



# CommunityHealth Improvement Plan

Mercy Hospital  
Ozark Arkansas

Fiscal Year 2023-2025



*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 Hospital Ozark's extended service area includes six zip codes, both rural and suburban settings; however, this stands as the main acute care facility within the region drawing from each of the communities served. The CHNA report will focus on Franklin County, where the acute care facility sits. Mercy Hospital Ozark is a 25-bed critical access hospital serving Franklin County. Our primary and specialty care physicians provide high-quality healthcare. Mercy Hospital Ozark has an experienced team of caring professionals, who also happen to be your friends and neighbors.

We are affiliated with Mercy Fort Smith Hospital, a Mercy hospital ranked as one of the nation's top integrated health care providers. Mercy provides skilled nursing care for hospital patients who've had some recovery but aren't quite well enough to return home. If you or a loved one is recovering from a stroke, illness, injury or surgery, our Swing Bed program can provide the skilled nursing and therapy care you need. Our recent 14,700 square foot, \$5 million expansion provides state-of-the-art therapy and rehabilitation services, a community room, and a new space for specialty outreach clinics.

Franklin County was named after Benjamin Franklin. The landscape of Franklin County is rugged terrain in the northern half, and rolling farmlands, forested ridges, and isolated mountains in the south. The county claims the first oil strike in Arkansas and sits on a vast field of coal, clay, iron, shale, and other minerals; however, agriculture is still the main basis of its economy. Altus, AR has grown to be the winemaking capital in Arkansas. Ozark represents small-town living surrounded by mountains, rivers, forests, and lakes. Ozark Lake and Arkansas River provide plenty of fishing opportunities. Aux Arc Park stretches along the river providing a playground, campsites, boat launching ramps and other facilities for the outdoor enthusiast.

# I. Implementation Plan by Prioritized Health Need

## Prioritized Need #1: Anxiety/Depression

**Goal: Increase access to outpatient behavioral health services for primary care patients.**

<b>PROGRAM 1: Concert Health Collaborative Care for Primary Care Physicians</b>
<b>PROGRAM DESCRIPTION:</b> Mercy Hospital Ozark will collaborate with Concert Health to support primary care 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.
<b>ACTIONS THE HEALTH SYSTEM INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</b> <ol style="list-style-type: none"> <li>1. Consistent with the Behavioral Health Service Line model of care, Mercy Hospital Ozark will implement the Concert Health Collaboration in primary care clinics.</li> <li>2. Train providers in use of the care approach.</li> <li>3. Promote the initiative.</li> <li>4. Identify gaps in care.</li> </ol>
<b>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</b> <ol style="list-style-type: none"> <li>1. By the end of FY23, the initiative will go live in Mercy Ozark primary care clinics. And 10 patients will be engaged.</li> <li>2. By the end of FY24, 20 referrals will have been made to Concert Health, and 10 patients will have engaged in collaborative care.</li> <li>3. Increase access to community resources through referrals to Community Health Workers.</li> </ol>
<b>PLAN TO EVALUATE THE IMPACT:</b> <ol style="list-style-type: none"> <li>1. Track number of primary care physicians participating in program.</li> <li>2. Track number of referrals to Concert Health per month.</li> <li>3. Track percentage of patients referred to Concert Health who enroll in the program (conversion rate).</li> <li>4. Track number of referrals of uninsured and Medicaid patients per month.</li> <li>5. Track referrals to Community Health Workers for needs related to social determinants of health by Concert Health.</li> </ol>

**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 Ozark 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)

## Prioritized Need #2: Transportation

**Goal: Decrease barriers to health care for at-risk persons in rural communities.**

**PROGRAM 2: Area Agency on Aging/CHW collaboration**

**PROGRAM DESCRIPTION:** Mercy Hospital Ozark will collaborate with Area Agency on Aging to provide transportation services offered to and from Mercy Hospital Ozark to Mercy Hospital Fort Smith. Community Health Worker will identify at-risk patients to assist them in getting transportation to and from Mercy Hospital Ozark which will act as a transportation hub in the area.

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

1. Community Health Worker is identifying patients who have appointments in Fort Smith.
2. Community Health Worker contacts patient three days before appointment to arrange transportation from Mercy Hospital Ozark to Mercy Hospital Fort Smith.
3. Community Health Worker will increase number of persons who are uninsured to Medicaid with transportation needs.
4. Collaborate with local Ozark Health Council to assist persons to the from their homes to Mercy Hospital Ozark.

**ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):**

**Short-Term Outcomes:**

1. By the end of FY23, Community Health Worker will assist 15 patients to their appointments in Fort Smith.

**Medium-Term Outcomes:**

1. By the end of FY24, Community Health Worker will increase participation 10% above prior year.

<p><b>Long-Term Outcomes:</b></p> <ol style="list-style-type: none"> <li>1. By the end of FY25, Community Health Worker will continue increasing participation 10% above the prior year.</li> </ol>
<p><b>PLAN TO EVALUATE THE IMPACT:</b></p> <p>Impact evaluation approach will be dependent on program piloted. Measurement tools will include, but are not limited to:</p> <ol style="list-style-type: none"> <li>1. Numbers of patients and community members served.</li> <li>2. Total number of transports</li> </ol>
<p><b>PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:</b></p> <ol style="list-style-type: none"> <li>1. Cost of coworker time.</li> <li>2. Operational budgeted support as appropriate.</li> <li>3. Grant funding as possible.</li> </ol>
<p><b>COLLABORATIVE PARTNERS:</b></p> <ol style="list-style-type: none"> <li>1. Area Agency on Aging</li> </ol>

## Prioritized Need #3 & 4: Obesity and Diabetes

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

**Secondary Goal: Reduce prevalence of Type II diabetes within the rural areas.**

<p><b>PROGRAM 1: Diabetes Prevention Program</b></p>
<p><b>PROGRAM DESCRIPTION:</b> Initiate the Diabetes Prevention Program (DPP) program in Logan County (Ozark). The 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><b>ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</b></p> <ol style="list-style-type: none"> <li>1. Publicize the program to primary care physicians and community members.</li> <li>2. Begin the year-long program with a minimum of 22 sessions to meet CDC recognition.</li> <li>3. Present 16 modules within the first six months.</li> <li>4. Maintain a fully recognized DPP program by ensuring that participants meet program goals and data is submitted to CDC as required.</li> </ol>
<p><b>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</b></p> <p><b>Short-Term Outcomes:</b></p> <ol style="list-style-type: none"> <li>1. By end of FY23, we will pilot the first group participating in the first 16-modules.</li> </ol> <p><b>Medium-Term Outcomes:</b></p> <ol style="list-style-type: none"> <li>1. By end of FY24, the first pilot cohort group from FY23 will complete a year-long program.</li> <li>2. By the end of FY24, the second cohort group will have been initiated.</li> </ol>



**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

## II. Other Community Health Programs

Mercy Ozark may conduct other community health programs not linked to a specific prioritized health need. These programs may address a new community health need by improving access to health care services, enhancing the health of the community, advancing health care knowledge, or relieve or reduce government burden to improve health. The need for these programs may come 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.

<b>Community Benefit Category</b>	<b>Program</b>	<b>Outcomes Tracked</b>
Community Health Improvement Services	Just Serve	Persons served
	Harbor House	Persons served

## III. Significant Health Needs Not Being Addressed

A complete description of the health needs prioritization process is available in the CHNA report. Two health issues identified in the 2022 CHNA process— domestic violence, and substance abuse —were not chosen as priority focus areas for development of the current Community Health Improvement Plan. These issues will be addressed indirectly in implementation strategies developed to meet the prioritized needs in areas that may overlap. For example, mental health treatment can assist with substance use and domestic violence. Additionally, related community partnerships, evidence-based programming, and sources of financial and other resources will be explored during this three-year CHIP cycle. Mercy Ozark will support, as able, the efforts of partner agencies and organizations currently working to address these needs within the community.

**Mercy**

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