Community Health Improvement Plan

Mercy Hospital Ardmore

Fiscal Year 2023-2025

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 Hospital Ardmore (Mercy Ardmore) completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors in April 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 Ardmore community area. The CHNA identified three prioritized health needs the hospital plans to focus on addressing during the next three years: Access to Care, Behavioral Health, and Food Insecurity. The complete CHNA report is available electronically at mercy.net/about/community-benefits.

Mercy Ardmore is affiliated with Mercy, one of the largest Catholic health systems in the United States. Located in Ardmore, Oklahoma, Mercy Ardmore's primary service area spans six counties across south-central Oklahoma. Mercy Hospital Ardmore is a full-service hospital with 190 licensed beds, more than 700 coworkers and 12 clinic locations, including 4 for primary care. Mercy Clinic is a physician-governed group practice comprised of more than 20 board-certified and board eligible primary care physicians and advanced practice providers serving in the Ardmore area. This provider partnership gives patients access to the best quality care in the country with access to an entire health care team and advanced services. Mercy Clinic physicians have access to an electronic health record that is shared at Mercy facilities in four states. Patients may connect to their own health record and health teams anywhere they connect to the internet through My Mercy.

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 2021 CHNA and this resulting CHIP will provide the framework for Mercy Hospital Ardmore 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 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, 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 using reports and dashboards. 2. Assist uninsured patients in applying 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. Each CHW will assist at least 50 patient per year with community and medication assistance resources. 2. By the end of each fiscal year for the next three years, each CHW will enroll 20 patients in Mercy Financial Assistance, 30 in Medicaid, and 10 in Marketplace insurance plans. 3. 50% of new patients to each CHW without a primary care provider will establish care with a PCP at a Mercy clinic, FQHC, free clinic, or other clinic within 6 months. 4. Patients enrolling in CHW program will demonstrate reduced ED utilization.
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, Medicaid, and Marketplace insurance plans. 3. Measure number of patients successfully establishing a primary care home. 4. Record number of patients receiving community resource and medication assistance. 5. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing CHW services.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Compensation and benefits for full-time Community Health Worker.
2. Office space and indirect expenses dedicated to CHW work.

COLLABORATIVE PARTNERS/ROLE:

1. Mercy Clinics
2. Carter County Health Department

PROGRAM 2: Dispensary of Hope

PROGRAM DESCRIPTION: The Dispensary of Hope is a charitable medication distributor that delivers critical medicine donated by pharmaceutical manufacturers for free to the people who need it the most but cannot afford it. By partnering with Dispensary of Hope, Mercy Pharmacy can get access to their charitable formulary, connecting self-pay patients with the direst financial need to essential medicines across a range of drug classes, including insulins, anti-infectives, and psychotropics.

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

1. In contract with the Dispensary of Hope, Mercy Pharmacy will manage charitable formularies within participating pharmacies, including maintaining inventory and making weekly orders.
2. Mercy will use attestation form to enroll qualifying patients in the Dispensary of Hope program and will promote the formulary with Mercy providers and co-workers across relevant departments, including Hospitalists and ED physicians, Care Management, Diabetes Education, Behavioral Health, and Mercy Clinic.
3. Mercy will communicate with community partners, including other healthcare providers, to promote the use of the formulary for patients in need.
4. Mercy will work to connect qualifying patients with Mercy Financial Assistance and Medicaid and Medicare as applicable.
5. Mercy will standardize Dispensary of Hope processes, including Dispensary of Hope renewal processes, across communities to ensure seamless co-worker and patient experience and to improve patient outcomes.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Set baseline number of 30-day prescriptions filled /month
2. Increase/maintain number of patients served / month
3. Increase/maintain number of patient encounters / month

Medium-Term Outcomes:

1. Increase/maintain the dollars saved for patients by 5% monthly

Long-Term Outcomes:

1. Each year, 10% reduction in ED visits
2. Each year, 10% reduction in total cost of care.

PLAN TO EVALUATE THE IMPACT:

1. Mercy Pharmacy will provide monthly reports on the number of patients served, number of prescriptions filled, and estimated cost savings to patient.

2. Mercy will coordinate with Mercy Decision Support to conduct a yearly utilization analysis to understand the impact of the Dispensary of Hope program on patient readmissions and ED utilization, as well as on financial impact on total cost of care

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Annual contract fees to Dispensary of Hope for formulary access ($12,500 per year per pharmacy)
2. Pharmacist support for formulary management (responsibilities include: monthly and quarterly reports, ordering medications)
3. Marketing and communications support, in the form of flyers, rack cards, enrollment cards, etc.
4. Training for co-workers to understand enrollment process for Dispensary of Hope

COLLABORATIVE PARTNERS:

1. Dispensary of Hope
2. Mercy Pharmacy, Community Health & Access, Care Management, Hospitalists, Mercy Clinics West

PROGRAM 3: Community Pop-Up Clinics Collaboration

PROGRAM DESCRIPTION: In collaboration with the regional Health Department's mobile units, Good Shepherd Community Clinic (FQHC), and City of Ardmore, we will be collaborating to offer uninsured and underinsured patients the opportunity to be seen by a provider at least once a year. A significant number of underserved members of our community can't access care due to transportation or mobility issues, which is why free "pop-up" clinics will be established. These clinics will be hosted in the underserved areas of Ardmore, mainly on the East side of town, including at the local community center.

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

1. Community Health will meet with Mercy Clinic providers to volunteer at the clinic.
2. Help develop program plans with community partners for sustainability.
3. Collaborate with key community partners to obtain support and volunteers for the clinic.
4. Establish financial support system for possible clinic needs.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short Term Outcomes

1. Provide health evaluation to 50% of patients seen in clinic.
2. Connect 20% of uninsured patients with Community Health Worker.

Medium Term Outcomes

1. Screen 75% uninsured patients for SDoH utilizing Basic Needs Questionnaire.
2. Increase insurance coverage of uninsured patient population in the clinic by 10%

Long Term Outcomes

1. Connect patients to Primary Care Providers in the area.
2. Decrease uninsured patient visits to ED.

PLAN TO EVALUATE THE IMPACT:

1. Record number of patient encounters at each clinic.
2. Track number of patient referrals to healthcare services.
3. Track number of patient referrals to community resources.
4. Track number of uninsured patient conversion to Medicaid.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Mercy Community Health and Mercy Clinics will help coordinate medical provider volunteers for events.
2. Mercy Clinics will help provide needed medical equipment
3. Mercy Hospital and Clinics will help cover indirect expenses related to coordination of clinic.

COLLABORATIVE PARTNERS/ROLE:

1. HFV Wilson Community Center
2. Carter County Health Department
3. Good Shepherd Community Clinic
4. City of Ardmore

Prioritized Need #2: Behavioral Health

Goal 1: To increase access to behavioral health services in both the emergency and primary care setting.

PROGRAM 1: vBH- Virtual Behavioral Health

PROGRAM DESCRIPTION: Mercy's Virtual Behavioral Health (vBH) program provides integrated, regional support for 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 HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

1. Operate a hub-based model of virtual care, where clinical vBH co-workers respond to incoming referrals, conduct telephonic behavioral health assessments, and facilitate outgoing referrals for ongoing diagnosis, treatment, and support.
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):

Short-Term Outcomes:

1. Each year, the vBH program will increase the number of patient assessments completed by 20% Ministry-Wide.

Medium-Term Outcomes:

2. Across the Ministry, the vBH program will maintain a 70% connection to treatment rate.

Long-Term Outcomes:

3. Over 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 HOSPITAL PLANS TO COMMIT:

1. Cost of coworker and clinician time, including Regional Resource Behavioral Health RNs and LPNs and Patient RN Advocates.
2. Operational budgeted support as appropriate.
3. Indirect expenses related to EMR and clinic operations

COLLABORATIVE PARTNERS/ROLE:

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

PROGRAM 2: Concert Health Collaborative Care for Primary Care Physicians

PROGRAM DESCRIPTION: Mercy Hospital Ardmore & Clinics 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 Hospital Ardmore 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 Hospital Ardmore Primary Care Clinics.

2. By the end of FY24, 200 referrals will have been made to Concert Health, and 100 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

Prioritized Need #3: Food Insecurity

Goal 1: To increase access to healthy food and resources to patients identified as food insecure by Mercy Hospital Ardmore and Clinics.

PROGRAM 1: Catherine's Pantry Program

PROGRAM DESCRIPTION: Catherine's Pantry Program would be a partnership between Mercy Hospital, Mercy Clinics, Mercy Health Foundation, and the Food and Resource Center of Southern Oklahoma to drive improved health outcomes for patients experiencing food insecurity. Food insecurity is an emerging factor for chronic disease, and although food insecurity on it's own will not relieve adults of their illness, such reductions could make chronic diseases easier to manage thus improving a patient's health and well-being.

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

1. Identify centric area within the hospital and/or clinic to safely maintain food pantry items.
2. Screen patients for food insecurity in both the hospital and clinic settings.
3. Collaborate with internal and external partners to receive weekly/monthly food products and produce for patients.
4. Connect patients with local food-related resources.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. By the end of each fiscal year, at least 50% of patients identified as food insecure will be given food pantry items.

Medium-Term Outcomes:

1. Increase patients receiving items from baseline in FY23.
2. Changes in behavior and decision making

Long-Term Outcomes:

1. Changes in status or health or life conditions
2. Patient connections to available food resources in the community.

PLAN TO EVALUATE THE IMPACT:

1. Track number of patients receiving Food Pantry items on a monthly basis.
2. Track number of patients given referrals to local Food and Resource Center or other community pantries.
3. Track number of food items provided to patients on a monthly basis.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Appropriate space for food pantry.
2. Partnership with local community resources.
3. Indirect expenses related to organization of pantry items.

COLLABORATIVE PARTNERS:

1. Mercy Clinics
2. Food and Resource Center
3. Ardmore Institute of Health

III. Other Community Health Programs

Mercy Hospital Ardmore 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	Carter County Healthy Living Committee	Persons served
	Diabetes Support Group	Persons served
	Ardmore Behavioral Health Collaborative	Persons served
	Community health education talks	Persons served
	United Way of Southern Oklahoma	Persons served
	Hospital medication assistance program	Persons served
	Transportation assistance programs	Persons served, cost of services
	Diabetes Prevention Program	Persons served
Health Professions Education	Internal Medicine Residency Program	Number of residents
	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	Mental Health Services Crisis Unit, Girls on the Run, Ardmore Behavioral Health Collaborative	Cost of services
Community Building Activities – Workforce Development	Carter County College Fair	Number of students
	Teen Shadowing Program	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 2021 CHNA process—heart disease, obesity, and affordable housing—were not chosen as priority focus areas for development of the current Community Health Improvement Plan. This is due to Mercy's current lack of resources available to address these needs and the intention to focus on the three 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 Hospital Ardmore will consider focusing on these issues should resources become available. Until then, Mercy Ardmore will support, as able, the efforts of partner agencies and organizations currently working to address these needs within the community.

Efforts toward the reduction of diabetes are well established, which is why it will not be a need specifically addressed in our 2022 CHIP. Our Diabetes Prevention Program is fully recognized by the Centers for Disease Control and our diabetes team has established a great support group. Mercy Ardmore and Mercy Clinics will continue to fund this program, but will focus our efforts on access to care, behavioral health, and food insecurity.

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