



CommunityHealth Improvement Plan

Mercy Hospital
Waldron Arkansas

Fiscal Year 2023-2025



Your life is our life's work.

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I. Introduction

Mercy Hospital Waldron 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 Waldron, Arkansas. The CHNA identified four prioritized health needs the hospital plans to address during the next three years: cancer, diabetes, substance use, and mental health. The complete CHNA report is available electronically at mercy.net/about/community-benefits.

Mercy Hospital Waldron is a 24-bed critical access hospital serving Scott County. Our primary and specialty care physicians provide high-quality healthcare. Mercy Hospital's experienced team of caring professionals, who also happen to be your friends and neighbors.

Mercy Hospital Waldron is affiliated with Mercy Hospital Fort Smith, a Mercy hospital ranked as one of the nation's top integrated health care providers. When you need us, you have access to a large team of medical professionals and resources that complement the great care you receive at our hospital in Waldron, AR.

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 Hospital Waldron 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: Diabetes

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

| PROGRAM 1: Diabetes Prevention Program |
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| PROGRAM DESCRIPTION: Initiate the Diabetes Prevention Program (DPP) program in Scott County (Waldron). 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. |
| ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: <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): <p>Short-Term Outcomes:</p> <ol style="list-style-type: none">1. By end of FY23, we will pilot the first group participating in the first 16-modules. <p>Medium-Term Outcomes:</p> <ol style="list-style-type: none">1. By end of FY24, the first pilot cohort group from FY23 will complete a year-long program.2. By the end of FY24, the second cohort group will have been initiated. <p>Long-Term Outcomes:</p> <ol style="list-style-type: none">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

Prioritized Need #2: Cancer

Goal: Increase Cancer Awareness

PROGRAM 1: Health Seminars – AR Dept of Health

PROGRAM DESCRIPTION: Provide education classes for community members with Arkansas Department of Health to reduce smoking and vaping and Cancer prevention.

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

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:**

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:

1. 20% increase in knowledge of subject matter based on pre and post-tests.

Long-Term Outcomes:

1. Increase attendance to health seminars by 20%.

PLAN TO EVALUATE THE IMPACT:

Track number of participants attending each seminar.

1. Track number of participants referred to CHW from each seminar.

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| 2. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing health seminars. (Medium-term) |
| 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: |
| 1. Waldron Health Council |
| 2. Arkansas Department of Health |
| 3. Local schools and churches |

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| PROGRAM 2: Area Agency on Aging/CHW collaboration |
| PROGRAM DESCRIPTION: Mercy Hospital Waldron will collaborate with Area Agency on Aging to provide transportation services offered to and from Mercy Hospital Waldron to Mercy Hospital Fort Smith. Community Health Worker will identify at-risk patients to assist them in getting transportation to and from Mercy Hospital Waldron 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 Waldron 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 Waldron Health Council to assist persons to the from their homes to Mercy Hospital Waldron. |
| 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. |
| Long-Term Outcomes: |
| 1. By the end of FY25, Community Health Worker will continue increasing participation 10% above the prior year. |
| PLAN TO EVALUATE THE IMPACT: |
| Impact evaluation approach will be dependent on program piloted. Measurement tools will include, but are not limited to: |
| 1. Numbers of patients and community members served. |
| 2. Total number of transports |
| PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: |
| 1. Cost of coworker time. |

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| <ol style="list-style-type: none"> 2. Operational budgeted support as appropriate. 3. Grant funding as possible. |
| COLLABORATIVE PARTNERS: <ol style="list-style-type: none"> 1. Waldron Health Council 2. Area Agency on Aging |

Prioritized Need #3: Substance Use

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

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| PROGRAM 1: Waldron Health Council |
| PROGRAM DESCRIPTION: Mercy Hospital Waldron will collaborate with community partners to conduct a current assessment of substance treatment services, identify any existing gaps in access, 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: <ol style="list-style-type: none"> 1. Conduct an internal inventory of existing programs within Mercy. 2. Conduct an external inventory of existing local community services offered by other health systems, non-profits, and for-profit agencies. 3. Review data from any existing community assessments, resource list inventories, and other reports. 4. Identify gaps in service, explore solutions, and develop a plan within the Waldron Health Council. 5. Assist with Guidance Center in adding Peer Recovery Specialist to Waldron Health Council. |
| ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): Short-Term Outcomes: <ol style="list-style-type: none"> 1. By the end of FY23, the internal and external assessments of resources will be completed. Medium-Term Outcomes: <ol style="list-style-type: none"> 1. By the end of FY24, community need gaps will be identified and a plan, including funding support, will be proposed for pilot initiative(s). Long-Term Outcomes: <ol style="list-style-type: none"> 1. By the end of FY25, the pilot plan, if adopted, will be implemented and initial outcome data presented. |
| PLAN TO EVALUATE THE IMPACT: Impact evaluation approach will be dependent on program piloted. Measurement tools will include, but are not limited to: <ol style="list-style-type: none"> 1. Number of internal behavioral/addiction services available. 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: <ol style="list-style-type: none"> 1. Cost of coworker time. |

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| <ul style="list-style-type: none"> 2. Operational budgeted support as appropriate. 3. Grant funding as possible. |
| <p>COLLABORATIVE PARTNERS:</p> <ul style="list-style-type: none"> 1. Harbor House 2. Guidance Center 3. Waldron Health Council 4. Sebastian County Opioid Taskforce |

Prioritized Need #4: Mental Health

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

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| <p>PROGRAM 1: Concert Health Collaborative Care for Primary Care Physicians</p> |
| <p>PROGRAM DESCRIPTION: Mercy Hospital Waldron 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.</p> |
| <p>ACTIONS THE HEALTH SYSTEM INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ul style="list-style-type: none"> 1. Consistent with the Behavioral Health Service Line model of care, Mercy Hospital Waldron 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> <ul style="list-style-type: none"> 1. By the end of FY23, the initiative will go live in Mercy Waldron primary care clinics. And 10 patients will be engaged. 2. By the end of FY24, 20 referrals will have been made to Concert Health, and 10 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 the 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 Waldron 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)

II. Other Community Health Programs

Mercy Waldron 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.

| Community Benefit Category | Program | Outcomes Tracked |
|---------------------------------------|-----------------------------|-------------------------|
| Community Health Improvement Services | Waldron Chamber of Commerce | Persons served |
| | Tyson Foods | Persons served |
| | Mayor's Office | Persons served |
| | Guidance Center | Persons served |

Significant Health Needs Not Being Addressed

A complete description of the health needs prioritization process is available in the CHNA report. One health issue identified in the 2022 CHNA process— COVID-19—was not chosen as priority focus area for development of the current Community Health Improvement Plan. This issue will be addressed indirectly in implementation strategies developed to meet the prioritized needs in areas that may overlap. For example, the Cancer educational seminar shall assist with improving early detection. Additionally, related community partnerships, evidence-based programming, and sources of financial and other resources will be explored during this three-year CHIP cycle. Mercy Waldron 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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