Community Health Improvement Plan

Mercy Hospital Washington

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 4
II. Implementation Plan by Prioritized Health Need 5
    Prioritized Need #1: Mental Health / Substance Use
    Prioritized Need #2: Obesity
    Prioritized Need #3: Housing Instability
III. Other Community Health Programs Conducted by the Hospital 12
IV. Significant Community Health Needs Not Being Addressed 14

I. Introduction

Mercy Washington completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors in June 2022. 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 Washington. The CHNA identified four prioritized health needs the hospital plans to focus on addressing during the next three years: Housing Instability, Substance Use/Mental Health, and Obesity. The complete CHNA report is available electronically at mercy.net/about/community-benefits.

Mercy Washington is a 100-bed acute-care hospital located in Washington, 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 Needs Assessment (CHNA), the community served by Mercy Washington will be defined as the four-county Washington region made up of Franklin, Crawford, Gasconade, and Warren Counties.

This three-year Community Health Improvement Plan (CHIP), aimed at addressing the prioritized health needs identified in the CHNA, will guide the coordination and targeting of resources, and the planning, implementation and evaluation of both new and existing programs and interventions. The 2022 CHNA and this resulting CHIP will provide the framework for Mercy Washington 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: Mental Health / Substance Use

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

PROGRAM 1: 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 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 ERE intervention partners.
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: • Track number of program referrals. (Output) • Track number of appointments scheduled. (Output) • 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 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)
- Compass Health
- Franklin County Health Department

Goal 2: Integrate behavioral health specialists into primary care services.

PROGRAM 2: 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.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

- By the end of FY23, the initiative will go live in Mercy primary care clinics.

Medium-Term Outcomes:

- By the end of FY24, 400 referrals will have been made to Concert Health, and 200 patients will have 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: Provide navigation, treatment, and companionship for members with substance use disorder.

PROGRAM 3: Certified Peer Specialist (CPS) Program
PROGRAM DESCRIPTION: The Certified Peer Specialist program connects adults living with or at risk for substance use disorder or co-occurring disorder to Medication Assisted Treatment (MAT) services, behavioral therapies, recovery support services, and psychosocial services in coordination with Certified Peer Specialists—people who have been successful in the recovery process who help others experiencing similar situations.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Develop referral pathway to Certified Peer Specialist 2. Create awareness campaign for providers and co-workers 3. Increase X-waivered providers to assist in MAT services
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): 1. Refer to appropriate treatment facility for recovery journey 2. Continued engagement for finding employment 3. Reduced recovery relapse and overdoses
PLAN TO EVALUATE THE IMPACT: 1. Track number of patient referrals to program 2. Track patient program satisfaction 3. Track specific life improvements (i.e. employment, housing, childcare)
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Marketing assistance and materials 2. Community Health Worker patient assistance
COLLABORATIVE PARTNERS/ROLE: 1. Foundations For Franklin County 2. HOPE for Franklin County Coalition 3. Franklin County Treatment Court 4. Franklin County Health Department 5. Freedom Center for Recovery 6. Local Ambulance Districts

PROGRAM 4: Mercy Substance Use Recovery Clinic

PROGRAM DESCRIPTION: Substance Use Recovery clinics in Cuba and Union to treat patients who are struggling with opiate, substances and alcohol recovery. We safely provide medication assisted treatment (MAT) with oral and injectable options to stabilize patients as they recover. The clinics also provide counseling and motivational sessions for patients to remain on the right path.

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

1. Communicate out to various partners for community awareness
2. Provide care team with resources to address clinical and non-clinical needs
3. Refer to significant programs for holistic treatment

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

1. **Comprehensive treatment for patients with substance use disorder**
2. **Safe stabilization during withdrawal process**
3. **Hope and healing for people struggling with substance use disorder**
4. **Appropriate utilization of healthcare resources**

PLAN TO EVALUATE THE IMPACT:

1. Track patients served in clinic
2. Track number of visits scheduled
3. Track type of medical interventions
4. Track patients visit engagement (visit show-rate)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Staff and provider compensation
2. Infrastructure/Space maintenance
3. Marketing materials for communication
4. Community Health Worker assistance
5. Medication Assistance

COLLABORATIVE PARTNERS/ROLE:

1. Prevent+Ed
2. Franklin County Health Department
3. Foundations for Franklin County
4. Preferred Family Health
5. Franklin County Treatment Court

Prioritized Need #2: Obesity

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

PROGRAM 1: **Community Health Worker Program**
PROGRAM DESCRIPTION: Community Health Workers (CHWs) serve as liaisons/links between health care and community and social services, screening for needs related to social determinants of health, and facilitating access to services and improving the quality and 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. Franklin County Community Resource Board
2. Local St. Vincent de Paul Societies
3. Compass Health
4. Prevent+ED
5. Foundations for Franklin County

PROGRAM 2: **Jump into Health – School Programming**

PROGRAM DESCRIPTION: Jump into Health builds a baseline knowledge of the importance of a healthy lifestyle in elementary school-aged children. Health educators will provide lesson plans based on prevention and health lifestyle education. Students will be awarded for high levels of engagement.

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

1. Create up-to-date lesson plans, handouts, and activities
2. Re-start program 2023 school year
3. Make an updated pre and posttest to evaluate the effectiveness of the lesson plans provided
4. Obtain prizes to provide throughout the program
5. Obtain a bicycle to donate to one student in each participating classroom for the end of the program drawing

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

1. Improved student choices around diet and nutritional intake
2. Improved student outlook, attitude, and knowledge of a healthy lifestyle
3. Increased physical activity throughout school year

PLAN TO EVALUATE THE IMPACT:

1. Track pre- and post-BMI
2. Track physical activity
3. Track course attendance
4. Track pre- and post-test on course content

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Registered Dietitian
2. Education Coordinator
3. Course materials
4. Program engagement awards

COLLABORATIVE PARTNERS:

1. School District of Washington Nursing
2. Revolution Cycles
3. Washington Parks and Recreation Department
4. Washington YMCA

PROGRAM 3: **Healthy Shelves – Food Pantry Assistance**
PROGRAM DESCRIPTION: The Healthy Shelves program includes various activities to improve food pantries to provide healthier food and become a hub for health improvement activities. These include food availability and consumption, food pantry development and food acquisition and distribution.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. *To be determined based on further program development*
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): 1. *To be determined based on further program development*
PLAN TO EVALUATE THE IMPACT: 1. *To be determined based on further program development*
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. *To be determined based on further program development*
COLLABORATIVE PARTNERS: 1. MU Extension Office 2. Loving Hearts 3. Washington Farmers Market 4. Others based on further program development

Prioritized Need #3: Housing Instability

Goal 1: Provide support for unhoused community members to transition into sustainable housing.

PROGRAM 1: Life's River: Housing Support Center
PROGRAM DESCRIPTION: Life's River will assist underserved families within the community to find permanent, sustainable housing. The organization will provide employment assistance, household essential training, and other important programs for transitioning the fragile families into more stable living.
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. 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 Life's River 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 (Public Safety) 3. Medication Assistance (Pharmacy)
COLLABORATIVE PARTNERS/ROLE: 1. United Way of Franklin County Area 2. Franklin County Community Resource Board 3. Harvest Table 4. Local Police Departments 5. Missouri Job Center

PROGRAM 2: Vital Documents Programming
PROGRAM DESCRIPTION: Vital documents are integral for finding employment, housing and other essential life functions. Creating a formal assistance program to ensure underserved patients are able to obtain these resources remains necessary.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Help with financial cost of obtaining vital documents 2. Assistance with navigation and processes of obtaining documents 3. Educating on use and importance of documents
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): 1. Enhanced community employment opportunities 2. Improved civic engagement (voting) 3. Stabilized shelter options off street and out of tent
PLAN TO EVALUATE THE IMPACT: 1. Track number of referrals to this ID document program 2. Number of IDs obtained 3. Number of patients then connected to housing and employment options
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Healthcare Career Pipeline 2. Marketing / Communication materials 3. Volunteer and Staff Assistance
COLLABORATIVE PARTNERS: 1. Foundations for Franklin County 2. Franklin County Community Resource Board 3. Local Churches 4. Scenic Regional Library

III. Other Community Health Programs

Mercy 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: 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**
Community Health Improvement Services	Diabetes Education
	Dialysis services for indigent patients
	Community Health Fairs & Screenings
	Community health education talks
	Dispensary of Hope
	Transportation assistance programs
	New Mom and Breastfeeding Support Group
	Car Seat Safety Check
Health Professions Education	Internal Medicine Residency Program
	Health professions student education – nursing, imaging, therapy, pharmacy, medical student, lab, emergency medical technician, and advanced practice nursing
Financial and In-Kind Contributions	First Aid and EMS Standby for community walks and runs
Workforce Development	Healthcare Academy
	Teen and college student volunteer programs
Environmental Improvements	

IV. Significant Health Needs Not Being Addressed

A complete description of the health needs prioritization process is available in the CHNA report. Three health issues identified in the 2022 CHNA process—transportation assistance, internet access and health education—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 reduce the incidence of obesity in the community may also lead to impactful health education. 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 Washington will consider focusing on these issues should resources become available. Until then, Mercy will support, as able, the efforts of partner agencies and organizations currently working to address these needs within the community.

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