Community Health Improvement Plan

Mercy Hospital Washington

Fiscal Year 2019 – 2021

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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 Washington (MHW) completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors in May 2019. The CHNA took into account 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 Franklin County, Missouri. The CHNA identified three prioritized health needs the hospital plans to focus on addressing during the next three years:

- Access to Care - Navigation to Services and Social Determinants of Health
- Behavioral Health - Mental Health and Substance & Opiate Use
- Childhood Obesity – Food and Nutritional Education

The complete CHNA report is available electronically at www.mercy.net/about/community-benefits.

Mercy Hospital Washington is a medium-sized acute care hospital located in Franklin County, Missouri, approximately 50 miles from St. Louis. It is affiliated with Mercy, one of the largest Catholic health systems in the United States. MHW is staffed for approximately 100 patients, employs 900 co-workers, operates a Level III trauma center, and Level II STEMI and Stroke Centers. McAuley Clinic at Mercy Hospital Washington is a rural health clinic that provides comprehensive primary care, family medicine, women's health care, ADHD treatments and mental health services to those who are uninsured or have Medicaid.

This three-year Community Health Improvement Plan (CHIP), aimed at addressing the prioritized health needs identified in the CHNA, will guide the coordination and targeting of resources, and the planning, implementation and evaluation of both new and existing programs and interventions. The 2019 CHNA and this resulting CHIP will provide the framework for Mercy Hospital Washington as it works in collaboration with community partners to advance the health and quality of life for the community members it serves.

To learn more about Mercy Hospital Washington and to find a copy of this report online, visit www.mercy.net.

II. Implementation Plan by Prioritized Health Need

Prioritized Need #1: Access to Care

GOAL 1: Connect uninsured and at-risk patients in the MHW Emergency Department to a primary care provider, health coverage assistance and/or services to address social determinants of health

PROGRAM 1: Community Health Worker Program and Emergency Department Social Workers Program
PROGRAM DESCRIPTION: Community Health Workers (CHWs) serve as liaisons/links between health care entities and other community and social services. CHWs screen patients for needs related to social determinants of health and facilitates access to these services to improve the quality and culture competence of care. CHWs work one-on-one with at-risk patients, acting as patient advocates, assisting patients in applying for health care coverage and government programs, such as Medicaid and disability, along with health care financial assistance and other community resources. Both the CHW and social workers located in the Mercy Hospital Washington Emergency Department identify patients without a current primary care provider (PCP) and assist in setting up their follow-up appointment with a PCP.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Identify uninsured and at-risk patients in need of assistance in Mercy emergency department and clinics, and through the use of reports and dashboards. 2. CHWs will assist uninsured patients with applying for Mercy financial assistance, Medicaid programs, and other mainstream government services. 3. CHWs and Emergency Department social workers will assist patients without an established primary care provider in establishing care with a primary care clinic or provider. 4. CHWs will screen patients for needs related to social determinants of health and connect patients to community resources to meet identified needs. 5. CHWs will connect patients with other community resources and national programs, including medication resources, as needed.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. By the end of each fiscal year for the next three years, each CHW will enroll 30 patients in Mercy financial assistance, 20 in Medicaid and 8 in mainstream government programs (FY19 six months = 19 FA; 10 Medicaid, 4 SSI/SSDI/Food Stamps)

2. 65% of new patients without a primary care provider referred to each CHW will establish care with a PCP at a Mercy clinic, FQHC, free clinic or other clinic
3. Each CHW will assist at least 35 patients per year with community and medication assistance resources.
4. ED Social Workers will refer 100 ED patients without a primary care provider to a provider to establish care at a Mercy clinic, FQHC, free clinic or other clinic per year.

Medium-Term Outcomes:

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

Long-Term Outcomes:

1. 75% of patients enrolled in CHW program will have improved health outcomes, improved well-being and demonstrate improvement in measures of social determinants of health.

PLAN TO EVALUATE THE IMPACT:

1. Track number of new and ongoing encounters conducted by each CHW. (Output)
2. Track number of patients successfully enrolled in Mercy financial assistance, Medicaid and government mainstream services (Short-term)
3. Measure number of patients successfully establishing a primary care home. (Short-term)
4. Record number of patients receiving community resources and medication assistance (Short-term)
5. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing CHW and SW services (Medium-term)
6. Analyze pre and post intervention bad debt for cohort of patients utilizing CHW services (Medium-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Salary and benefits for full-time Community Health Worker
2. Utilization of ED Social Workers to connect patients to PCP
3. Office space and indirect expenses dedicated to CHW work.
4. Services offered through Mercy's McAuley Clinic
5. Services offered through Mercy Financial Eligibility

COLLABORATIVE PARTNERS:

1. MO DHSS offices
2. Church food pantries and assistance programs
3. Franklin County Health Department
4. Pharmaceutical manufacturers assistance programs
5. MO Career Centers

Prioritized Need #1: Access to Care

PROGRAM 2: McAuley Clinic
PROGRAM DESCRIPTION: McAuley Clinic provides comprehensive primary care, family medicine, women's health care, mental health services, prenatal and pediatric care to uninsured, underinsured and Medicaid-eligible patients in more than five counties.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Provide primary care services to uninsured, underinsured and Medicaid eligible patient. 2. Screen patients for needs related to social determinants of health and connected to community resources to meet identified needs. 3. Connect patients with other community resources and national programs, including medication resources, as needed.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. McAuley Clinic statistics for past year will be researched in order to establish baselines. 2. # of Uninsured patients seen for primary care will increase by 10% 3. # of Medicaid patients seen for primary care will increase by 10% 4. # of patients referred to clinic social worker to address non-medical needs (social determinants of health) will increase by 10% ***Medium-Term Outcomes:*** 1. New patients will demonstrate a 10% reduction in ED utilization and reduced inpatient admissions. 2. New patients will demonstrate a reduction in their total bad debt. ***Long-Term Outcomes:*** 1. 75% of patients enrolling in McAuley Clinic will have improved health outcomes, improved well-being and demonstrate improvement in measures of social determinants of health.
PLAN TO EVALUATE THE IMPACT: 1. Track number of new patients to primary care. (Output) 2. Track number of patients successfully enrolled in Mercy financial assistance, Medicaid and government mainstream services (Short-term) 3. Record number of patients receiving community resources and medication assistance (Short-term) 4. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing McAuley Clinic (Medium-term) 5. Analyze pre and post intervention bad debt for cohort of McAuley Clinic patients (Medium-term)
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Salary and benefits for McAuley clinic co-workers
2. Office space and indirect expenses dedicated to McAuley Clinic.
3. Services offered through Mercy Financial Eligibility

COLLABORATIVE PARTNERS:

1. MO DHSS offices
2. Church food pantries and assistance programs
3. Franklin County Health Department
4. Pharmaceutical manufacturers assistance programs
5. MO Career Centers

Prioritized Need #2: Behavioral Health – Mental Health

Goal 1: Reduce patient visits of high utilizers of Mercy Hospital Washington's emergency room who present with behavioral health issues

PROGRAM 1: Emergency Room Enhancement (ERE)
PROGRAM DESCRIPTION: The Behavioral Health Network's 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 program are connected to a peer-support specialist and community behavioral health resources. The program provides after-hours/weekend scheduling, as well as telephonic and mobile outreach crisis services for consumers referred to the ERE project.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Community Health Leaders maintain on-going relationships with BHN and other community partners through participation in regional meetings and facilitation of data sharing and process improvement. 2. Emergency Department staff facilitate referrals to ERE intervention partners.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. Increase the number of high utilizers in the Emergency Department with mental health needs referred to the ERE program by 30% each year (FY19=17) ***Medium-Term Outcomes:*** 1. Increase the number of appointments scheduled by ERE intervention partners with community and hospital providers by 30% each year. (FY19=9) 2. Increase cumulative engagement rate by 5% each year (FY19=59%) ***Long-Term Outcomes:*** 1. Patients reached by the ERE program will demonstrate a 10% reduction in ED utilization over three years. 2. Patients reached by the ERE program will demonstrate a 10% reduction in inpatient readmissions over three years.
PLAN TO EVALUATE THE IMPACT: 1. BHN will track the number of ERE program referrals. (Output) 2. BHN will track number of ERE appointments scheduled. (Output) 3. BHN will track percent engagement rate. (medium-term outcome) 4. Mercy will track ED utilization rates and inpatient readmissions. (Long-term outcome)
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Support and educate ED staff to identify and facilitate ERE referrals 2. Staff time and indirect cost as necessary to maintain ongoing partnership with BHN and community agencies

COLLABORATIVE PARTNERS:

1. Behavioral Health Network of Greater St. Louis (BHN)
2. Compass Health Network
3. Preferred Family Health/Bridgeway

Prioritized Need #2: Behavioral Health – Mental Health

Goal 2: Increase access to mental health care for uninsured and at-risk persons.

PROGRAM 2: Mercy Outpatient Behavioral Health

PROGRAM DESCRIPTION:
The hospital will collaborate with community partners to assess services and gaps in behavioral health services currently offered and implement collaborative approaches to meet community behavioral health needs.

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

1. Expand Mercy's Intensive Outpatient Program (IOP) to include more uninsured patients and adolescent patients, including those in foster care
2. Expand use of Virtual Behavioral Health
3. Expand use of Mercy's BH Regional Access Center
4. Strengthen relationships with community behavioral health care providers and participate in community coalitions
5. Redesign Emergency Room to provide separate Behavioral Health space

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. By the end of FY20, the internal and external assessments will be completed
2. IOP enrollment of uninsured adult patients will increase by 10% (FY19=23@100%; 11@70-90%)
3. IOP enrollment of adolescent patients will increase by 10%
4. Referrals to inpatient care will improve by 10% utilizing Mercy's BH Regional Access Center

Medium-Term Outcomes:

1. By the end of FY21, community need gaps will be identified and a plan, including funding support, will be presented for pilot initiative(s).
2. BH patients will experience shortened length of wait-time in emergency department by 10%.
3. Redesign of ED with BH patients in one area will provide a safer environment for patients and co-workers with more therapeutic environment for patients – optimizing expertise for staff for treatment.
4. Improve referral process across all BH providers by identifying existing or start-up Franklin County Behavioral Health Providers Network and set regular meetings

Long-Term Outcomes:

1. By the end of FY22, the pilot will be implemented and initial outcome data presented
2. Comprehensive continuum of behavioral health resources that functions as integrated recovery.

PLAN TO EVALUATE THE IMPACT: 1. Impact evaluation approach will be dependent on program piloted. Measurement tools will include, but are not limited to: 2. Number of Internal Behavioral Health Programs 3. Numbers of patients and community members served. 4. Analyses of available outcomes data, for example, utilization, readmission, and contribution margin. 5. The percentage of emergency department visits that are behavioral health related.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT 1. Mercy’s BH Regional Access Center 2. MHW IOP 3. Operational budgeted support as appropriate 4. Philanthropy support as needed
COLLABORATIVE PARTNERS 1. Preferred Family Health/Bridgeway 2. Compass Health Network 3. Other community partners

Prioritized Need #2: Behavioral Health – Substance and Opioid Use

Goal 1: Increase access to recovery support and treatment services for patients who have overdosed on opioids

PROGRAM 1: Engaging Patients in Care Coordination (EPICC)
PROGRAM DESCRIPTION: The EPICC program, in partnership with the Behavioral Health Network of Greater St. Louis (BHN) connects opioid overdose survivors treated in emergency rooms to recovery support and substance use treatment services, including Medication Assisted Treatment (MAT). Individuals must be over the age of 18 and meet diagnostic criteria for opioid dependence. Intensive referral and linkage services are provided by peer Recovery Coaches.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Facilitate referrals to BHN peer Recovery Coaches from the Emergency Department. 2. Increase availability of medication assisted treatment (MAT) by supporting buprenorphine waivers for Mercy clinicians. 3. Promote opioid overdose education and Narcan distribution in the community.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. Increase the number of referrals of ED patients with opioid dependence to the EPICC program by 10% each year (FY19=66) ***Medium-Term Outcomes:*** 1. Increase the number of appointments scheduled by EPICC peer-recovery coaches at hospital outreach by 10% each year. (FY19=46) 2. Maintain at least a 50% engagement rate at 2-week follow-up each year (FY19=42%). ***Long-Term Outcomes:*** 1. Patients reached by the EPICC program will demonstrate a 10% reduction in ED utilization over three years. 2. Patients reached by the EPICC program will demonstrate a 10% reduction in inpatient readmissions over three years. 3. Reduce opioid-related deaths by 10% over three years (2017 Franklin County=24)
PLAN TO EVALUATE THE IMPACT: 1. BHN will track number of program referrals. (Output) 2. BHN will track number of appointments scheduled. (Output) 3. BHN will track percent engagement rate. (Short-term outcome) 4. Mercy will track # of MAT waivered clinicians. (Medium-term outcome) 5. Mercy will record number of nonfatal overdoses in emergency department. (long-term outcome) 6. Mercy will record ED utilization rates and inpatient readmissions. (Long-term outcome)
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Support and educate ED staff to identify and facilitate EPICC referrals
2. Staff time and indirect cost as necessary to maintain ongoing partnership with BHN and community agencies
3. Mercy Clinic will continue to educate and promote clinicians to provide MAT

COLLABORATIVE PARTNERS:

1. Behavioral Health Network of Greater St. Louis
2. Compass Health Network
3. Preferred Family Health/Bridgeway

Prioritized Need #2: Behavioral Health – Substance and Opioid Use

GOAL 2: Increase prevention initiatives and substance use treatment programs for uninsured and at-risk persons.

PROGRAM 1: Substance Use Services Inventory/Assessment/Pilot
PROGRAM DESCRIPTION: The hospital will collaborate with Mercy Ministry Controlled Substances Operational Task Force, local Mercy Behavioral Health teams and community partners to conduct a current assessment of services offered, identify any existing gaps and pilot creative collaborative approaches to meet community need.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Conduct an internal inventory of existing Mercy behavioral health services (i.e. Inpatient, Outpatient, Intensive Outpatient Programs (IOP), Counseling Services, Classes, Support Groups, Regional Access Center services, Virtual Care Center (VCC) initiatives). 2. Conduct an external inventory of existing local community services offered by other health systems, non- profit and for-profit agencies. 3. Review data from any existing documents/community assessments, resource list inventories and focus group reports. 4. Identify gaps in service, explore Mercy Virtual Care Center solutions and other best practice options, IOP, Medication Assisted Treatment (MAT) and pilot a minimum of one initiative. 5. Promote and utilize the Prescription Drug Monitoring Program (PDMP). Explore integration into EPIC 6. Participate in the HRSA Opioid Prevention Planning Grant with NCADA Consortium
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. By the end of FY20, the internal and external assessments will be completed. ***Medium-Term Outcomes:*** 1. By the end of FY21, community need gaps will be identified and a plan, including funding support, will be presented for pilot initiative(s). ***Long-Term Outcomes:*** 1. By the end of FY22, the pilot will be implemented and initial outcome data presented
PLAN TO EVALUATE THE IMPACT: Impact evaluation approach will be dependent on program piloted. Measurement tools will include, but are not limited to: 1. Number of Internal Substance Use Programs 2. Program Referrals and numbers of patients and community members served 3. Appointments Scheduled 4. Engagement Rate at 2-week follow-up

5. Increase in number of Medication Assisted Treatment (MAT) providers as applicable.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Ministry Controlled Substances Operational Task Force and Medical Marijuana Task Force 2. Catherine's Fund support 3. Community Health Leader research/project management support 4. Operational budgeted support as appropriate 5. Philanthropy support as needed 6. IOP 7. BH Regional Access Center 8. Opioid Task Force MHW, Mercy East 9. Narcan Training and Omnicell 10. M.D. Suboxone Training and Treatment
COLLABORATIVE PARTNERS: 1. Bridgeway/PFH 2. Compass Health 3. NCADA – HRSA Grant 4. HOPE Coalition – Healthy Outcomes thru Prevention & Education 5. Franklin County Health Department 6. BHN – EPICC (WINGS)

Prioritized Need #3: Childhood Nutrition\Obesity

- **Food Access**
- **Nutrition Education**

Goal 1: To increase access to nutritious and affordable foods.

PROGRAM 1: The hospital will collaborate with community partners to assess services and gaps in food access and nutrition services currently offered and implement collaborative approaches to meet community needs.

PROGRAM DESCRIPTION: Develop educational seminars/events focused on informing parents/children about healthy food options and activity levels.

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

1. Conduct an internal inventory of existing Mercy nutritional services
2. Conduct an external inventory of existing local community services offered by other health systems, non- profit and for-profit agencies.
3. Review data from any existing documents/community assessments, resource list inventories and focus group reports.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

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

Medium-Term Outcomes

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

Long-Term Outcomes:

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

PLAN TO EVALUATE THE IMPACT:

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

1. Number of Food Access and Nutritional Programs
2. Numbers of patients and community members served
3. Analyses of available outcomes data, for example, utilization, readmission, and contribution margin

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Mercy Pediatricians and Physicians
2. Mercy Nutritionists

COLLABORATIVE PARTNERS:

1. Franklin County Health Department
2. Public Schools
3. YMCA

4. Harvest Table Meal Program
5. Food Pantries
6. University of Missouri Extension programs

III. Other Community Health Programs

Mercy Hospital Washington 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:

1. Improve access to health care services
2. Enhance the health of the community
3. Advance medical or health care knowledge
4. 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	New Mom's Support Group	850 served
	Jump into Health Pediatric Weight Loss Program	230 served
	Meals on Wheels	7,836 served
	Car Seat Education & Safety Check	1,345 served
	Narcan training to law enforcement & EMS	71
	Head Safe Program (Bike helmets)	325 served
Health Professions Education	Nurses/Nursing Students	39 served
	Other Health Professionals	283 served
	Physicians/Medical Students	5
Donated Space	Homeless Shelter in Café	18 served
	Alcoholics Anonymous	270 served
Financial and In-Kind Contributions/Donations	MO Physicians Health Program Sponsorship	$1,500
	Alzheimer's Association Sponsorship	$500

	Warren & Franklin County Backstoppers	$565
	St. Borgia High School Sponsorship	$1,000
	East Central College Foundation	$500
Community Building – Workforce Development	Pathways to Employment	5 served
Community Building – Coalition Building/Board Membership	HOPE for Franklin County	Board member
	Foundations for Franklin County	Board member
	Missouri Narcotics Officers Association	Member
	Franklin County Provider Services Coalition	Member
	Franklin County Homeless Task Force	Participant

IV. Significant Health Needs Not Being Addressed

Mercy Hospital Washington (MHW) will continue to support, collaborate and partner with community agencies to address these additional top community needs, but not as part of our Community Health Improvement Plan.

- **Asthma/Lung disease/Pneumonia/Influenza**

In April 2018, Mercy opened a COPD clinic in Washington that provides free COPD education, such as the correct use of inhalers and nebulizers, manufacturer assistance forms if they cannot afford medications and assessment for pulmonary rehabilitation, nutritional counseling or other services. MHW will continue to donate flu vaccine to Franklin County Health Department to protect more in our community.

- **Cancers and Tobacco Use**

Mercy's David C. Pratt Cancer Center in Washington offers patients who live and work in the Franklin County region access to the area's most advanced diagnostic and treatment services and clinical trials. Community cancer screenings and education continue to be offered regionally. Efforts to address tobacco cessation will continue through Mercy's Certified Health and Wellness Coach/Mercy Road to Freedom program through Mercy's Cardiopulmonary Rehab area. Additionally, Mercy will continue to advocate and promote tobacco prevention.

- **Violence: Domestic Trafficking**

MHW works closely with domestic violence, sex trafficking and family services agencies, such as Alternatives to Living in Violent Environments (ALIVE) and local law enforcement to insure patients are given safe choices while in a hospital setting. Mercy has begun safety awareness and educational campaigns which includes internal training videos, restroom resource posters, and the incorporation of a safety screening/referral question which cues up in each patient's Mercy's Electronic Medical Record (EMR).

The following needs are not being addressed:

- **Physical Environment: Air/Water Quality, Housing and Transportation**

Collaboration with local coalitions addressing homelessness and housing will continue as will Mercy's support of industry, government, non-governmental organizations and the public in addressing air and water quality and transportation in our area. Mercy is researching transport options for many its locations, such as HealthTran that specializes in providing rural health transportation.

NOTES:

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