



CommunityHealth Improvement Plan

Mercy Hospital
Fort Smith Arkansas

Fiscal Year 2023-2025



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I. Introduction

Mercy Hospital Fort Smith Arkansas completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors in May 2022. The CHNA considered input from the county health department, community members, members of medically underserved, low-income, and minority populations and various community organizations representing the broad interests of the community of Fort Smith, Arkansas. The CHNA identified three prioritized health needs the hospital plans to address during the next three years: anxiety/depression, obesity/overweight, and smoking/vaping. The complete CHNA report is available electronically at mercy.net/about/community-benefits.

Mercy Hospital Fort Smith is a 336 acute-care hospital located in Fort Smith, Arkansas affiliated with Mercy, a large Catholic health system. Mercy Hospital Fort Smith employs more than 1,885 co-workers (hospital) and 56 primary and specialty clinic locations (Sebastian County, AR): Chaffee Crossing, Cliff Drive, Free Ferry, Hope Campus, McAuley, Fianna Hills, Greenwood, Rogers Avenue Internal Medicine, Dallas Street and Towson Avenue. Mercy Clinic is a physician-governed group practice comprised of 203 board-certified and board-eligible primary caregivers serving the Fort Smith area.

Mercy Fort Smith includes a heart and vascular center, inpatient rehabilitation, outpatient surgery center, neonatal intensive care unit (Level 3A), orthopedic hospital, and emergency department. This provider partnership gives patient access to the best quality care in the country with access to an entire health care team and advances services, including the Breast Center & mobile mammography unit, and the Hembree Cancer Center.

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 Fort Smith as it works in collaboration with community partners to advance the health and quality of life for the community members it serves.

I. Implementation Plan by Prioritized Health Need

Prioritized Need #1: Anxiety/Depression

Goal: Increase access to outpatient behavioral health services.

PROGRAM 1: Concert Health Collaborative Care for Primary Care Physicians
<p>PROGRAM DESCRIPTION: Mercy Fort Smith 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.</p>
<p>ACTIONS THE HEALTH SYSTEM INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ol style="list-style-type: none">1. Consistent with the Behavioral Health Service Line model of care, Mercy Fort Smith will implement the Concert Health Collaboration in primary care clinics.2. Train providers in use of the care approach.3. Promote the initiative.4. Identify gaps in care.
<p>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</p> <ol style="list-style-type: none">1. By the end of FY23, the initiative will go live in all Mercy Fort Smith primary care clinics, and 50 patients will have engaged.2. By the end of FY24, 100 referrals will have been made to Concert Health, and 100 patients will have engaged in collaborative care.3. By the end of FY25, 150 referrals will have been made to Concert Health, and 150 patients will be engaged in collaborative care.4. Patients will have access to community resources through referrals to Community Health Workers.

PLAN TO EVALUATE THE IMPACT:

1. Track number of primary care physicians participating in program.
2. Track number of referrals to Concert Health per month.
3. Track percentage of patients referred to Concert Health who enroll in program (conversion rate).
4. Track number of referrals of uninsured and Medicaid patients per month.
5. 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:

1. Cost of coworker and physician time.
2. Operational budgeted support as appropriate.
3. Indirect expenses related to EMR and clinic operations

COLLABORATIVE PARTNERS:

1. Mercy Behavioral Health Service Line Leadership
2. Mercy Virtual Behavioral health (VBH)
3. Concert Health

PROGRAM 2: Virtual Behavioral Health

PROGRAM DESCRIPTION: Mercy's Virtual Behavioral Health (VBH) program provides integrated, regional support for inpatients and emergency department patients with behavioral health needs. Based out of local and centralized Ministry locations, VBH coworkers 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:

1. Consistent with the Behavioral Health Service Line model of care, Mercy Fort Smith will implement VBH in the ED and hospital.
2. Collaborate with external partners and behavioral health service providers to ensure a strong regional network for care coordination and social service navigation.
3. 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.
4. Analyze true cost of care and return on investment analysis (ROI) for VBH patients and explore prospective for further developing complex care model

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

1. Each year, the VBH program will increase the number of patient assessments completed by 10%.
2. Across the Ministry, the VBH program will maintain a 70% connection to treatment rate.
3. Over a 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:

1. VBH will track assessments and consultations conducted.
2. VBH will track number of patients who are referred to BH resources and connected to appropriate treatment.
3. Mercy will evaluate cost-impact of expanded behavioral health services, including on hospital readmissions.

PROGRAMS AND RESOURCES THE HEALTH SYSTEM PLANS TO COMMIT:

1. Cost of coworker and clinician time.
2. Operational budgeted support as appropriate.
3. Indirect expenses related to EMR and clinic operations

COLLABORATIVE PARTNERS:

1. Mercy Behavioral Health Service Line Leadership
2. Mercy Virtual Behavioral Health (VBH)

PROGRAM 3: Catherine's Light

PROGRAM DESCRIPTION: The Catherine Light program is a collaborative initiative focusing on pregnant mothers and families experiencing medical and/or behavioral health crisis; including but not limited to depression, drug and alcohol abuse, poverty, domestic abuse, and a lack of educational resources. Providers at Mercy OB/GYN office will identify patients in need of extended resources and refer them to a dedicated case worker who will work in collaboration with Community Health Worker to connect patient with resources within Mercy and the greater Fort Smith community. Accessibility, proper treatment, safety, compassion, and education will be the main areas of focus.

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

1. Provide pregnancy and postpartum evaluations.
2. Provide the new families with education and support with community resources.
3. Provide the new mom and/or families with short-term counseling or support groups as needed by patient(s).

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. 20 patients referred to Community Health Worker by Catherine's Light clinic.

Medium-Term Outcomes:

<ol style="list-style-type: none"> 1. Patients receiving services from the program will demonstrate a 25% reduction ED utilization and reduction inpatient admissions. <p>Long-Term Outcomes:</p> <ol style="list-style-type: none"> 1. 10% reduction in low birth rates.
<p>PLAN TO EVALUATE THE IMPACT:</p> <ol style="list-style-type: none"> 1. Track number of patients referred from OB/GYN and Labor and Delivery to Catherine’s Light. (Short-term) 2. Track number of patients referred to Community Health Worker. (Output) 3. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing the program. (Medium-term)
<p>PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:</p> <ol style="list-style-type: none"> 1. Cost of practice manager, behavioral health clinician, and community health worker time. 2. Indirect expenses of clinic.
<p>COLLABORATIVE PARTNERS:</p> <ol style="list-style-type: none"> 1. McAuley Clinic 2. Mercy Foundation Fort Smith 3. Hope Campus 4. Community Rescue Missions

Prioritized Need #2: Obesity/Overweight

Primary Goal: Reduce obesity/overweight through Diabetes Prevention Program.

Secondary Goal: Reduce prevalence of Type II diabetes within the community.

<p>PROGRAM 1: Diabetes Prevention Program</p>
<p>PROGRAM DESCRIPTION: The Diabetes Prevention Program (DPP) is a CDC evidence-based lifestyle change program, led by a trained lifestyle coach, to reduce the risk of developing type 2 diabetes in adults with prediabetes or who are at risk for diabetes.</p>
<p>ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ol style="list-style-type: none"> 1. Publicize the program to primary care physicians and community members. 2. Begin the year-long program with a minimum of 22 sessions to meet CDC recognition. 3. Present 16 modules within the first six months. 4. Maintain a fully recognized DPP program by ensuring that participants meet program goals and data is submitted to CDC as required.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. By end of FY23, the first group participating the first 16-modules.

Medium-Term Outcomes:

1. By end of FY24, the cohort group from FY23 will complete a year-long program.
2. The second cohort group will start in FY24.

Long-Term Outcomes:

1. By end of FY25, a new cohort group will start on year-long program.
2. All previous cohort groups will be monitored for weight loss and HbA1C.

PLAN TO EVALUATE THE IMPACT:

1. Program will comply with CDC guidelines for DPP
2. Program will teach lasting lifestyle changes, rather than simply completing the curriculum
3. Program will emphasize moderate changes in diet and physical activity that leads to 5% to 7% weight loss in the first 6 months
4. DPP coach will discuss strategies for self-monitoring of diet and physical activity, building participant self-efficacy and social support to maintain lifestyle changes, and problem-solving to overcome common weight loss, physical activity, and healthy eating challenges
5. Weigh-in will occur for all participants at each session
6. Provide participants with educational materials to support program goals

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Cost of program coordinator time
2. Financial assistance for uninsured participants.
3. Indirect expenses related to meeting space and overhead.

COLLABORATIVE PARTNERS:

1. Arkansas Department of Health

Goal 2: Reduce overweight/obesity

PROGRAM 2: Cooking Matters

PROGRAM DESCRIPTION: Educational cooking class focusing on the underserved and at-risk populations. Classes vary on topics relevant to healthy, nutritious meals.

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

1. Collaboration with Mercy's dietician to identify at-risk population.
2. Assist at-risk populations with education about healthy cooking and eating.
3. Schedule cooking classes with community groups.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

1. By the end of FY2023, hold at least 2 cooking classes.

2. Connect 10% of attendees with Mercy and community resources (food banks).

PLAN TO EVALUATE THE IMPACT:

1. Track number of people attending each seminar.
2. Track number of people referred to CHW from each seminar. (short-term)
3. Track number of train the trainers and how many classes they are providing.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Cost of coworker's time
2. Equipment, space, and materials for meetings to be successful

COLLABORATIVE PARTNERS/ROLE:

1. Fort Smith Community Health Council
2. Arkansas Department of Health
3. Mercy Dietician/Nutritionist
4. United Way

Prioritized Need #3: Smoking/Vaping

Goal: Increase smoking/vaping education

PROGRAM 1: Health Seminars – AR Dept of Health & Harbor House
PROGRAM DESCRIPTION: Provide education classes for community members with Arkansas Department of Health to reduce smoking and vaping.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: <ol style="list-style-type: none">1. Identify at-risk community members.2. Assist participants with connecting them to educational materials and resources.3. Educate community members about the importance of a healthy lifestyle.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): Short-Term Outcomes: <ol style="list-style-type: none">1. By the end of FY23, host a quarterly health seminar related to smoking/vaping.2. Connect 10% of attendees with Mercy and community resources. Medium-Term Outcomes: <ol style="list-style-type: none">1. 20% increase in knowledge of subject matter based on pre and post-tests. Long-Term Outcomes: <ol style="list-style-type: none">2. Increase attendance to health seminars by 20%.
PLAN TO EVALUATE THE IMPACT: <ol style="list-style-type: none">1. Track number of participants attending each seminar.2. Track number of participants referred to CHW from each seminar.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: <ol style="list-style-type: none">1. Cost of coworker’s time2. Equipment, space, and materials for meetings to be successful
COLLABORATIVE PARTNERS: <ol style="list-style-type: none">1. Fort Smith Community Health Council2. Arkansas Department of Health3. Harbor House4. Local churches

Goal: Smoking cessation program for pregnant mothers-to-be

PROGRAM 2: Be Well Baby
PROGRAM DESCRIPTION: Collaborative program with Arkansas Department of Health, HomeTown Health, providing expectant mothers with tobacco cessation, carbon monoxide monitoring, and smoking cessation incentives.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: <ol style="list-style-type: none">1. Identify pregnant women who are 36-week gestation or less who use tobacco products.2. Provide educational materials regarding Baby Be Well program and smoking cessation.3. Enroll pregnant women into the Baby Be Well program via 10 prenatal and postpartum telephone sessions with a cessation counselor.4. Expectant mother can earn up to \$250 in vouchers for diapers and wipes to be redeemed with Walmart stores and/or Walmart.com
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): <p>Short-Term Outcomes:</p> <ol style="list-style-type: none">1. By the end of FY23, refer 10 pregnant mothers to the Baby Be Well program.2. Connect 10% of attendees with Mercy and community resources. <p>Medium-Term Outcomes:</p> <ol style="list-style-type: none">1. 20% increase in knowledge of subject matter based on pre and post-tests. <p>Long-Term Outcomes:</p> <ol style="list-style-type: none">1. Increase number of mother’s who abstained from smoking at time of baby’s birth.
PLAN TO EVALUATE THE IMPACT: <ol style="list-style-type: none">1. Track number of patients attending referred to Baby Be Well. (Output)2. Track number of patients referred to CHW.3. Track number of patient to Catherine’s Light with additional resources. (short-term)4. Analyze baby birth weight data for cohort of patients utilizing Baby Be Well smoking cessation. (Medium-term)
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: <ol style="list-style-type: none">1. Cost of coworker’s time2. Equipment, space, and materials for meetings to be successful
COLLABORATIVE PARTNERS: <ol style="list-style-type: none">1. Fort Smith Community Health Council2. Arkansas Department of Health3. Local schools and churches4. Catherine’s Light

Goal: Decrease smoking/vaping among teens

PROGRAM 3: Harbor House
PROGRAM DESCRIPTION: Partner with Harbor House to provide educational classes for teenage students in the local school district. The classes will focus on smoking cessation and vaping among teenage students.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: <ol style="list-style-type: none">1. Identify at-risk students.2. Partner with Harbor House to provide smoking cessation seminar for students.3. Assist students with educational resource regarding smoking and vaping.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): <p>Short-Term Outcomes:</p> <ol style="list-style-type: none">1. By the end of FY23, Harbor House and CHW will conduct one health seminar related to smoking and vaping per quarter.2. Connect 10% of attendees with Be Well Arkansas and Hometown Health. <p>Medium-Term Outcomes:</p> <ol style="list-style-type: none">1. 20% increase in knowledge of subject matter based on pre and post-tests. <p>Long-Term Outcomes:</p> <ol style="list-style-type: none">1. Increase attendance to health seminars by 20%.
PLAN TO EVALUATE THE IMPACT: <ol style="list-style-type: none">1. Track number of students attending each seminar.2. Track number of students referred to Be Well Arkansas and HomeTown Health.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: <ol style="list-style-type: none">1. Cost of coworker's time2. Equipment, space, and materials for meetings to be successful
COLLABORATIVE PARTNERS: <ol style="list-style-type: none">1. Fort Smith Community Health Council2. Arkansas Department of Health3. Local schools and churches4. Harbor House

II. Other Community Health Programs

Mercy Fort Smith 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	Flu Shot Clinics	Persons served, cost of services
	Fort Smith Family Literacy Hospital Tour	Persons served, Staff hours
	Mercy Transport Van	Persons served, Staff hours
	Mobile Mammography Van	Persons served, Staff hours
	Prenatal and Childbirth Classes	Persons served, Staff hours
	McAuley Assistance Program	Persons served
Health Professions Education	Health professions student education – nursing, imaging, therapy, pharmacy, medical student, lab, emergency medical technician, and advanced practice nursing	Number of students

Financial and In-Kind Contributions	Donald W. Reynolds Care Support House	Cost of services
	Ronald McDonald House	Cost of services
	Hamilton House	Cost of services
	Good Samaritan Clinic	Cost of services
	United Way	Cost of services

III. 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— pulmonary disease, COVID-19, and heart disease —were not chosen as priority focus areas for development of the current Community Health Improvement Plan. The top three needs described above were far and away the most identified issues or needs by the community. These issues will be addressed indirectly in implementation strategies developed to meet the prioritized needs in areas that may overlap. For example, the Diabetes Prevention program described in this document addresses diabetes as a risk factor for heart disease. Smoking and vaping cessation programs will improve pulmonary diseases. Additionally, related community partnerships, evidence-based programming, and sources of financial and other resources will be explored during this three-year CHIP cycle.

Mercy

14528 S. Outer Road
Chesterfield, MO 63107
314.579.6100



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