Community Health Improvement Plan

Mercy Hospital St. Louis

Fiscal Year 2023 - 2025

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.

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I. Introduction

Mercy Hospital St. Louis (MHSL) is an 859-bed, private room hospital located in St. Louis, Missouri. It is one of five hospitals in Mercy's East Community and the only Level 1 (highest level) trauma center in St. Louis County. MHSL's campus includes Mercy JFK Clinic, which focuses on serving the health needs of individuals who are uninsured or underinsured; Mercy Heart and Vascular Hospital; the David C. Pratt Cancer Center; and Mercy Children's Hospital, the only full-service pediatric hospital in St. Louis County and one of only two hospitals in the state of Missouri to have a Level III (highest level) neonatal intensive care unit.

MHSL's primary service area is St. Louis County. Throughout the county, Mercy operates Mercy Clinic physician offices, outpatient hospital services and Mercy-GoHealth Urgent Care centers. In 2015, Mercy also opened the world's first virtual care center, located in St. Louis County. It addresses critical community health needs, such as transportation barriers to accessing care, which most often impact lower-income and non-ambulatory patients, and provider shortages in the surrounding rural communities comprising MHSL's extended service area.

Mercy's mission is to deliver "compassionate care and exceptional service" to every community member, especially the most vulnerable among us. To do so, we must understand the needs of the community and establish strategic programs to address those needs. This was the work of the FY2022 Community Health Needs Assessment (CHNA). Conducted every three years, the CHNA seeks to align with and to bolster regional assessments conducted across both St. Louis city and county, and to engage traditional and non-traditional partners in both medical and community-based agencies and organizations in understanding community issues.

The CHNA identified seven top-priorities of which four have been chosen as health needs for the Mercy Hospital St. Louis community. We will strive diligently to address these needs over the next three years through a **health equity** framework:

- Access to Care
- Behavioral Health
- Maternal and Child Health
- Trauma-Informed Care

As always, we seek to develop a rich and rewarding network of partnerships with our neighbors. We welcome any thoughts you may have on ways to achieve our goal for a healthier community.

II. Implementation Plan by Prioritized Health Need

Health Equity

Mercy Hospital St. Louis is committed to addressing disparities in health outcomes across all programs, to promote health and racial equity in our region. This is aligned with Mercy's vision and values; because all people are created in the image and likeness of God, each person deserves to be treated with respect. Through our influence, we seek to relieve misery and address its causes and support persons who struggle for full dignity, with particular concern for people who are economically poor and who face systemic barriers to health.

Prioritized Need #1: Access to Care

Goal: Increase access to comprehensive, high-quality health care services.

ATC 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 Mercy clinics, emergency department, inpatient settings, community events, and through the use of reports and dashboards.
- Assist uninsured patients apply for Mercy financial assistance, Medicaid programs, and Marketplace insurance plans.
- 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):

- By the end of each month, each CHW will have recorded 20 new and 20 ongoing encounters.
- By the end of each fiscal year for the next three years, each CHW will enroll 80 patients in Mercy financial assistance 10 in Medicaid
- Each CHW will assist at least 100 patients per year with community and medication assistance resources.
- 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.

- Each year, clinic patients enrolled in in CHW program will demonstrate a 10% reduction in no-show rate for follow-up clinic appointments.

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 Community Health Workers.
- Mileage and travel expenses required for CHW work.
- Office space and indirect expenses dedicated to CHW work.

COLLABORATIVE PARTNERS:

- Integrated Health Network – Community Referral Coordinator
- St. Patrick's Center – Hospital to Healthy Housing Coordinator
- Dispensary of Hope
- Mercy Hospital St. Louis Patient Access, Care Management, Pharmacy and Emergency Department
- Unite Us

ATC PROGRAM 2: Community Referral Coordinator 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:

- 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 a FQHC 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 a Care Manager, Social Worker, or CHW 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 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 56% 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

ATC PROGRAM 3: Dispensary of Hope

PROGRAM DESCRIPTION:

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

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

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

HP2030 ALIGNMENT

- Objective AHS-06: Reduce the proportion of people who can't get prescription medicines when they need them

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

- Increase the number of 30-day prescriptions filled by 10% monthly
- Increase the number of patients served by 10% monthly
- Increase the number of patient encounters by 10% monthly

Medium-Term Outcomes:

- Increase the dollars saved for patients by 5% monthly

Long-Term Outcomes:

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

PLAN TO EVALUATE THE IMPACT:

- 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, Diabetes Education, Behavioral Health
- Integrated Health Network and regional FQHCs

Prioritized Need #2: Behavioral Health

Goal 1: Increase accessibility of behavioral health services and supports for individuals with complex care needs.

BH 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: • 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.
HP2030 ALIGNMENT • 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
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** • Increase the number of referrals of high ED utilizers with mental health needs to the ERE program by 40% each year. ***Medium-Term Outcomes:*** • 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. ***Long-Term Outcomes:*** • 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.
PLAN TO EVALUATE THE IMPACT: • 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.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: • 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)

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

PROGRAM DESCRIPTION:

The BHN's Hospital Community Linkages (HCL) Inpatient project utilizes a designated liaison to identify and refer potential behavioral health patients, 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:

- 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

- 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:

- Increase the number of referrals of potential behavioral health consumers to the HCL program by 20% each year.

Medium-Term Outcomes:

- 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:

- 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:

- 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:

- 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:

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

BH PROGRAM 3: vBH - Virtual Behavioral Health

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 THE HEALTH SYSTEM 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.
- Maintain internal coordination between relevant stakeholders, including Population Health, Behavioral Health, and Community Health, for ongoing assessment of community needs, assets, and barriers, and increased data and service integration for improved continuity of care and patient outcomes.
- Analyze true cost of care and return on investment analysis (ROI) for vBH patients and explore prospective for further developing complex care model.

HP 2030 ALIGNMENT

- 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:

- *Developmental*: Each year, the vBH program will increase the number of patient assessments completed by 20% Ministry-Wide.

Medium-Term Outcomes:

- *Developmental*: East – Each year, the vBH program will increase the number of referrals made to IOP and Long-Acting Injection (LAI) Clinics by 10%.
- *Developmental*: Across the Ministry, the vBH program will maintain a 70% connection to treatment rate.

Long-Term Outcomes:

- *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:

- 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: • 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)

BH PROGRAM 4: Clinical BEACN

PROGRAM DESCRIPTION:

The purpose of Clinical BEACN is to create a system of care to improve the health and wellbeing of a small group of individuals, especially those who are homeless or housing unstable, who experience combinations of medical, behavioral health, and social challenges that result in extreme patterns of healthcare cost and utilization, and that often do not yield lasting benefit, despite the frequency of interactions. Through a complex care model that supports coordinated, comprehensive, person-centered, and equitable treatment of patients, Clinical BEACN provides wraparound case management and support to "super-utilizers" in order to facilitate greater stability, health, and quality of life.

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

- Provide staff support to cross-agency, multi-disciplinary team, and sub-workgroups to establish work needed, receive recommendations to advance the initiative, address holistic needs of super-utilizers, including physical, BH and social determinants of health, and leverage resources and personnel expertise as needed
- Develop a process for electronic information sharing among partners, including alerting systems, enhanced communications and navigation of information sharing protocols, and provide input on outcomes to be tracked to demonstrate project impact
- Establish discharge criteria for Clinical BEACN Patients, as well as criteria for monthly attestation based on per member per month within the first three months of Clinical BEACN Implementation
- Develop protocolized care plans within Epic hospital patient data system so super-utilizers receive appropriate, standard care as well as performance metrics for community mental health centers and other community BH providers to ensure accountability

HP2030 ALIGNMENT

- 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
- Objective MHMD-R01: Increase the proportion of homeless adults with mental health problems who get mental health services

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes (Outputs/Process):

- Clinical BEACN will serve at least 35 Mercy hospital patients in the City of St. Louis and St. Louis County through successful outreach, enrollment, and referral.

Medium-Term Outcomes:

- *Developmental:* Each year, 70% of patients enrolled in Clinical BEACN who were unhoused at the time of enrollment will be placed in permanent housing through connection to the Coordinated Entry process established for the St. Louis City and St. Louis County Continuums of Care (CoCs).
- *Developmental:* Each year, 90% of patients targeted by Clinical BEACN who were uninsured at the time of enrollment will be enrolled in insurance coverage.
- *Developmental:* Each year, 70% of patients targeted by Clinical BEACN who lacked a primary care home at time of enrollment will be connected to a Primary Care Provider.
- *Developmental:* Each year, 60% of patients targeted by Clinical BEACN who were unemployed at time of enrollment will be connected to workforce training and/or meaningful employment.

Long-Term Outcomes:

- *Developmental:* Each year, patients targeted by Clinical BEACN will demonstrate a 40% reduction in inpatient hospitalizations
- *Developmental:* Each year, patients targeted by Clinical BEACN will demonstrate a 40% reduction in ED visits

PLAN TO EVALUATE THE IMPACT:

- Track number of patients who qualify and are referred to the Clinical BEACN program, along with the number of patients who are successfully outreached and enrolled.
- Track healthcare utilization of patients enrolled in Clinical BEACN cohorts
- Document and report on individual patient outcomes of those in the cohort, including housing and work status and engagement in behavioral health care.
- Analyze true cost of care for super-utilizers and return on investment analysis (ROI) for Clinical BEACN patients and prospective for a complex care model

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Staffing support (hours/FTE)
- Financial investment (340B)

COLLABORATIVE PARTNERS:

- Behavioral Health Network (BHN)
- Places for People (PfP)
- Gateway Housing First
- Missouri Hospital Association (MHA)

Goal 2: Increase access to behavioral health services for primary care patients.

BH PROGRAM 5: Concert Health Collaborative Care for Primary Care Physicians
PROGRAM DESCRIPTION: Mercy 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: • 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 • 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:*** • By the end of FY24, the initiative will go live in service of 548 total Mercy primary care providers in Adult and Women's Health, on-boarding 464 providers in addition to the current 84. ***Medium-Term Outcome:*** • By the end of FY24, 736 total referrals per month will be made to Concert Health across Adult, Women's Health and Pediatric providers, and 444 patients per month will be engaged in collaborative care. • Increase access to community resources through referrals to Community Health Workers.
PLAN TO EVALUATE THE IMPACT: • 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: • 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

Goal 3: Increase access to substance use treatment, services, and support for at-risk persons.

BH PROGRAM 6: SURP- Substance Use Recovery Program

PROGRAM DESCRIPTION:

Mercy Substance Use Recovery Program (SURP) is an integrated, mission-driven, patient-centric approach to Opioid Use Disorder. SURP will ensure that any patient seeking care through Mercy will be connected to ongoing care for Opioid Use Disorder regardless of geography, clinical setting, or ability to pay. Through a virtual-first care experience, SURP provides Medication-Assisted Therapy (MAT), primarily through buprenorphine, for patients with Opioid Use Disorder. Patients who participate in SURP are also connected to support services, including counseling, behavioral therapies, and general primary care, to implement a holistic harm-reduction care model. By offering proactive telephonic outreach and virtual treatment and support options, SURP can increase access to essential behavioral health services and facilitate continuity and ease of care for patients.

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

- 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.
- SURP will explore development of expanded inpatient services for the co-management of patients with Opioid Use Disorder through a harm-reduction model, including consultation with inpatient clinicians to address treatment and referral options.
- Community Health Leaders will maintain ongoing relationship with vBH team, and facilitate reporting of outcomes to relevant hospital stakeholders.

HP2030 ALIGNMENT

- 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

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

- To increase the number of referrals of ED patients to SURP program by 25% each year.
- To increase the number of ambulatory referrals by 10% 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.

Medium-Term Outcomes:

- Maintain engagement of 10% of patients that engage through a six-month period.

Long-Term Outcomes:

- 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 waivered 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)
- Aviary Recovery Program

BH PROGRAM 7: Engaging Patients in Care Coordination (EPICC)

PROGRAM DESCRIPTION:

The Behavioral Health Network's Engaging Patients in Care Coordination (EPICC) program 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, and are provided intensive referral and linkage services through peer Recovery Coaches.

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

- 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.

HP2030 ALIGNMENT

- 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

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

- Increase the number of referrals of ED patients with opioid dependence to the EPICC program by 25% each year.

Medium-Term Outcomes:

- 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.

Long-Term Outcomes:

- 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.

PLAN TO EVALUATE THE IMPACT:

- BHN will track number of program referrals.
- BHN will track number of appointments scheduled.
- BHN will track percent engagement rate.
- 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

Prioritized Need #3: Maternal & Child Health

Goal 1: Prevent pregnancy complications and maternal deaths and improve women's health before, during, and after pregnancy.

Goal 2: Improve the health and safety of infants.

MCH PROGRAM 1: Centering Pregnancy

PROGRAM DESCRIPTION:

Centering Pregnancy is an evidence-based framework that provides group prenatal care that is patient-centered and relationship-focused to improve health outcomes for moms and babies. By integrating essential and extended clinical prenatal visits with facilitative discussion, interactive activities, and group support, moms are empowered to engage in their healthcare in a meaningful way and build trust and community with their healthcare provider and other expectant moms. Mercy providers will work with Good Shepherd Children and Family Services to offer Centering Pregnancy to pregnant moms who are at increased risk for complications in pregnancy and childbirth.

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

Following programmatic disruption due to COVID-19, Mercy will explore the feasibility of restarting the Centering Pregnancy Program at Good Shepherd Children and Family Services in order to make the program more sustainable and reach more moms in need:

- Mercy will engage in conversations with community partners to assess capacity, need, and current COVID-19 procedures.
- Mercy will identify providers who are willing to participate in Centering Pregnancy programming, as well as co-workers who can provide administrative support.
- Mercy will assess internal and external grant options for funding support, including the Missouri Foundation for Health, Mercy Health Foundation, Caritas, and 340B, that can cover funding for materials, license cost, and time for Medical Assistant support.

HP2030 ALIGNMENT

- Objective MICH-07: Reduce preterm births
- Objective MICH-08: Increase the proportion of pregnant women who receive early and adequate prenatal care

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

- By Q3FY23, identify relevant internal and external stakeholders who can actively engage in program planning, implementation, and evaluation of the Centering Pregnancy program.
- By Q3FY23, identify potential referring agencies for Centering Pregnancy program, including community-based organizations, Mercy providers and FQHCs.

Medium-Term Outcomes:

- By the end of FY23, identify, apply for, and secure supplementary grant funding to support program implementation and help offset costs.
- By the end of FY23, identify metrics to track program success and facilitate sustainability.

Long-Term Outcomes:

- In FY24-FY25, pilot and implement Centering Pregnancy program, reaching on average 10 women per session.

PLAN TO EVALUATE THE IMPACT:

- Mercy will utilize a Gantt chart and project management tools to track progress on program planning.
- *Developmental*: Mercy will track patient outcomes related to attendance/engagement in program, exchange calls, gestational age at delivery, birth weight and breastfeeding

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Staffing (physician) salaried support
- Indirect costs related to transportation and supplies (scales, heart monitors, blood pressure cuffs, doppler, and class materials)

COLLABORATIVE PARTNERS:

- Good Shepherd Children and Family Services
- Missouri Baptist Girls Home
- Mercy Family Medicine Residency Program
- Mercy Birthing Center

MCH PROGRAM 2: Safe Sleep First Project

PROGRAM DESCRIPTION:

The Safe Sleep First Project (SS1st) focuses on evidence-based frameworks to promote the practice of infant safe sleep, especially for communities of color, where systemic inequalities place babies at greater risk for illness, injury, and death. In St. Louis, Black babies are seven times more likely to die than white babies from SUIDS. Many parents and caregivers are unaware that how their baby sleeps can put them at a higher risk of infant death. For examples, some families co-sleep with their babies as bonding time or to protect them from unsafe living conditions, but this puts them at risk for suffocation. For other families, a crib may simply be too expensive. Most infant deaths can be avoided by practicing the ABCs of Safe Sleep: Babies sleep safest **A**lone, on their **B**ack and in their **C**rib, bassinet, or portable crib. Through a regional, multi-sector team, SS1st provides training and resources so that caregivers throughout St. Louis receive consistent information and messaging about safe sleep regardless of where they get their information.

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

- Mercy will appoint a consistent representative for the SS1st to regularly attend SS1st meetings and deepen community partners.
- Mercy will provide infant safe sleep education, coordination, and materials (including pack and plays) for families and providers as part of a 16-organization collaborative, and will align patient messaging and education to build capacity for improved care for those most in-need.
- Mercy's messaging about safe sleep on social media channels and in publications will be consistent with the guidelines set by the American Academy of Pediatrics and as agreed up on by the SS1st team.
- Mercy will work toward becoming a Cribs for Kids Certified Safe Sleep Hospital.
- Mercy will assist with planning and implementing the annual Safe Sleep Summit as requested.
- Mercy will assist with planning and implementing Safe Sleep City activities as requested.

HP2030 ALIGNMENT

- Objective MICH-02: Reduce the rate of infant deaths
- Objective MICH-15: Increase the proportion of infants who are put to sleep on their backs
- Objective MICH-D03: Increase the proportion of infants who are put to sleep in a safe sleep environment

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

- By the end of Q1FY23, Mercy will identify the appropriate internal stakeholders to engage in Safe Sleep First's council and oversee implementation of SS1st activities.
- By the end of Q2FY23, Mercy's internal team will receive training and support on safe sleep guidelines and patient education.

Medium-Term Outcomes:

- By FY24, Mercy will provide infant safe sleep education to 90% of families, and will supply 60 pack and plays per quarter to families in need.

Long-Term Outcomes:

- Mercy will become a Cribs for Kids Certified Safe Sleep Hospital by the end of FY25.
- By FY25, the St. Louis region will achieve a 10% decrease in racial disparities in infant mortality.

PLAN TO EVALUATE THE IMPACT:

- Gantt chart and project management tools to track progress on program planning.
- Mercy will track the number of staff members trained with Safe Sleep approved materials.
- Mercy will track the number of social media messages published using Safe Sleep First education.
- Mercy will track the number of pack and plays distributed to families with financial and social need.
- Safe Sleep First Partners will report regional epidemiological data of SUIDS and infant deaths.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Staff time in program implementation, meeting attendance, etc. in support of SS1st activities
- Indirect expenses related to transportation, as necessary
- Sponsorship of Generate Health/FLOURISH events as requested

COLLABORATIVE PARTNERS:

- FLOURISH St. Louis – Infant Health Action Team
- Nurses for Newborns
- Generate Health
- SSM Health and SSM Health Cardinal Glennon Children's Hospital
- BJC Healthcare

MCH PROGRAM 3: NICU Breast Pump Loaner Program

PROGRAM DESCRIPTION:

In the Neonatal Intensive Care Unit (NICU), human milk is treated like lifesaving medication. Among the many lifetime health benefits linked to infant consumption of human milk, expert recommendations and evidence-based practices advocate for the use of human milk diets in premature infants to mitigate risks for necrotizing enterocolitis (NEC). However, minority mothers in St. Louis are more likely to experience extended separation from their babies in the NICU, which means that their babies are at risk of a delay in receiving the lifetime health benefits linked to consumption of human milk. The costliness of high-quality mechanical breastmilk pumps and other common logistical concerns are identified as barriers to care for this underserved population.

With support of a grant through the Vermont Oxford Network (VON), Mercy Hospital St. Louis' NICU will lend hospital-grade mechanical breast pumps to mothers in need and provide education on pump usage, bridging the potential gap of weeks or months for a similar quality pump to be available via State of Missouri programs. Related social determinants of health for patients will be identified and addressed individually. Social navigation services will be provided to facilitate access to nutritional support, transportation assistance, and other help as needed. When a mother no longer has need of the loaner breast pump, care management staff will facilitate the return of the machine to the hospital. The Mercy Kids Lactation Team will be responsible for cleaning, maintaining, and organizing the pumps. These durable high-end machines are anticipated to provide years of service.

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

- NICU nursing staff will collaborate with Mercy Health Foundation and VON to secure funding for 10 hospital-grade mechanical breastmilk pumps with secure carrying cases.
- Mercy NICU staff will lend hospital-grade mechanical breast pumps to any low-income mothers in need whose baby would benefit, and will provide education and support on pump usage, including making referrals to Mercy's lactation peer-mentoring program.
- Social navigation services will be provided through Care Management to facilitate access to nutritional support, transportation assistance, and other help as needed, including referrals to State of Missouri WIC programs.
- Mercy Hospital St. Louis NICU staff will add value to the program through their compassionate and personalized care services. Efforts will include staff education, patient education, peer-mentorship facilitation, community resource navigation, and an ongoing commitment to learning and improving. Patients will never be charged for these supplemental services.

HP2030 ALIGNMENT

- Objective MICH-02: Reduce the rate of infant deaths
- Objective MICH-15: Increase the proportion of infants who are breastfed exclusively through age 6 months
- Objective MICH-16: Increase the proportion of infants who are breastfed at 1 year

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

- Each fiscal year, Mercy's NICU will provide loaner breast pumps to 100 moms, by screening and identifying NICU moms with financial and social need.

- Each fiscal year, 80% of moms who receive a loaner breast pump will be connected to WIC and other social service programs.
- Each fiscal year, 100% of self-pay moms who receive a loaner breast pump will be connected to Medicaid.

Medium-Term Outcomes:

- Each quarter, babies supported by the breast pump loaner program will see a 10% decreased length of stay in the NICU.
- Each quarter, babies supported by the breast pump loaner program will see a 10% decrease in NEC incidence.

Long-Term Outcomes:

- By FY25, the St. Louis region will achieve a 10% decrease in infant mortality.

PLAN TO EVALUATE THE IMPACT:

- Mercy's NICU will track the number of mothers/babies served.
- Mercy's NICU will track the number of mothers connected to WIC and other social service programs.
- Mercy's NICU will track the number of self-pay mothers and babies connected to Medicaid.
- Mercy's NICU will track the length of stay, incidence of NEC, and infant mortality rates of program participants, as well as relevant maternal health outcomes.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- $21,345 in grant funding through VON for the purchase of 10 hospital-grade mechanical breastmilk pumps with secure carrying cases.
- FTE/time of NICU staff for training and support
- FTE/time of care management for social needs support

COLLABORATIVE PARTNERS/ROLE:

- Vermont Oxford Network (VON) – grant funder

MCH PROGRAM 4: Milk Depot

PROGRAM DESCRIPTION:

In the NICU, human milk is treated like lifesaving medication, and in the state of Missouri, Medicaid will even reimburse hospitals for the cost of donor milk for critically ill babies or those in the NICU. Among the many lifetime health benefits linked to infant consumption of human milk, expert recommendations and evidence-based practices advocate for the use of human milk diets in premature infants to mitigate risks for necrotizing enterocolitis (NEC). Human milk can also be used in cases of absent or insufficient lactation, illness requiring temporary interruption of breastfeeding, immunodeficiency disorders, and the treatment of infectious diseases.

The Milk Bank, a non-profit based in Indiana, "provides pasteurized donor human milk (PDHM) by prescription or physician order to hospitals and outpatients throughout the United States," including to Mercy Hospital St. Louis (themilkbank.org). By becoming a Milk Depot location, Mercy St. Louis can collect approved donations from area donors that can be stored and sent to The Milk Bank for bottling, pasteurization, testing, and reallocation to mothers in need across the Midwest, including those in the Greater St. Louis Region.

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

- Mercy Hospital St. Louis will manage an on-site collection facility for donor milk to be pumped or dropped off and stored, and will arrange for shipments of donor milk to The Milk Depot.
- Mercy will market the Milk Depot to enroll new donors, through rack cards in hospital community spaces and OBGYN and Pediatric offices, as well as wall clings in all hospital pumping rooms and lactation suites.

HP2030 ALIGNMENT

- Objective MICH-02: Reduce the rate of infant deaths
- Objective MICH-15: Increase the proportion of infants who are breastfed exclusively through age 6 months
- Objective MICH-16: Increase the proportion of infants who are breastfed at 1 year

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

- Each quarter, Mercy will increase the number of individual donors to the Milk Depot by 15%.
- Each quarter, Mercy will increase the total volume of human milk donated to the Milk Depot by 20%.

Medium-Term Outcomes:

- BY FY24, Mercy Hospital St. Louis' Milk Depot will collect a greater volume of donor milk than is used by Mercy patients from the Milk Bank.

Long-Term Outcomes:

- By FY25, the proportion of infants in St. Louis who are breastfed exclusively through age six months will increase by 10%.
- By FY25, the proportion of infants in St. Louis who are breastfed exclusively through age one year will increase by 5%.

PLAN TO EVALUATE THE IMPACT:

- Mercy will track the number of donors who participate in the Milk Depot, as well as the number of co-workers who donate.

• Mercy will track monthly volume of contribution to the Milk Depot, as well as volume of donor milk utilized by Mercy patients from the Milk Bank. • Mercy will gather epidemiological data from HealthyPeople2020, Nurses for Newborns, Generate Health, FLOURISH St. Louis, and St. Louis Partnership for a Healthier Community to understand breast feeding rates in the region.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: • Private, secure space for on-site collection facility • Co-worker time for maintaining collection facility, gathering, and shipping donations, and tracking progress • Funding for indirect expenses, such as marketing
COLLABORATIVE PARTNERS/ROLE: • The Milk Bank • SSM Health Cardinal Glennon Children's Hospital

MCH PROGRAM 5: Mercy-wide Policy: Mercy Kids Care of the Substance-Exposed Newborn

PROGRAM DESCRIPTION:

Infants who are exposed to maternal substance use in utero may experience physiological withdrawal symptoms after birth due to the abrupt discontinuing of the substance. Commonly described Neonatal Abstinence Syndrome (NAS) signs include central nervous system irritability (e.g., tremors, hypertonia, sleep disturbance, high-pitched cry), autonomic nervous system over activity (e.g., nasal stuffiness, tachypnea) and gastrointestinal dysfunction (e.g., feeding intolerance, diarrhea). The evidence-based care model Eat, Sleep, Console (ESC) drives primary support through nonpharmacological interventions. However, evidence notes, 20% to 40% of infants may still require pharmacological intervention.

As a Ministry, Mercy will enact a new policy to guide the care team in the treatment of all substance exposed infants. These infants will receive nonpharmacological support through environment modifications and integration of parents/caregivers with a primary role. Key elements include a formalized standard approach to symptom management focused on the primary caregiver's ability to perform the basic skills for infant growth and development. If the infant symptoms are unable to be controlled, pharmacological interventions will be considered following medical provider direction.

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

- Any infant exposed to maternal substance use in utero will receive non-pharmacological care.
- Any infant with a gestational age of 35 weeks or greater who had chronic exposure in-utero, and has a risk for developing withdrawal symptoms that would interfere with their ability to eat, sleep, and be consoled will be monitored for withdrawal symptoms in a hospital setting for four to seven days for known opioid exposure, and at provider discretion based on expected onset and duration of symptoms for all other exposures.
- Infant that are assessed via a scoring tool will have non-pharmacological interventions, which may include environmental modifications to decrease infant stimulation, swaddling tightly in a light blanket, gently rocking, or swaying in vertical motions, protecting sleep time, offering a pacifier for non-nutritive sucking, and infant massage (if trained professionals are available).
- Mercy will engage the mother and caregiver in the care of the infant. Mothers/caregivers will remain with infant as much as possible in the Well Newborn, Special Care Nursery, and NICU spaces to promote attachment. Mercy care teams will maintain mother-Infant dyad by not separating mother and baby unless clinical care needs, for either or both, warrant separation. If separation is needed, utilize methods of communication, which may include, telephone, pictures, teleservices to connect and promote maternal infant bonding.
- Infant feeding will occur on demand and feeding assistance will be provided to optimize infant nutrition.
- Infant therapeutic goals will be evaluated throughout admission, and at minimum will include effectively breastfeeding or bottle feeding as appropriate for gestational age; consoling within 10 minutes or less by utilizing all nonpharmacological interventions available; and sleeping for 60 consecutive minutes.
- Pharmacological treatment will be considered to prevent complications when moderate to severe signs of NAS occur in infants who do not respond to nonpharmacological therapies or

when the chosen NAS assessment tool has reached the threshold to begin treatment based on organizational guidelines.

- In the event an infant does not meet ESC requirements and all non-pharmacological interventions and available pharmacological interventions on well newborn unit have been maximized, Mercy will initiate a neonatology consult and anticipate a possible transfer to a higher level of care for further evaluation and treatment.
- Clinical documentation and assessment will begin within 4 hours of birth. Infants may be assessed on the mother skin-to-skin or swaddled and held by caregiver.

HP2030 ALIGNMENT

- Objective MICH-17: Increase the proportion of children who receive a developmental screening
- Objective MICH-02: Reduce the rate of infant deaths
- Objective MICH-15: Increase the proportion of infants who are breastfed exclusively through age 6 months

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

- *Developmental:* Mercy will assess 100% of infants at-risk for NAS within four hours of birth, and provide ongoing assessment routinely with feeds/cares at nursing discretion or as ordered by provider.
- *Developmental:* Mercy will assess and document, per shift, maternal-infant bonding, maternal-demonstrated capability to care for the infant, and nonpharmacological approaches to care throughout the hospital stay.

Medium-Term Outcomes:

- *Developmental:* Each FY, Mercy will demonstrate a 10% reduction in infants requiring pharmacological intervention for NAS.
- *Developmental:* Each FY, Mercy will demonstrate a 15% increase in breastfeeding behavior among mothers/caregivers and infants treated with the ESC

Long-Term Outcomes:

- *Developmental:* Each FY, Mercy will demonstrate a 5% reduction in length of stay for maternal-infant dyads treated with the ESC model.
- *Developmental:* By FY25, the St. Louis region will achieve a 10% decrease in infant mortality.

PLAN TO EVALUATE THE IMPACT:

- Mercy will track the number of mothers/babies served.
- Mercy will track the developmental progress of patients, along with relevant outcomes and behaviors such as interventions used, breastfeeding rates, and social outcomes for mother/caregiver and infant.
- Mercy will track clinical outcomes, such as length of stay, incidence of NAS, and infant mortality rates of patients, as well as relevant maternal health outcomes.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Clinical and staff support for care of infants and mothers/caregivers

COLLABORATIVE PARTNERS/ROLE:

- Mercy Neonatal Intensive Care Unit
- Mercy Kids
- SURP

MCH PROGRAM 6: Maternal SUD Collaborative Care Model

PROGRAM DESCRIPTION:

Mercy Hospital St. Louis will engage a multidisciplinary team across Maternal Fetal Medicine, Labor and Birth, Neonatal ICU, Mercy Kids, Mercy vBH and Population Health (SURP) to develop a sustainable model in providing comprehensive, streamlined, and accessible care for pregnant women with Substance Use Disorder (SUD) and their babies. Through a combination of standardized prenatal screening and seamless coordination of consultation, pre-natal care, harm-reduction strategies (MAT) and comprehensive social and clinical support, Mercy aims to promote women in achieving greater stability while reducing risks for preterm births, low birthweight, and other social and health challenges.

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

- Mercy will develop guidelines and tools for universal screening of substance use disorder for women's services using the 4P NIDA CRAFT assessment tool.
- Mercy will increase capacity for engaging patients in MAT through additional X-waivered providers and video consultations to create flexibility in scheduling.
- Mercy will centralize workspaces for maternal health, mental health services, and education for added convenience for patients seeking care.

HP2030 ALIGNMENT

- Objective MICH-D02: Reduce the proportion of women who use illicit opioids during pregnancy
- Objective MICH-02: Reduce the rate of infant deaths
- Objective MICH-15: Increase the proportion of infants who are breastfed exclusively through age 6 months

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

- *Developmental*: By Q3FY23, Mercy will engage relevant leaders, clinicians, and co-workers on a planning committee to assess opportunities, barriers, capacity and needs for fetal care framework.
- *Developmental*: By FY24, Mercy will standardize a screening tool for OUD for women's services in Epic.

Medium-Term Outcomes:

- *Developmental*: By FY24, Mercy will standardize a pregnancy encounter guide for use with pregnancy patients with OUD

Long-Term Outcomes:

- *Developmental*: By FY25, Mercy will develop a program framework to streamline referral and treatment for pregnant women with SUD, as well as guidelines for assessment and long-term support of mothers and infants.

PLAN TO EVALUATE THE IMPACT:

- Mercy will utilize project management tools to evaluate the progress of organizational planning around the care team and process change.
- Mercy will track engagement of women in treatment, through number of prenatal visits attended, successful referrals for support services, and relapse rates of patients through urine drug screens.

- Mercy will track mental health stability of patients through EPDS scores.
- Mercy will track outcomes of infants, through birthweight, length of stay, and NICU admissions.
- Mercy will track how many infants are discharged with mother/caregiver vs. with child division, how many infants are getting pediatric appointments scheduled at discharge, and whether or not infants are connected to other resources for ongoing social support at discharge.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Clinical and staff support for care of infants and mothers/caregivers and space/resources to develop care model

COLLABORATIVE PARTNERS:

- Mercy Internal Partners: Maternal and Fetal Medicine, NICU, Mercy Kids, vBH, Population Health, SURP
- SSM St. Mary's Wish Clinic

Prioritized Need #4: Trauma-Informed Care

Goal 1: Support the dissemination, implementation, and sustainability of best practices in systems-level trauma-informed approaches.

TIC PROGRAM 1: Program Research and Development

PROGRAM DESCRIPTION:

Mercy will collaborate with Alive & Well Communities, a leader in trauma-informed advocacy and community building in the state of Missouri, to explore the need, capacity, and readiness for trauma-informed care approaches, and will develop a three-year plan for piloting trauma-informed programming and support for areas of need within Mercy Hospital, focusing on the Neonatal Intensive Care Unit, and Mercy Clinic to enhance the quality, effectiveness, and delivery of services provided to patients, and support the holistic wellbeing and sense of efficacy for care providers. This phase of program development will focus on co-worker and community need for trauma-informed support, current programs offered, existing gaps, and concerns for sustainability and growth, and will research and develop pilot program opportunities to collaborate that will meet the needs of the community.

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

- Conduct an external inventory of existing local community services offered by other health systems, non- profit, and for-profit agencies.
- Review data from any existing documents/community assessments, resource list inventories and focus group reports.
- Implement a readiness assessment across relevant Mercy departments.
- Identify gaps in service, explore best practice examples and collaborative pilot options.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

- By the end of FY23, the internal and external assessments will be completed.

Medium-Term Outcomes:

- By the end of FY24, community need gaps will be identified and a plan, including funding support, will be presented for pilot initiative(s).

Long-Term Outcomes:

- By the end of FY25, 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:

- Number of co-workers trained in trauma-informed approaches.
- Analyses of available outcomes data.

PROGRAMS AND RESOURCES THE HEALTH SYSTEM PLANS TO COMMIT:

- Cost of coworker time.
- Operational budgeted support as appropriate.
- Philanthropy support as needed.

COLLABORATIVE PARTNERS:

- Alive and Well Communities

III. Other Community Health Programs

Mercy St. Louis 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. 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	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 – physicians, physical therapy, dietary, social work, pharmacy, nursing, and other health professionals	Number of students
Financial and In-Kind Contributions	Blood Drives	Cost of services
	Community Flu Vaccines	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
	Cash/In-Kind Contributions	Cost of services
Community Building Activities – Economic Development	Board Memberships	Cost of services
	Coalition Building	Cost of services
Subsidized Health Services	Emergency and Trauma Services	Cost of services
	Behavioral Health Services	Cost of services
Health Care Support Services	340B Program	Cost of services
	Health Care Support Services	Cost of services

IV. 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.

- Violence in the Community

Infectious disease physicians at Mercy will continue to address this issue through collaborative work. Mercy will not, however, take a lead role on this issue as there are some limitations to the organization's partnerships in this area as a Catholic Health System.

- Sexually Transmitted Infections

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 outreach priorities.

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

NOTES:

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Mercy

Your life is our life's work.