Community Health Improvement Plan

Mercy Hospital Lincoln

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.

Table of Contents

I. Introduction

Lincoln County is committed to carrying out its mission to deliver compassionate care and exceptional service for all members of the communities it serves, with special attention to those who are marginalized, underserved, and most vulnerable. As part of the Community Health Needs Assessment, the Lincoln Community convened a collaboration of area health care and non-profit partners to conduct a comprehensive community health survey and various focus group sessions. Available secondary health data was also obtained, and Lincoln community indicators were compared to those of Missouri and the United States.

Mercy Lincoln is a critical access hospital located in Troy, Missouri affiliated with Mercy, a large Catholic health system. Headquartered in St. Louis, Mercy serves millions of people each year in multiple states across the central United States. For the purposes of this Community Health Improvement Plan (CHIP), the community served by Mercy Lincoln will be defined as the three-county Lincoln region made up of Lincoln, St. Charles, and Warren Counties.

This three-year CHIP is aimed at addressing the prioritized health needs identified in the CHNA, will guide the coordination and targeting of resources, and the planning, implementation and evaluation of both new and existing programs and interventions. The 2022 CHNA and this resulting CHIP will provide the framework for Mercy Lincoln as it works in collaboration with community partners to advance the health and quality of life for the community members it serves.

II. Implementation Plan by Prioritized Health Need

Prioritized Need #1: Behavioral Health

Goal 1: Increase access to health care for uninsured and at-risk persons.

BH PROGRAM 1: LINCS
PROGRAM DESCRIPTION: The Behavioral Health Network's (BHN) LINCS 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 LINCS project are connected to community resources and inpatient and outpatient services through the BHN. 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 LINCS intervention partners.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): • Increase the number of referrals of high ED utilizers with mental health needs to the LINCS • Increase the number of appointments scheduled by LINCS intervention partners with community and hospital providers • Maintain at least an 80% cumulative engagement rate each year. • Patients reached by the ERE program will demonstrate a 10% reduction in ED utilization
PLAN TO EVALUATE THE IMPACT: • BHN will track number of program referrals. (Output) • BHN will track number of appointments scheduled. (Output) • BHN will track percent engagement rate. (Medium-term outcome) • Mercy will report on ED utilization rates and inpatient readmissions. (Long-term)
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: • Support and education for ED staff to identify and facilitate LINCS 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) • Compass Health

PROGRAM 2: 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
- Community Health Leaders will maintain ongoing relationship with vBH team, and facilitate reporting of outcomes to relevant hospital stakeholders.

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 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. (Output)
- SURP will track number of patients who initiate care/engage with program. (Output)
- Mercy to track the number of MAT waivered clinicians. (Medium-term outcome)
- Mercy track ED utilization rates and readmissions. (Long-term outcome)

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:

- Behavioral Health Network of Greater St. Louis (BHN) – EPICC Program
- Behavioral Health Response (BHR)
- Aviary Recovery Program

PROGRAM 3: Family Empowerment Outreach Center

PROGRAM DESCRIPTION:

The St. Louis Crisis Nursery provides short-term, safe haven for more than 3,000 children a year whose families are faced with an emergency or crisis. Through a Family Engagement Specialist, the Crisis Nursery Family Empowerment Outreach Center at Mercy Hospital Lincoln assists area families with children under 12 with crisis intervention, community referral, case management support, home visitation, and parent education groups to prevent child abuse and neglect and promote healthy families. The program also meets the immediate concrete needs of families through providing food bags, diapers, emergency fund assistance, cleaning supplies and other needed household items during sessions.

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

The Family Empowerment Program (FEP) will:

- Provide Lincoln County families with children 0-12 years with services that help minimize stress, reduce isolation and empower families to achieve goals that ensure stability and safety, ultimately reducing risk for child abuse/neglect.
- Provide trauma-informed parent education to families in need of social support and parenting resources.
- Offer crisis intervention through a Family Engagement Specialist, available at the Empowerment Outreach Center, in home, or in the community.
- Provide concrete support for families struggling to meet basic needs through provision of supplies such as food, diapers, formula, hygiene supplies, transportation assistance and financial assistance as needed.
- Connect families directly with other community resources and supports to address targeted needs.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term:

- The Family Empowerment Program will establish a presence in the Lincoln County community, reaching 50 Lincoln County families in the first year with proven prevention programming that includes crisis intervention, concrete support to meet immediate needs, case management, and parenting education.
- The Crisis Nursery will provide additional concrete support to under resourced area families through distribution of critically needed supplies at large scale supply distribution events.
- Families enrolled in home-based Family Empowerment Programming will meet with a Family Engagement Specialist at least one time per month throughout course of the year to work toward long term safety & stability goals.

- 90% of all FEP participants will reduce their stress levels during sessions, as indicated by a decrease in stress score from pre to post intervention on the In-Session Stress Scale.

Long-Term:

- 90% of all FEP participants will increase their Family Protective Factors by completion of FEP participation, as indicated by new skills in at least 3 of the 5 protective factor domains.
- 95% of all families participating in FEP services will remain intact, free from substantiated reports of child abuse or neglect.
- 85% of FEP participants enrolled in home-based services will increase positive coping skills by graduation, as indicated by an increase in positive coping score on the Brief COPE Assessment from pre to post.

PLAN TO EVALUATE THE IMPACT:

- Track number of home/office/field visits conducted by Family Engagement Specialist.
- Track number of participating families in FEP.
- Track number of Parent Education events held and participants.
- Record number of community members receiving community resource assistance for basic need items (food, diapers, clothing, etc.).
- Record the number of referrals made to community resources.
- Assess families enrolled in FEP through pre/post intervention Stress Scale, ongoing assessment of Family Protective Factors in each of the Five Protective Factor Domains, and the Brief COPE Assessment. The Stress Scale and Family Protective Factors Assessment are conducted at each session, while the Brief COPE is administered at baseline, midpoint, and graduation in order to document progress.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Storage, workspace, and indirect expenses dedicated to supporting the work of the Family Engagement Specialist.

COLLABORATIVE PARTNERS:

- St. Louis Crisis Nursery
- Birthright
- Parents as Teachers
- Local School Districts
- Local Food Pantries
- WIC Office
- Lincoln County Resource Board

Prioritized Need #2: Housing Instability

Goal 1: Increase access to health care for uninsured and at-risk persons.

PROGRAM 1: Bridge of Hope Lincoln County
PROGRAM DESCRIPTION: Bridge of Hope Lincoln County partners with civil, faith, and nonprofit organizations to equip Lincoln County individuals and families with resources and hope to walk alongside people in need.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Assist in data analytics and metrics for broader community. 2. Create referral pathway for at-risk patients to organization. 3. Assist in facilitating transportation for organizational clients. 4. Navigate clients to appropriate medical services. 5. Assist in prescription assistance program enrollment. 6. Provide care navigation for substance use disorder treatment. 7. Provide health education programming for chronic disease management.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): 1. Transition families out of poverty 2. Create more quality candidates in workforce 3. Transition into permanent housing (rent or owned) 4. Chronic disease management through stable living conditions
PLAN TO EVALUATE THE IMPACT: 1. Referrals to Bridge of Hope from Mercy Hospital/Clinic 2. Patients established with primary care 3. Connection to benefits/ financial assistance programs 4. Measure number of patients screened for social needs 5. Assistance with permanent housing applications ie: HUD 6. Provide navigation to appropriate healthcare services
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Community Health Worker assistance 2. Transportation Assistance 3. Medication Assistance (Pharmacy)
COLLABORATIVE PARTNERS/ROLE: 1. Lincoln County Health Department 2. Compass Health 3. Sts. Joachim and Anne Care Service 4. St. Vincent de Paul – Sacred Heart & Immaculate Conception

Prioritized Need #3: Transportation Access

Goal 1: Provide assistance through transportation resources to access healthcare, food and employment

PROGRAM 1: **Community Health Worker Program**
PROGRAM DESCRIPTION: Community Health Workers (CHWs) serve as liaisons/links between health care and community and social services, screening for needs related to social determinants of health, and facilitating access to services and improving the quality and culture competence of care. CHWs work one-on-one with at-risk patients and community members, acting as patient advocates, assisting patients in applying for insurance, Medicaid, and financial assistance and connecting patients with community resources.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Identify uninsured and at-risk patients and community members in need of assistance in Mercy clinics, emergency department, inpatient settings, community events, and through the use of reports and dashboards. 2. Assist uninsured patients apply for Mercy financial assistance, Medicaid programs, and Marketplace insurance plans. 3. Assist patients without an established primary care provider in establishing care with a primary care clinic or provider. 4. Screen patients for needs related to social determinants of health and connect patients to community resources to meet identified needs. 5. Connect patients with other community resources, including medication resources, as needed.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): 1. By the end of each fiscal year for the next three years, each CHW will enroll 50 patients in Mercy financial assistance, 20 in Medicaid, and 10 in Marketplace insurance plans. 2. 90% of new patients to each CHW without a primary care provider will establish care with a PCP at a Mercy clinic, FQHC, free clinic, or other clinic within 6 months. 3. Each CHW will assist at least 50 patient per year with community and medication assistance resources.
PLAN TO EVALUATE THE IMPACT: 1. Track number of new and ongoing encounters conducted by each CHW. 2. Track number of patients successfully enrolled in Mercy financial assistance, Medicaid, and Marketplace insurance plans. 3. Measure number of patients successfully establishing a primary care home. 4. Record number of patients receiving community resource and medication assistance. 5. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing CHW services. 6. Analyze pre and post intervention bad debt for cohort of patients utilizing CHW services.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

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

COLLABORATIVE PARTNERS/ROLE:

1. Carroll County Health Unit / Program Staffing
2. Eureka Springs Homeless Shelter / Security

PROGRAM 2: Ride Sharing / Coordination Development

PROGRAM DESCRIPTION:

Expanding transportation capacity in our region is critical. Mercy looks to leverage Lyft (ride-share platform) and OATS (LINC) to ensure patients have assistance returning home from the emergency department and arriving/returning from scheduled clinical appointments. Current efforts to coordinate and track transportation needs has been MO Rides – state-wide transportation resource.

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

1. Identify patients with barriers to transportation for medical purposes
2. Coordinate patient rides through Lyft Concierge platform and LINC program
3. Communicate with community to recruit/expand drivers available
4. Discuss future strategy and tracking capacity with MO Rides

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

1. Appointment No Show Rates Decrease
2. Emergency Department Throughput
3. Reduced Emergency Department Utilization

PLAN TO EVALUATE THE IMPACT:

1. Number of Emergency Department Rides Provided
2. Number of Clinic Appointment Rides Scheduled
3. Number of Clinic Appointment Rides Provided
4. Number of Patients Served
5. Number of rides requested through MO Rides

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Funding for Initial Lyft Rides
2. Funding for LINC Rides
3. Care Coordination Platform
4. Riding Scheduling Assistance Co-worker

COLLABORATIVE PARTNERS:

1. Lyft
2. MO Rides
3. OATS (LINC)
4. Saint Louis Crisis Nursery
5. Compass Health
6. Lincoln County Economic Development

III. Other Community Health Programs

Mercy Lincoln 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	Air Power Lung Support Group	Persons served
	Diabetes Support Group	Persons served
	Dialysis services for indigent patients	Persons served, cost of services
	Community Health Fairs & Screenings	Persons served
	Community health education talks	Persons served
	Healthy for Life	Persons served
	Hospital medication assistance program	Persons served
	Transportation assistance programs	Persons served, cost of services
Health Professions Education	Internal Medicine Residency Program	Number of residents
	Health professions student education – nursing, imaging, therapy, pharmacy, medical student, lab, emergency medical technician, and advanced practice nursing	Numbers of students
Financial and In-Kind Contributions	First Aid and EMS Standby for community walks and runs	Cost of services
Community Building Activities – Workforce Development	Bentonville High School Ignite Program	Number of students

	M.A.S.H. program for high school students	Number of students
	Teen and college student volunteer programs	Number of students
Community Building Activities – Environmental Improvements	Mercy Trails Project	Cost of project

IV. Significant Health Needs Not Being Addressed

A complete description of the health needs prioritization process is available in the CHNA report. Two health issues identified in the 2022 CHNA process—health education and internet access —were not chosen as priority focus areas for development of the current Community Health Improvement Plan due Mercy's current lack of resources available to address these needs and the intention to focus on the three prioritized health needs. These issues will be addressed indirectly in implementation strategies developed to meet the prioritized needs in areas that may overlap. For example, efforts to improve behavioral health care access could improve internet access through virtual programs. Additionally, related community partnerships, evidence-based programming, and sources of financial and other resources will be explored during the next three-year CHIP cycle. Mercy Lincoln will consider focusing on these issues should resources become available. Until then, Mercy Lincoln will support, as able, the efforts of partner agencies and organizations currently working to address these needs within the community.

NOTES:

Mercy
14528 S. Outer Road
Chesterfield, MO 63107
314.579.6100

Mercy

Your life is our life's work.