Community Health Improvement Plan

Mercy Hospital Northwest Arkansas

Fiscal Year 2019 - 2021

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 Northwest Arkansas (Mercy NWA) completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors in April 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 Northwest Arkansas. The CHNA identified four prioritized health needs the hospital plans to address during the next three years: Access to Care, Behavioral Health, Diabetes/Obesity, and Homelessness. The complete CHNA report is available electronically at mercy.net/about/community-benefits.

Mercy NWA is affiliated with Mercy, a large Catholic health system in the United States. Located in Rogers, Arkansas, Mercy NWA's primary service area spans six counties across Northwest Arkansas and Southwest Missouri. The acute-care hospital has 208 licensed beds, and includes a heart and vascular center, outpatient surgery center, neonatal intensive care unit (Level IIIA), and emergency department. Mercy NWA, the only non-profit hospital in Benton County, is one of the area's largest employers with over 2,400 coworkers. Mercy NWA is in the process of significant expansion to better meet the health care needs of the region. Growth through renovation and construction of primary and specialty clinics, a multispecialty facility in Springdale and a patient tower on Mercy NWA's main campus will create 1,000 additional health care jobs and add over 100 patient beds. The $247 million investment will improve access to excellence in health care, increase economic development, and enhance quality of life throughout the primary service area.

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 NWA 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: Access to Care

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

PROGRAM 1: **McAuley Clinic Without Walls**
PROGRAM DESCRIPTION: McAuley Clinic Without Walls (MCWW) is a program designed to provide primary care to homeless and uninsured patients utilizing Mercy's existing financial assistance policy. A Community Health and Access Coordinator (CHAC) serves as the point of contact for the patients and manages the program.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Identify potential uninsured community members at Samaritan Community Center health screening events and other outreach events. 2. Provide outreach to local homeless shelters with information on the program and services available to uninsured patients. 3. Assist each community member in gathering the required paperwork and completing a Mercy financial assistance application. Submit applications to FA team. 4. Provide assistance to patients in navigating appointment scheduling, transportation, and meeting other needs that may be barriers to accessing care.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. By the end of each fiscal year for the next three years, 50 new uninsured patients will be enrolled in the McAuley Clinic Without Walls program. 2. Each new MCWW patient will establish care with a PCP within six months. 3. The average first appointment show rate for the program will be greater than 85%. ***Medium-Term Outcomes:*** 1. Patients participating in MCWW will utilize USPSTF-recommended preventive services within one year. 2. Patients participating in MCWW will meet with the CHAC twice per year to better manage their health and well-being. ***Long-Term Outcomes:*** 1. Patients participating in MCWW program will have improved health outcomes and health literacy to be better engaged in their health care decisions.
PLAN TO EVALUATE THE IMPACT: 1. Track number of new and renewal applications submitted and approved. (Output) 2. Track total number of first new patient appointments made. (Short-term) 3. Measure first appointment show rates. (Short-term) 4. Tabulate demographic profile of patients served. (Short-term) 5. Review electronic records of MCWW patients to track health care utilization and health outcomes. (Medium and long-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. 50% staff time of Community Health and Access Coordinator.
2. Physician time, staff time, and indirect expenses needed to deliver care.

COLLABORATIVE PARTNERS:

1. Samaritan Community Center
2. Souls Harbor
3. Havenwood
4. Restoration Village
5. Benton County Health Department

PROGRAM 2: **Specialty Clinic Access for Community Clinic Uninsured Patients**

PROGRAM DESCRIPTION: A partnership agreement established in 2016 between Community Clinic NWA, a Federally Qualified Health Center (FQHC), facilitates uninsured patients of the FQHC, once qualified for Mercy financial assistance, to be seen and treated by Mercy specialists in ten different specialties.

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

1. Assist uninsured patients of the FQHC in applying for Mercy financial assistance.
2. Provide appointments for uninsured patients with Mercy specialists.
3. Manage a process to improve transition of care for Community Clinic primary care patients to Mercy specialists.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. By the end of each fiscal year for the next three years, 140 specialty clinic appointments will be made for uninsured patients of the FQHC.
2. At least ten specialty clinics will treat uninsured patients of the FQHC.

Medium-Term Outcomes:

1. Uninsured patients being seen by specialists in this program will obtain necessary follow up care or surgery as determined by treating physician.

Long-Term Outcomes:

1. Uninsured patients being seen by specialists in this program will have improved health outcomes.

PLAN TO EVALUATE THE IMPACT:

1. Number of applications processed. (Output)
2. Number of specialty clinic appointments scheduled. (Short-term)
3. Total number of appointments made by specialty per fiscal year. (Short-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. 10% staff time of Manager-Central Provider Referrals.
2. Physician time, clinic staff time, hospital and clinic indirect expenses.

COLLABORATIVE PARTNERS:

1. Community Clinic Northwest Arkansas

PROGRAM 3: **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):

Short-Term Outcomes:

1. By the end of each month, each CHW will have recorded 20 new and 20 ongoing encounters.
2. 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 10 in Marketplace insurance plans.
3. CHWs will assist patients without a current primary care provider to establish care with a PCP at a Mercy clinic, FQHC, free clinic, or other clinic.
4. Each CHW will assist at least 50 patients per year with community and medication assistance resources.

Medium-Term Outcomes:

1. Patients enrolling in CHW program will demonstrate a 20% reduction in ED utilization and inpatient admissions.
2. Patients enrolling in CHW program will demonstrate a 20% reduction in their total bad debt.

Long-Term Outcomes:

1. Patients enrolling 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 Marketplace insurance plans. (Short-term)

3. Measure number of patients successfully establishing a primary care home. (Short-term)
4. Record number of patients receiving community resource and medication assistance. (Short-term)
5. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing CHW 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 two full-time Community Health Workers.
2. Mileage and travel expenses required for CHW work.
3. Office space and indirect expenses dedicated to CHW work.

COLLABORATIVE PARTNERS:

1. Samaritan Community Center
2. United Way of Benton County
3. Community Clinic Northwest Arkansas
4. Benton County Health Department
5. Hark at the Center for Collaborative Care

Goal 2: Increase access to preventive services for residents of Northwest Arkansas.

PROGRAM: **Samaritan Center Community Health Screens**
PROGRAM DESCRIPTION: A partnership with Samaritan Community Center, a local soup kitchen, food pantry, and community resource center, to provide free health screens to at-risk and uninsured community members in Rogers and Springdale.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Identify potential uninsured community members at the Samaritan Community Center locations in Rogers and Springdale. 2. Perform free blood pressure, blood sugar, blood lipids, and HbA1C screening tests four times per year at each Rogers and Springdale location. 3. Provide brief health education interventions for participants being tested, especially those with abnormal results. 4. Refer participants to local health care providers, assisting participants in obtaining timely appointments if necessary. 5. Refer eligible participants to McAuley Clinic Without Walls (MCWW) program as appropriate.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. Samaritan Center clients will have blood pressure, blood sugar, lipids, and HbA1C tests done during health screening events and results recorded. 2. 50% of clients participating in screening events will be from under-represented minority populations. 3. Referrals to MCWW and appropriate health care providers will be made for all eligible participants at screening events. 4. 50% of clients participating in screening events will receive at least one educational intervention. ***Medium-Term Outcomes:*** 1. 25% of participants in health screening events who do not have a primary care provider will establish care with a PCP in the community. ***Long-Term Outcomes:*** 1. Participants in health screening events will demonstrate increased knowledge of health conditions and risk factors for chronic disease. 2. Participants in health screening events will have improved disease management and health outcomes.
PLAN TO EVALUATE THE IMPACT: 1. Track number of screening events offered. (Output) 2. Track total number of participants and total numbers of screening tests performed. (Output) 3. Measure percentages of screening tests which are abnormal. (Short-term) 4. Tabulate demographic profile of participants served. (Short-term)

5. Record number of participants receiving active assistance with referrals and referred to MCWW . (Short-term) 6. Record number of participants receiving educational interventions. (Short-term)
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Mercy program coordinator and staff time. 2. Laboratory equipment, cartridges, and supplies.
COLLABORATIVE PARTNERS: 1. Samaritan Community Center 2. University of Arkansas

Goal 3: Increase the number of practicing primary care physicians in the NWA region.

PROGRAM: Internal Medicine Residency Program
PROGRAM DESCRIPTION: In partnership with the University of Arkansas for Medical Sciences, Mercy supports the UAMS-NW Community Internal Medicine Residency Program, a three-year training program for medical school graduates in the specialty of internal medicine. The program began in 2016 with its first class of 8 residents and will increase its class size to 11 residents beginning in 2019. A class of 8 transitional year interns will be added in 2020. A criterion for selection to the program is the desire to practice community and/or academic general internal medicine in Arkansas.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Mercy NWA financially supports the residency program, including resident salaries. 2. The hospital provides infrastructure and supervision for the majority of the inpatient clinical rotations and training opportunities for the residents.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. By the end of fiscal year 2022, 11 internal medicine residents will have successfully completed the training program. The program will graduate 8 internal Medicine residents in fiscal year 2020 and 2021. 2. Internal medicine residents will gain exposure and experience in outpatient general internal medicine practice. ***Medium-Term Outcomes:*** 1. Focus of the program is to retain graduating residents and expand access to care in Northwest Arkansas and underserved areas of Arkansas. ***Long-Term Outcomes:*** 1. Number of practicing primary care physicians in NWA will increase.
PLAN TO EVALUATE THE IMPACT: 1. Record total numbers of residents enrolled in internal medicine residency program annually. (Short-term) 2. Record number of residents graduating from the program annually. (Short-term) 3. Track post-graduation plans of graduating residents annually. (Medium-term)
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Staff and physician salaries. 2. Indirect expenses related to graduate medical education and training. 3. Travel scholarships to support rotations in the Marshall Islands in order to better understand and appreciate health issues affecting this population which has a significant presence in NWA.
COLLABORATIVE PARTNERS: 1. University of Arkansas for Medical Sciences Northwest 2. Veterans Health Care System of the Ozarks

Goal 4: Increase access to forensic exams by victims of sexual assault in NWA.

PROGRAM: Regional SANE Coordinator

PROGRAM DESCRIPTION: A partnership with three Northwest Arkansas advocacy centers to provide coordination, collaboration, and oversight of Sexual Assault Nurse Examiners (SANEs) providing forensic examinations to adult and child victims of abuse. These nurses play a vital role in ensuring victims' proper medical care and that evidence is preserved for prosecution.

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

1. The Regional SANE Coordinator will oversee the work of all Sexual Assault Nurse Examiners providing care to victims of assault at the three NWA advocacy centers, building and maintaining a coordinated SANE program to collectively serve the forensic needs of Northwest Arkansas.
2. The Regional SANE Coordinator will maintain a roster of trained SANE nurses to do exams at all three centers as well as copies of annual contractual agreements, malpractice insurance, and ongoing continuing education records.
3. The Regional SANE Coordinator will provide ongoing training to hospital staff and nurses in handling sexual assault cases and develop protocols for evaluation and referral of victims of assault presenting to area hospitals and health care facilities.
4. Regional SANE Coordinator will work with statewide support agencies (CACs of Arkansas, Arkansas Coalition Against Sexual Assault, Arkansas Commission Against Child Abuse, Rape and Domestic Violence) to provide guidance and support for programs as able.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. By the end of each fiscal year, a sufficient number of new nurses will have been trained to maintain a fully staffed SANE program.
2. Provide coverage for all medical exams at each of the three advocacy centers to ensure access to exams for victims of sexual assault.
3. By the end of the next fiscal year, complete an MOU with each NWA hospital covered by the SANE program.
4. Maintain partnership with Walgreens pharmacies to provide free HIV post-exposure prophylaxis (PIP) to patients in need.

Medium-Term Outcomes:

1. NWA law enforcement professionals will be satisfied with the processes and procedures for SANE exams in NWA.
2. Victims of sexual assault will be screened and treated in timely manner, maintaining their dignity.

Long-Term Outcomes:

1. Compassionate, timely care for all victims of sexual assault in NWA.

PLAN TO EVALUATE THE IMPACT:

1. Track number of established nurses and number of new nurses trained per fiscal year. (Short-term)

2. Track total number of medical exams performed by SANE nurses in NWA each year. (Short-term)
3. Record completed MOUs with hospitals. (Short-term)
4. Track number of patients per year receiving free PIP. (Short-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Fringe benefits for Regional SANE Coordinator.
2. Office space and indirect expenses for program needs.

COLLABORATIVE PARTNERS:

1. Children's Advocacy Center of Benton County
2. Children's Safety Center
3. NWA Center for Sexual Assault

Prioritized Need #2: Behavioral Health

Goal: Increase access to outpatient behavioral health services for uninsured and at-risk persons.

PROGRAM 1: **Charitable Behavioral Health Services**
PROGRAM DESCRIPTION: Many uninsured and underinsured patients being seen by mental health providers need counseling and therapy services but are unable to afford them. This program provides free counseling sessions by LCSW interns under the supervision of staff mentors to patients in need.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Identify uninsured and underinsured patients in need of therapy services and offer them services of the program. 2. Schedule participating patients with LCSW interns for counseling sessions utilizing a special code to ensure that no bill is generated. 3. Provide mentoring and supervision of the LCSW interns by staff therapists, psychologists, and psychiatrists. 4. Utilize staff social worker to assist patients in meeting other needs related to social determinants of health and identifying appropriate community resources.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. 200 hours of counseling will be provided by LCSW interns each quarter. 2. Interns participating in the program will improve their counseling skills as demonstrated in their evaluation processes. ***Medium-Term Outcomes:*** 1. 50% of patients participating in the program will demonstrate clinical improvement in their conditions based on and decreased health care utilization. ***Long-Term Outcomes:*** 1. Community mental health measures, such as depression and suicide rates, will improve.
PLAN TO EVALUATE THE IMPACT: 1. Track number of interns providing services. (Output) 2. Track total number of counseling hours provided. (Short-term) 3. Maintain documentation of intern evaluations by their preceptors. (Short-term) 4. Review electronic records of patients participating in the program to track progress of clinical conditions health care utilization and health outcomes. (Medium and long-term)
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Mental health provider time dedicated to supervising and mentoring interns. 2. Manager time coordinating the program. 3. Staff time, office space and other indirect expenses needed to deliver care.

COLLABORATIVE PARTNERS:

1. John Brown University
2. University of Arkansas

PROGRAM 2: **Psychiatry Primary Care Support**

PROGRAM DESCRIPTION: Mercy NWA psychiatrists devote a specific number of hours per week supporting primary care physicians in caring for patients with mental health issues. Psychiatrists are assigned to a specific cohort of primary care physicians and make themselves available for phone and electronic consultations.

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

1. Mercy will support its integrated adult psychiatrists in dedicating approximately 1 hour per week to activities related to clinical support of primary care physicians.
2. Primary care physicians and staff will be educated in use of this program.
3. Epic SmartPhrase will be developed for use by primary care physicians requesting assistance in patient care.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. By the end of the fiscal year, 3 adult psychiatrists and 1 psychiatric nurse practitioner will be participating in the program.
2. By the end of the fiscal year, all primary care physicians will have received education and information about the program.
3. 4 hours of physician time per month per physician will be committed to this program.

Medium-Term Outcomes:

1. Measurable medium-term outcomes will be developed by end of first year of the program.

Long-Term Outcomes:

1. Patients with mental health conditions will experience improved mental health.

PLAN TO EVALUATE THE IMPACT:

1. Track number of psychiatrists and primary care physicians participating in program per fiscal year. (Short-term)
2. Track number of psychiatrist hours dedicated to program. (Short-term)
3. Track number of patients assisted by the program. (Short-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Psychiatrist and program coordinator time.
2. Indirect expenses related to EMR and clinic operations.

COLLABORATIVE PARTNERS:

1. Primary care division of Mercy NWA clinic physicians.

PROGRAM 3: Behavioral Health Strategic Plan

PROGRAM DESCRIPTION: Mercy NWA will collaborate with community partners to conduct a current assessment of behavioral health services offered, identify any existing gaps and develop a plan to pilot creative collaborative approaches to meet community behavioral health needs.

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

1. Conduct an internal inventory of existing Mercy behavioral health 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 community assessments, resource list inventories and other reports.
4. Identify gaps in service, explore Mercy ministry solutions and other best practice options, and develop a plan to pilot a minimum of one initiative.

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 proposed for pilot initiative(s).

Long-Term Outcomes:

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

PLAN TO EVALUATE THE IMPACT:

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

1. Number of internal behavioral health programs.
2. Numbers of patients and community members served.
3. Analyses of available outcomes data, for example, utilization, readmission, and change in contribution margin.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Cost of coworker time.
2. Operational budgeted support as appropriate.
3. Grant funding as possible.

COLLABORATIVE PARTNERS:

1. To be determined based on pilot program(s) proposed.

Prioritized Need #3: Diabetes/Obesity

Goal: Decrease the prevalence of pre-diabetes and diabetes in Northwest Arkansas.

PROGRAM: Diabetes Prevention Program
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. Program began in January 2017 and achieved full CDC recognition in June 2018.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Conduct the year-long program consisting of 26 class sessions, offering various class times and meeting locations to meet the needs of the participants. 2. Maintain a roster of trained lifestyle coaches to offer the program. 3. Publicize the program to primary care physicians and community members. 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. 50 new participants per fiscal year will enroll in the program and complete the first 4 sessions. 2. Retention rate for participants attending at least 4 sessions will be greater than 60%. 3. Average weight loss for participants completing the program will be at least 5%. 4. Percent of participants completing program who have achieved at least 150 minutes of physical activity/week will be at least 70% ***Medium-Term Outcomes:*** 1. 60% of participants completing the program will reduce their HbA1C or fasting glucose levels to normal. ***Long-Term Outcomes:*** 1. Rates of diabetes and prediabetes will be reduced in Northwest Arkansas.
PLAN TO EVALUATE THE IMPACT: 1. Track number of new participants who enroll in the program and complete the first 4 sessions in each fiscal year and cumulative total since program inception. (Output) 2. Track number of participants who have completed their first of year of the program in each fiscal year and cumulative total since program inception. (Output) 3. Track the program cumulative retention rate for participants completing the first 4 sessions. (Short-term) 4. Track the percent of participants annually receiving partial or full financial assistance to cover program costs. (Short-term) 5. Calculate and record the average weight loss for all participants under the NWA DPRP recognition code completing the program who have attended at least 3 or more sessions and had a time span between the 1st and last session of at least 9 months (consistent with CDC-reported program data). Report this outcome in December and

June of each year (number of participants included in measure and % weight loss). (Short-term)

6. Record the percent of participants completing their first year of the program in the fiscal year who have achieved at least 150 minutes of physical activity/week. (Short-term)
7. Record the percent of participants completing their first year of the program each fiscal year who have reduced their HbA1C or fasting glucose to normal levels. (Medium-term)
8. Calculate changes in HbA1C levels for participants completing their first year of the program each fiscal year (Medium-term):
    a. Average beginning HbA1C
    b. Average ending HbA1C
    c. Average percent change in HbA1C
9. Calculate changes in fasting glucose levels for participants completing their first year of the program each fiscal year (Medium-term):
    a. Average beginning fasting glucose
    b. Average ending fasting glucose
    c. Average percent change in fasting glucose

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Cost of program coordinator time (grant offset).
2. Financial assistance for participants unable to afford the cost of the program.
3. Indirect expenses related to meeting space and overhead.

COLLABORATIVE PARTNERS:

1. Arkansas Department of Health

Prioritized Need #4: Homelessness

Goal 1: Decrease food insecurity among homeless persons in Northwest Arkansas.

PROGRAM: Motel Meal/Outreach Program
PROGRAM DESCRIPTION: Weekly meal outreach program to homeless residents of a local motel and near-homeless individuals and families in partnership with numerous community groups. Program is intended to provide meals, connections for residents to community resources, and provide personal relationships and engagement with a stable group of volunteers. Program began as a response to significant number of child abuse cases reported at a motel.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Facilitate community coalition of multiple churches, nonprofit organizations, and businesses in providing weekly meals on a schedule. 2. Maintain a group of community partners and hospital coworkers and departments to participate in program. 3. Assist motel residents in connecting to community resources to meet unmet needs.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. Serve 75 meals per week. 2. Maintain sufficient community partners and churches to sustain program (20). ***Medium-Term Outcomes:*** 1. Increase by 10% number of community partners and churches. ***Long-Term Outcomes:*** 1. Homeless residents of local motels will have improved safety and quality of life.
PLAN TO EVALUATE THE IMPACT: 1. Track number of days per fiscal year meals are served. (Output) 2. Track total number of individual meals served per fiscal year. (Output) 3. Track total number of community partners and churches involved in the program per fiscal year. (Short-term)
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Program coordinator and staff time 2. Cost of meals provided by Mercy hospital
COLLABORATIVE PARTNERS: 1. Hark at the Center for Collaborative Care 2. Children's Advocacy Center of Benton County 3. Restoration Village 4. Many NWA area churches, nonprofit organizations, and businesses participating in the program.

Goal 2: Reduce homelessness in Northwest Arkansas.

PROGRAM 1: Direct Assistance to Homeless Families
PROGRAM DESCRIPTION: Grant-funded financial assistance to homeless and near-homeless families with the goal of establishing or maintaining permanent housing. Homeless families in need are identified primarily through the motel meal/outreach program. Volunteer mentors participate in the program as mentors.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Mentor individuals and families identified through outreach programs in finding and maintaining permanent housing. 2. Apply grant funds to assist these individuals and families in paying deposits, first month rent, and other expenses.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. Utilize $7,000 per fiscal year of grant money as long as available for financial assistance to homeless and near-homeless families. 2. Assist 1 family per year in obtaining a donated car. ***Medium-Term Outcomes:*** 1. Assist ten families per year in moving out of homelessness. ***Long-Term Outcomes:*** 1. Families assisted will have improved safety and quality of life. 2. Rates of homelessness will decrease in Northwest Arkansas.
PLAN TO EVALUATE THE IMPACT: 1. Track number of people and families assisted financially per fiscal year. (Output) 2. Track number of volunteer mentors participating in the program per fiscal year. (Output) 3. Track total amount of grant-funded financial assistance provided per fiscal year. (Short-term) 4. Track total number of donated cars provided to homeless families per fiscal year. (Short-term) 5. Track total number of families moved out of homelessness per fiscal year and since the inception of the program. (Medium-term)
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Program coordinator time 2. Indirect expenses related to managing grant funding for program.
COLLABORATIVE PARTNERS: 1. Hark at the Center for Collaborative Care 2. Endeavor Foundation 3. Bob Maloney Auto 4. Many NWA churches and nonprofits participating in the program.

PROGRAM 2: Affordable Housing Initiative

PROGRAM DESCRIPTION: Planning has begun for a potential local affordable housing project financed by Low Income Tax Credits (LIHTC). The current proposal is for Mercy to donate or lease land at a nominal rate to the project and/or help facilitate a savings in total land purchased/donated in order to ensure reasonable cost for the project. Mercy staff will be involved in planning and implementing the project.

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

1. Convene collaborative of interested parties to explore and develop plans for the project.
2. Evaluate possible land donations for the project.
3. Participate in planning and development of project goals and objectives.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Project plan developed by the end of FY21.
2. Suitable land identified, and lease agreement developed subsequent to plan development.

Medium-Term Outcomes:

1. Application submitted for LIHTC to state of Arkansas by appropriate deadline.
2. Construction plan developed and initiated if LIHTC application successful.

Long-Term Outcomes:

1. Increase in affordable housing units available in NWA.
2. Reduction of homelessness in NWA.

PLAN TO EVALUATE THE IMPACT:

1. Track progress of project development.
2. Establish specific land available for donation to project.
3. Establish project timeline.
4. Monitor status and outcome of LIHTC application.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Coworker time and indirect expenses related to project planning and implementation.
2. Land donation for project.

COLLABORATIVE PARTNERS:

1. Endeavor Foundation
2. Strategic Realty
3. Mercy Housing

III. Other Community Health Programs

Mercy NWA 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
	Flu vaccines	Persons served
	Healthy for Life	Persons served
	Hospital medication assistance program	Persons served
	Safe Kids Northwest Arkansas	Persons reached
	Transportation assistance programs	Persons served, cost of services
Health Professions Education	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. Three health issues identified in the 2019 CHNA process—heart disease, cancer, and substance abuse—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 four 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 type 2 diabetes in the community may also reduce the incidence of heart disease. 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 NWA will consider focusing on these issues should resources become available. Until then, Mercy NWA will support, as able, the efforts of partner agencies and organizations currently working to address these needs within the community.

NOTES:

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Your life is our life's work.