicaid and Medicare as applicable. • Mercy will standardize Dispensary of Hope processes, including Dispensary of Hope renewal processes, across communities to ensure seamless co-worker and patient experience and to improve patient outcomes.
<p>HP2030 ALIGNMENT</p> <ul style="list-style-type: none"> • Objective AHS-06: Reduce the proportion of people who can't get prescription medicines when they need them
<p>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</p> <p>Short-Term Outcomes:</p> <ul style="list-style-type: none"> • Maintain the number 30-day prescriptions filled /month • Maintain the number of patients served / month • Maintain the number of patient encounters / month <p>Medium-Term Outcomes:</p> <ul style="list-style-type: none"> • Maintain the dollars saved for patients monthly <p>Long-Term Outcomes:</p> <ul style="list-style-type: none"> • Each year, will see a 10% reduction in ED visits • Each year, will see a 10% reduction in total cost of care
<p>PLAN TO EVALUATE THE IMPACT:</p> <ul style="list-style-type: none"> • Mercy Pharmacy will provide monthly reports on the number of patients served, number of prescriptions filled, and estimated cost savings to patient. • Mercy will coordinate with Mercy Decision Support to conduct a yearly utilization analysis to understand the impact of the Dispensary of Hope program on patient readmissions and ED utilization, as well as on financial impact on total cost of care

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Annual contract fees to Dispensary of Hope for formulary access (\$12,500 per year per pharmacy)
- Pharmacist support for formulary management (responsibilities include:)
- Marketing and communications support, in the form of flyers, rack cards, enrollment cards, etc.
- Training for co-workers to understand enrollment process for Dispensary of Hope

COLLABORATIVE PARTNERS:

- Dispensary of Hope
- Internal: Mercy Pharmacy, Community Health & Access, Care Management, Hospitalists, Mercy Clinic East
- External providers: Hancock Clinic, FQHC Partners

Prioritized Need #2: Behavioral Health & Substance Use

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

<p>PROGRAM 1: Hospital Community Linkages: Emergency Room Enhancement (ERE)</p>
<p>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.</p>
<p>ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ul style="list-style-type: none"> • 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. • ED personnel facilitate referrals to ERE intervention partners.
<p>HP2030 ALIGNMENT</p> <ul style="list-style-type: none"> • Objective MHMD-04: Increase the proportion of adults with serious mental illness who get treatment • Objective MHMD-03: Increase the proportion of children with mental health problems who get treatment
<p>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</p> <p>Short-Term Outcomes:</p> <ul style="list-style-type: none"> • Increase the number of referrals of high ED utilizers with mental health needs to the ERE program by 40% each year. <p>Medium-Term Outcomes:</p> <ul style="list-style-type: none"> • Increase the number of appointments scheduled by ERE intervention partners with community and hospital providers by 40% each year. • Maintain at least an 80% cumulative engagement rate each year. <p>Long-Term Outcomes:</p> <ul style="list-style-type: none"> • Patients reached by the ERE program will demonstrate a 10% reduction in ED utilization over 3 years. • Patients reached by the ERE program will demonstrate a 10% reduction in inpatient readmissions over 3 years.
<p>PLAN TO EVALUATE THE IMPACT:</p> <ul style="list-style-type: none"> • BHN will track number of program referrals. • BHN will track number of appointments scheduled. • BHN will track percent engagement rate. • Mercy will report on ED utilization rates and inpatient readmissions.
<p>PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:</p> <ul style="list-style-type: none"> • Support and education for ED staff to identify and facilitate ERE referrals.

- Staff time and indirect costs necessary to maintain ongoing partnership with BHN and community agencies.

COLLABORATIVE PARTNERS:

- Behavioral Health Network of Greater St. Louis (BHN)
- Behavioral Health Response (BHR)

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: <ul style="list-style-type: none"> • 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. • Clinical staff facilitate referrals to HCL liaison.
HP2030 ALIGNMENT <ul style="list-style-type: none"> • Objective MHMD-03: Increase the proportion of children with mental health problems who get treatment • Objective MHMD-04: Increase the proportion of adults with serious mental illness who get treatment
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): Short-Term Outcomes: <ul style="list-style-type: none"> • Increase the number of referrals of potential behavioral health consumers to the HCL program by 20% each year. Medium-Term Outcomes: <ul style="list-style-type: none"> • Increase the number of appointments scheduled by HCL liaisons with community and hospital providers by 30% each year. • Maintain at least an 85% kept appointment rate each year. Long-Term Outcomes: <ul style="list-style-type: none"> • Patients reached by the HCL program will demonstrate a 10% reduction in ED utilization over 3 years. • Patients reached by the HCL program will demonstrate a 10% reduction in inpatient readmissions over 3 years.
PLAN TO EVALUATE THE IMPACT: <ul style="list-style-type: none"> • BHN will track number of program referrals. • BHN will track number of appointments scheduled. • BHN will track percent kept appointment rate. • Mercy will record ED utilization rates and inpatient readmissions.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: <ul style="list-style-type: none"> • Support and education for clinical staff to identify and facilitate HCL referrals. • Staff time and indirect costs necessary to maintain ongoing partnership with BHN and community agencies.
COLLABORATIVE PARTNERS: <ul style="list-style-type: none"> • Behavioral Health Network of Greater St. Louis (BHN) • Behavioral Health Response (BHR)

PROGRAM: vBH - Virtual Behavioral Health
PROGRAM DESCRIPTION: Mercy’s Virtual Behavioral Health (vBH) program provides integrated, regional support for patients with behavioral health needs 24 hours a day, 7 days week, 365 days a year. Based out of both local and off-site 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, 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 THE HEALTH SYSTEM INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: <ul style="list-style-type: none"> • Consistent with the Behavioral Health Service Line model of care, Mercy South will implement vBH in the ED and hospital. • Community health leaders will maintain ongoing relationship with vBH team. • Patients will be identified at any level of care within Mercy and will be referred to vBH through EPIC.
HP 2030 ALIGNMENT <ul style="list-style-type: none"> • Objective MHMD-03: Increase the proportion of children with mental health problems who get treatment • Objective MHMD-04: Increase the proportion of adults with serious mental illness who get treatment • Objective MHMD-07: Increase the proportion of people with substance use and mental health disorders who get treatment for both
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): Short-Term Outcomes: <ul style="list-style-type: none"> • By the end of FY23, the initiative will go live in Mercy South ED and hospital Medium-Term Outcomes: <ul style="list-style-type: none"> • By the end of FY23, the number of assessments and consultations completed for Mercy South patients will maintain over each fiscal year through 2025 • Patients referred IOP program will increase by 10% each fiscal year • Patients referred to long-acting injection clinic will increase by 10% each fiscal year Long-Term Outcomes: <ul style="list-style-type: none"> • Developmental: Over three year period (FY23-FY25), patients who participated in vBH program will demonstrate a 10% decrease in hospital readmissions and ED visits.
PLAN TO EVALUATE THE IMPACT: <ul style="list-style-type: none"> • vBH will track assessments and consultations conducted • vBH will track number of patients who are referred to BH resources and connected to appropriate treatment • Mercy will evaluate cost-impact of expanded behavioral health services, including on hospital readmissions.
PROGRAMS AND RESOURCES THE HEALTH SYSTEM PLANS TO COMMIT: <ul style="list-style-type: none"> • Cost of coworker and physician time. • 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)

PROGRAM: Concert Health Collaborative Care for Primary Care Physicians
PROGRAM DESCRIPTION: Mercy Hospital South will collaborate with Concert Health to support 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 THE HEALTH SYSTEM INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: <ul style="list-style-type: none"> • Consistent with the Behavioral Health Service Line model of care, Mercy will implement the Concert Health Collaboration in primary care clinics. • Mercy will train primary care providers in use of the care approach. • Mercy will promote the initiative at participating clinics and provide necessary support to Concert Health for successful implementation. • Mercy will identify gaps in care and support expansion of services as necessary.
HP2030 ALIGNMENT <ul style="list-style-type: none"> • Objective AHS-R01: Increase the ability of primary care and behavioral health professionals to provide more high-quality care to patients who need it • Objective MHMD03: Increase the proportion of children with mental health problems who get treatment • Objective MHMD-04: Increase the proportion of adults with serious mental illness who get treatment
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): Short-Term Outcome: <ul style="list-style-type: none"> • By the end of FY23, the initiative will go live in Mercy South primary care clinics. Medium-Term Outcome: <ul style="list-style-type: none"> • By the end of FY25, 400 referrals will have been made to Concert Health throughout the Mercy Clinic East region including clinics in the MHS service area • By the end of FY25 200 patients will have engaged in collaborative care throughout the Mercy Clinic East region including clinics in the MHS service area • Increase access to community resources through referrals to Community Health Workers.
PLAN TO EVALUATE THE IMPACT: <ul style="list-style-type: none"> • Track number of primary care physicians participating in program. • Track number of referrals to Concert Health per month. • Track percentage of patients referred to Concert Health who enroll in program (conversion rate). • Track number of referrals of uninsured and Medicaid patients per month. • Track referrals to Community Health Workers for needs related to social determinants of health by Concert Health.
PROGRAMS AND RESOURCES THE HEALTH SYSTEM PLANS TO COMMIT: <ul style="list-style-type: none"> • Cost of coworker and physician time.

- 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)
- Concert Health

<p>PROGRAM 1: Engaging Patients in Care Coordination (EPICC)</p>
<p>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.</p>
<p>ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ul style="list-style-type: none"> • 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. • ED personnel facilitate referrals to BHN peer Recovery Coaches from the ED.
<p>HP2030 ALIGNMENT</p> <ul style="list-style-type: none"> • Objective SU-01: Increase the proportion of people with a substance use disorder who got treatment in the past year • Objective SU-DO2: Increase the proportion of people who get a referral for substance use treatment after an emergency department visit • Objective SU-DO3: Increase the rate of people with an opioid use disorder getting medications for addiction treatment • Objective MHMD-07: Increase the proportion of people with substance use and mental health disorders who get treatment for both
<p>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</p> <p>Short-Term Outcomes:</p> <ul style="list-style-type: none"> • Increase the number of referrals of ED patients with opioid dependence to the EPICC program by 25% each year. <p>Medium-Term Outcomes:</p> <ul style="list-style-type: none"> • Increase the number of appointments scheduled by EPICC peer Recovery Coaches at hospital outreach by 30% each year. • Maintain at least a 50% engagement rate at two-week follow-up each year. <p>Long-Term Outcomes:</p> <ul style="list-style-type: none"> • Patients reached by the EPICC program will demonstrate a 10% reduction in ED utilization over 3 years. • Patients reached by the EPICC program will demonstrate a 10% reduction in inpatient readmissions over 3 years. • Reduce opioid-related deaths by 15% over 3 years.
<p>PLAN TO EVALUATE THE IMPACT:</p> <ul style="list-style-type: none"> • BHN will track number of program referrals. • BHN will track number of appointments scheduled. • BHN will track percent engagement rate. • Mercy will track the number of MAT waived clinicians. • Mercy will report number of nonfatal overdoses in ED. • Mercy will record ED utilization rates and inpatient readmissions.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Support and education for ED staff to identify and facilitate EPICC referrals.
- 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:

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

<p>PROGRAM 1: SURP- Substance Use Recovery Program</p>
<p>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.</p>
<p>ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ul style="list-style-type: none"> • Consistent with Mercy’s care model, clinicians (primarily in the Emergency Department) will refer patients identified with Opioid Use Disorder to SURP program. • 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 ongoing relationship with vBH team and will facilitate reporting of outcomes to relevant hospital stakeholders.
<p>HP2030 ALIGNMENT</p> <ul style="list-style-type: none"> • Objective SU-01: Increase the proportion of people with a substance use disorder who got treatment in the past year • Objective SU-DO2: Increase the proportion of people who get a referral for substance use treatment after an emergency department visit • Objective SU-DO3: Increase the rate of people with an opioid use disorder getting medications for addiction treatment • Objective AHS-R01: Increase the ability of primary care and behavioral health professionals to provide more high-quality care to patients who need it • Objective MHMD-07: Increase the proportion of people with substance use and mental health disorders who get treatment for both
<p>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</p> <p>Short-Term Outcomes:</p> <ul style="list-style-type: none"> • To increase the number of referrals of ED patients to SURP program by 25% 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 <p>Medium-Term Outcomes:</p> <ul style="list-style-type: none"> • Maintain engagement of 10% of patients that engage through a six-month period <p>Long-Term Outcomes:</p> <ul style="list-style-type: none"> • 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.

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 waived clinicians.
- Mercy track ED utilization rates and readmissions.

PROGRAMS AND RESOURCES THE HOSPITAL 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:

- SURP
- Behavioral Health Network of Greater St. Louis (BHN)
- Behavioral Health Response (BHR)

Prioritized Need #3: Diabetes

PROGRAM 1: Comprehensive Diabetes Collaborative Program
PROGRAM DESCRIPTION: Reduce the disease burden of diabetes and improve the quality of life of persons living with diabetes. Currently in the process of determining program needs, availability of resources and plan for impact.
ACTIONS MERCY INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: <ul style="list-style-type: none"> • Increase the proportion of persons with diabetes who receive diabetes education • Increase the proportion of persons accessing diabetes care from diabetes advanced practice providers
HP2030 ALIGNMENT <ul style="list-style-type: none"> • Objective D-06: https://health.gov/healthypeople/objectives-and-data/browse-objectives/diabetes/increase-proportion-people-diabetes-who-get-formal-diabetes-education-d-06
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): Short-Term Outcomes: <ul style="list-style-type: none"> • Determine what data to collect and the process to collect it • Develop referral pathway to diabetes care services Medium-Term Outcomes: <ul style="list-style-type: none"> • Hire CDCES (Certified Diabetes Care and Education Specialist) to serve the South County service area Long-Term Outcomes: <ul style="list-style-type: none"> • Increase diabetes education by x% (still determining baseline) • Increase access diabetes care services and diabetes advanced practice providers by x% (still determining baseline)
PLAN TO EVALUATE THE IMPACT: <ul style="list-style-type: none"> • Track number of patients accessing diabetes care from diabetes advanced practice providers
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: <ul style="list-style-type: none"> • Data to track initiatives • CDCES position
COLLABORATIVE PARTNERS: <ul style="list-style-type: none"> • St. Louis Hospital Diabetes Collaborative

III. Other Community Health Programs

Mercy Hospital 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 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	Hospice Outreach & Education	Persons served
	Support Groups for Acute Rehab, Diabetes, Grief Support, Palliative Care and Stroke	Persons served
	Health Fairs, Presentations and Screenings	Persons served
	Transportation Assistance Programs	Persons served, cost of services
	Trauma Services Outreach	Persons served
Health Professions Education	Nurses and Nursing Students	Number of students
	Other Health Professionals	Number of students
	Community Based Vocational Instruction (CBVI)	Number of students
Financial and In-Kind Contributions	Other: Includes multiple cash, in-kind donations, fundraising costs, sponsorships, food and donated supplies to shelters and organizations, etc	Cost of services
Community Building Activities – Workforce Development	Disability Inclusion Task Force	Cost of services
	MHS STL Caps Program	Number of students
Economic Development	Fenton Chamber of Commerce, Kirkwood/Des Peres Chamber of Commerce, Lemay/Affton Chamber of Commerce, South County Chamber of Commerce, etc.	Cost of services
Community Building Activities – Coalition	Multiple Community agency partners include St. Louis Regional Health Commissions, STLPHC (St.	Cost of Services

Building & Board Membership	Louis Partnership for a Healthy Community, HEAL Healthcare Access Workgroup, Behavioral Health Network (BHN), Integrated Health Network (IHN), etc.	
Subsidized Health Services	Emergency and Trauma Services	Cost of Services
	Behavioral Health Services	Cost of Services

IV. Significant Health Needs Not Being Addressed

In any case of prioritization, there will be some areas of need 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 needs arose as a community concern. However, they will not be addressed at this time due to the need already being addressed at this time by another community organization or due to a limitation of resources:

- COVID-19
- Transportation

While these needs listed will not be specifically addressed in our priorities, they will most likely be impacted indirectly through the work in our other community health priorities. Mercy Hospital South will support, as able, the efforts of partner agencies and organizations currently working to address these needs within the community.

Mercy

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