Community Health Improvement Plan

Mercy Hospital Northwest Arkansas

Fiscal Year 2023-2025

Your life is our life's work.

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: Access to Care
Prioritized Need #2: Behavioral Health
Prioritized Need #3: Diabetes/Obesity/Nutrition
Prioritized Need #4: Food Insecurity
III. **Other Community Health Programs Conducted by the Hospital** 16
IV. **Significant Community Health Needs Not Being Addressed** 17

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 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 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/Nutrition, and Food Insecurity. 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 245 licensed beds, and includes an ambulatory surgery center, two free-standing emergency departments, outpatient rehabilitation and therapy services, and multiple primary care and specialty clinics. Mercy NWA, the only non-profit hospital in Benton County, is one of the area's largest employers.

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 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: **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, 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 Medicaid and financial assistance and connecting patients with community resources and medication assistance.
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 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 80 patients in Mercy financial assistance 10 in Medicaid 3. Each CHW will assist at least 100 patients per year with community and medication assistance resources. 4. Patients enrolling in CHW program will demonstrate reduced ED utilization. 5. Patients enrolling in CHW program will demonstrate a reduction in their total cost of care. 6. Clinic patients enrolling in CHW program will demonstrate reduced no-show rate for follow-up clinic appointments.
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 and Medicaid.

3. Track number of patients receiving community resource and medication assistance.
4. Analyze ED utilization clinic no-show rates for patients enrolled in CHW program.
5. Analyze total cost of care for patients enrolled in CHW program.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Compensation and benefits for 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. University of Arkansas for Medical Sciences Northwest
2. Community Clinic Northwest Arkansas
3. Benton County Health Department
4. Samaritan Community Center

PROGRAM 2: **Medication Assistance Program**

PROGRAM DESCRIPTION: Partnership with Debbie's Family Pharmacy to provide uninsured patients being discharged from the hospital with initial needed medications and supplies. Funded by donations to Mercy Foundation for needy and indigent patients who must meet established Mercy eligibility criteria. Program began November 2021.

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

1. Identify uninsured and at-risk patients being discharged from Mercy hospital who are unable to afford their discharge medications.
2. Coordinate prescribing and delivery of medications to patients.
3. Refer medication assistance patients to a Community Health Worker (CHW) to assist patients without an established primary care provider in establishing care with a primary care clinic or provider.
4. CHW will screen patients for needs related to social determinants of health and connect patients to community resources to meet identified needs.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

1. At least three patients will receive medication assistance each month.
2. $1000 of medication assistance will be provided to patients each month.
3. All medication assistance patients will be referred to a CHW.

PLAN TO EVALUATE THE IMPACT:

1. Track number of patients assisted, number of prescriptions filled, and cost of prescriptions provided.
2. Track referrals to CHWs and outcomes of those referrals.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Indirect expenses related to managing program.
2. Compensation and benefits for Community Health Workers.
3. Medication costs are reimbursed by Mercy Foundation.

COLLABORATIVE PARTNERS:

1. Debbie's Family Pharmacy

Goal 2: 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 now enrolls 12 residents per year. 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): 1. By the end of each fiscal year, 12 internal medicine residents will successfully complete the program. 2. Internal medicine residents will gain exposure and experience in outpatient general internal medicine practice. 3. Retain graduating residents and expand access to care in Northwest Arkansas and underserved areas of Arkansas. 4. Increase number of practicing primary care physicians in NWA.
PLAN TO EVALUATE THE IMPACT: 1. Record total numbers of residents enrolled in internal medicine residency program annually. 2. Record number of residents graduating from the program annually. 3. Track post-graduation plans of graduating residents annually.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Staff and physician salaries. 2. Indirect expenses related to graduate medical education and training.
COLLABORATIVE PARTNERS: 1. University of Arkansas for Medical Sciences Northwest 2. Veterans Health Care System of the Ozarks

Goal 3: Increase access to forensic exams for victims of sexual assault and abuse in NWA.

PROGRAM: NWA Forensic Nursing Program
PROGRAM DESCRIPTION: A partnership with three Northwest Arkansas advocacy centers to provide coordination, collaboration, and oversight of Forensic Nurse Examiners (FNEs) providing forensic examinations to adult and child victims of abuse and assault. These nurses play a vital role in ensuring victims' proper medical care and that evidence is preserved for prosecution. Mercy employs a Forensic Nursing Manager whose salary is subsidized by the centers, and provides benefits, expenses, oversight and support for the manager.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. The Forensic Nursing Manager will oversee the work of all Forensic Nurse Examiners providing care to victims of abuse and assault at the three NWA advocacy centers, building and maintaining a coordinated FNE program to collectively serve the forensic needs of Northwest Arkansas. 2. The Forensic Nursing Manager will maintain a roster of trained forensic 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 Forensic Nursing Manager will develop and implement periodic forensic nursing training activities. 4. The Forensic Nursing Manager 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. 5. Connect NWA regional forensic nursing initiatives to relevant state initiatives and state organizations.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): 1. By the end of each fiscal year, a sufficient number of new nurses will have been trained to maintain a fully staffed forensic nursing 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. Victims of sexual assault will be screened and treated in a timely manner, maintaining their dignity.
PLAN TO EVALUATE THE IMPACT: 1. Track number of new nurses trained per year. 2. Track total number of medical exams performed by forensic nurses in NWA monthly. 3. Track total number of hospital-based training sessions completed each year.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Fringe benefits and expenses for Forensic Nursing Manager. 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 primary care patients.

PROGRAM 1: Concert Health Collaborative Care for Primary Care Physicians
PROGRAM DESCRIPTION: Mercy NWA 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: 1. Consistent with the Behavioral Health Service Line model of care, Mercy NWA 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.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): 1. By the end of FY23, the initiative will go live in Mercy NWA primary care clinics. 2. By the end of FY24, 400 referrals will have been made to Concert Health, and 200 patients will have engaged in collaborative care. 3. Increase 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 co-workers 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 NWA 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 20%. 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)

Prioritized Need #3: Diabetes/Obesity/Nutrition

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

PROGRAM 1: 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): 1. 50 new participants per fiscal year will enroll in the program and complete the first 4 sessions. 2. Program retention rate will be at least 60% 3. Average weight loss for participants completing the program will be at least 4%. 4. Percent of participants completing program who have a reduction in HbA1C to normal levels will be at least 50%.
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. 2. Track number of provider referrals to DPP. 3. Track the program retention rate for participants completing the first 4 sessions. 4. 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). 5. 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.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Cost of program coordinator time 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

PROGRAM 2: Corazones Fuertes
PROGRAM DESCRIPTION: Health screening and Spanish-language, culturally relevant heart disease risk factor education programming for Hispanic women and their families living in Northwest Arkansas. The program is a partnership with the American Heart Association and their annual Vestido Rojo event and is proposed to begin in fall 2022.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Conduct screening for HbA1C, lipids, blood pressure, and ASCVD risk factor for participants of fall Vestido Rojo event annually. 2. Develop and deliver post-event educational seminars by physicians and other health experts on cardiovascular disease prevention and meaning of risk assessment numbers, nutrition and cooking, diabetes and prediabetes, physical activity, and stress reduction. 3. Conduct post-program follow-up screening for participants during the last seminar. 4. Connect community members with uncontrolled or high-risk results with timely or urgent care. 5. Assist participants with no PCP in establishing care with a PCP. 6. Connect eligible patients with the National Diabetes Prevention Program.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): 1. 300 community members will receive initial health screens during the annual Vestido Rojo event. 2. 50 community members will enroll in Corazones Fuertes program and complete at least 3 educational seminars. 3. 50% of program participants completing the program will report increased knowledge of nutrition, diabetes, and CVD risk factors. 4. 50% of program participants will report having made at least one significant lifestyle change by the end of the program. 5. 50% of program participants with initial abnormal HbA1C results will demonstrate improvement in HbA1C results at the end of the program. 6. 50% of program participants with initial abnormal blood pressure results will demonstrate improvement in blood pressure at the end of the program. 7. Community members with uncontrolled or high-risk results on health screenings will obtain timely health care.
PLAN TO EVALUATE THE IMPACT: 1. Track number of Vestido Rojo participants screened for HbA1C, lipids, blood pressure, and ASCVD risk score and number of participants screened during the last seminar. 2. Track number of participants attending educational seminars. 3. Administer pre and post-program questionnaires to participants to measure knowledge of nutrition, diabetes, and CVD risk factors; lifestyle change accomplished; and program satisfaction. 4. Measure and calculate changes in HbA1C and blood pressure readings of participants completing the program. 5. Track number of community members with uncontrolled or high-risk results on health screenings who are referred for timely or urgent follow-up care.

6. Track number of program participants with no PCP who are referred to a PCP to establish care.
7. Track number of participants who are referred to and enroll in a National Diabetes Prevention Program class.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Cost of supplies for health screening tests.
2. Cost of coworker time for program planning and implementation.
3. Cost of physician and expert speaker time.
4. Printing and office supplies.

COLLABORATIVE PARTNERS:

1. American Heart Association

Prioritized Need #4: Food Insecurity

Goal: Decrease food insecurity among persons at risk in Northwest Arkansas.

PROGRAM 1: Little Free Pantries

PROGRAM DESCRIPTION: The Little Free Pantry grassroots movement began in Fayetteville, Arkansas in 2013 based on the Little Free Library movement. Participating individuals and organizations host wooden boxes on posts containing food, personal care and paper items accessible to everyone all the time, no questions asked. Mercy coworkers opened the first Little Free Pantry (LFP) at Mercy Clinic Downtown Rogers in 2016. Food and other essentials are supplied by volunteer physicians, coworkers, and community members.

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

1. Coordinate the Little Free Pantry program at Mercy hospital and clinic locations.
2. Plan and conduct hospital-wide food drives to replenish LFPs.
3. Build and maintain LFPs at new and existing hospital and clinic locations.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

1. At least nine LFPs remain regularly stocked and available to community members.
2. Community members are aware of LFPs as a community resource for those in need.

PLAN TO EVALUATE THE IMPACT:

1. Track number of active LFPs.
2. Track amount of food obtained through regular food drives.
3. Pilot the tracking of door opening and closing of one LFP location using a counter device.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Cost of coworker time for program planning and evaluation and coordination of regular food drives.
2. Materials and labor for construction and repair of pantry boxes.

COLLABORATIVE PARTNERS:

1. Little Free Pantry. littlefreepantry.org

PROGRAM 2: Food Boxes Program
PROGRAM DESCRIPTION: Food boxes consisting of shelf-stable food for inpatients and outpatients in immediate need of food assistance.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Identify and explore potential community partners for collaboration and development of new program. 2. Identify patients in need of food assistance and supply them with food boxes at no charge. 3. Coordinate with potential community partners for delivery and tracking of food boxes provided to community members.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): 1. At least 50 families in need of food assistance will be provided with food boxes per year.
PLAN TO EVALUATE THE IMPACT: 1. Track number of people and families assisted with food boxes per month. 2. Track gender and race/ethnicity of recipients.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Cost of coworker time for program planning and evaluation and coordination with local community partners.
COLLABORATIVE PARTNERS: 1. Community partners to be identified. 2. Mercy NWA Community Outreach Committee.

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	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
	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

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—affordable housing, COVID-19, and heart disease —were not chosen as priority focus areas for development of the current Community Health Improvement Plan due to 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, the Corazones Fuertes program described in this document addresses diabetes as a risk factor for heart disease. Additionally, related community partnerships, evidence-based programming, and sources of financial and other resources will be explored during this 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.

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