MERCY HOSPITAL BOONEVILLE COMMUNITY
COMMUNITY HEALTH IMPROVEMENT PLAN (2016-2019)

An IRS-mandated Community Health Needs Assessment (CHNA) was recently completed for the Booneville Community. For the purposes of this Community Health Improvement Plan the Booneville Community includes: Johnson County, Logan County, Polk County, Scott County and Polk County in Arkansas. The Mercy Hospitals that serve these counties are:

- Mercy Hospital Booneville
- Mercy Hospital Paris
- Mercy Hospital Waldron

The Mercy Hospital Booneville Community CHIP is intended to be a "living" document, and will be updated as the CHIP work continues. The CHNA reports for each hospital may be accessed at: *https://www.mercy.net/about/community-benefits*.

Upon completion of these assessments, the IRS requires hospitals to implement a three-year plan to improve the community's health through strategies that address a significant community health need, as identified through the CHNA. The Community Health Improvement Plan (CHIP) must:

1. Describe the actions that the hospital intends to take to address the health need, the anticipated impact of these actions, and the plan to evaluate such impact
2. Identify the programs and resources that the hospital plans to commit to address the health need
3. Describe any planned collaboration between the hospital and other agencies in addressing the health need.

Attached is the CHIP for Mercy Hospital Booneville Community (MHBC). The health needs that have been prioritized in this CHIP are:

- Access to Care
  - Community Heath Worker
  - Navigation
- Mental Health
  - Support of Stabilization Unit
  - Support of the Hope Campus
  - Education
- Nutrition
  - Education
  - Obesity
  - Access to food

The Community Health Council for Mercy Hospital Fort Smith will oversee the Community Health Improvement Plan and monitor its progress. During the three year period, Community Health Councils will be developed in targeted rural communities.

Mercy

Priority Area/Community Need: ACCESS TO CARE

Narrative: As outlined in the 2016 MHBC Community Health Needs Assessment (CHNA), accessing health care is a challenge for many people in the Booneville Community. The uninsured rate for the report area is 30.18% with Yell County having the highest rate of 34.2% with the National rate of 20.76%. Additionally, cost of care, a shortage of providers to include those who will accept Medicaid and will see uninsured patients, poverty, and unmet health-related social needs contribute to access challenges.

MHBC implements targeted initiatives, which align with the goals of Healthy People 2020, and the Center for Medicare & Medicaid Services, to remove barriers to health care access.

CHNA Findings:

- The Booneville Community is in a Health Professional Shortage Area for primary health care.
- The uninsured rate for the report area is 30.18% for adults with the National rate at 20.76%. The uninsured rate for children in the report area is 7.97% with the National rate 7.54%.
- The population in the report area receiving Medicaid is 28.93% with the National rate at 20.21%.
- The number of primary care physicians for the report area is 46.4 per 100,000 population with the National rate of 74.5 per 100,000 population.

Goal #1: **COMMUNITY HEALTH WORKER** – Identify underserved and vulnerable population in the communities we serve to increase the number of patients who receive **follow-up and preventive care** from a healthcare provider, with emphasis on the uninsured and underinsured.

Objective: A Community Health Worker (CHW) will provide assistance to patients in navigating them through needed healthcare and social services. Such services will include assistance in finding a primary care or specialty care provider.

- **Activity:** Identify underserved and uninsured vulnerable population.
- **Activity:** Serve at-risk patients being seen and treated to include our rural- based clinics and hospitals.
- **Activity:** Serves as a connector, advocate, and resource for community-based agencies and Mercy departments/facilities, including emergency assistance needs.

- **Activity:** Evaluate current data on encounters/demand/capacity/outcomes of the existing full-time CHW to determine expansion of potential CHW services.

Objective: CHW will provide population health management to improve and manage the overall health of a population.

- **Activity:** Consistent site based outreach.
- **Activity:** Primary care navigation.
- **Activity:** Population specific patient navigation

Objective: CHW will manage the overall health of identified population through targeted interventions.

- **Activity:** Improve chronic disease self-management.
- **Activity:** Redirect patients to the most appropriate point of care, reducing ED encounters and IP readmissions.
- **Activity**: Monitor/report patient encounters and scheduled appointments.

Leaders/Departments Involved: Care Management, Emergency Department, Mercy Clinic, Finance/Eligibility Services, and Community Health

Community Partners: School based clinics, local Public Schools, local Department of Health and Community Churches

Evaluation Plan for Goal:

CHW will establish **baseline data and 3-year measureable outcomes** to include:

Outputs:
- Referrals to CHW
- CHW patient encounters
- Scheduled patients to receive follow-up/preventive care

Short-Term Outcomes:
- CHW face to face patient encounters
- CHW encounters resulting in scheduled appointment
- Show-rates for CHW scheduled appointments

Long-Term Outcomes:
- Reduced ED utilization for non-emergent care

- Reduced inpatient utilization with emphasis on patients with chronic conditions

Goal #2: **NAVIGATION** – Provide non-clinical support to overcome socioeconomic barriers to improve good personal health and chronic disease management to address **health-related social needs**

Objective: The CHW will screen for: housing instability, food insecurity, utility needs, interpersonal violence/abuse, and transportation needs beyond medical transportation.

- **Activity:** Develop a standardized health-related social needs screening tool in collaboration with care management, the emergency department and clinics.
- **Activity:** Train co-workers from the emergency department, clinics and care management on the screening requirements, tools, and activity/outcome reporting.

Objective: The CHW will provide support to identified underserved populations and partner with community churches and agencies to involve and engage key stakeholders with community resources.

- **Activity:** Develop and maintain a comprehensive community resource list.
- **Activity:** Train co-workers on how to access and use the community resource inventory.
- **Activity:** Assist/direct patient to needed community resources to include; scheduling appropriate physician appointments, arranging transportation, securing warm meals/groceries, getting prescriptions filled, and financial aid for prescriptions.
- **Activity:** Coordinate with Mercy clinic and principals in targeted neighborhoods/schools to offer free kindergarten and sports physicals.

Leaders/Departments Involved: Care Management, Emergency Department, Clinics and Community Health

Community Partners: County Health Departments, public schools, local Churches, Community Social Services, and Boys and Girls Clubs

Evaluation Plan for Goal:
CHW will establish **baseline data and reporting 3-year measureable outcomes** to include:

Outputs:

- Standardized Health-Related Social Needs Screening Tool
- Patient screenings
- Community Resource List
- Co-worker trainings on Community Resource List
- Community navigation services

Short-Term Outcomes: (*Data Source: Mercy)*

- Develop community resource list
- MHBC become educated and aware of community resources.
- MHBC start receiving referrals on identified at-risk population.

Long-Term Outcomes: *(Data Sources: Mercy, CMS)*

- Reduced cost of care, ED visits and admissions for identified at-risk population.

- Improved health and quality of care.

Priority Area/Community Need: MENTAL HEALTH AND EMOTIONAL WELLBEING

Narrative: There is a clear connection between mental and physical health. Mental health is fundamentally important to overall health and well-being. Mental and emotional well-being is defined as having the personal, family, and community resources to thrive, achieve one's full potential, engage productively with others and show resilience with life stressors. Mental disorders affect nearly one in five Americans in any given year. Mental disorders are illnesses that, when left untreated, can be just as serious and disabling as physical diseases, such as cancer and heart disease.

Due to the shortage of behavioral health providers, behavioral health access must be addressed on a regional level. Key leaders stressed the importance of additional supports for children and families as a key component in reducing the future need for mental health services. Mercy will implement a regional strategy building on services of its hospitals and clinics in the Mercy Central Community (Fort Smith, Booneville, Ozark, Paris and Waldron).

CHNA findings:

- The Booneville Community report area is declared a Health Professional Shortage Areas for mental health providers by the U.S. Department of Health and Human Services in 2015.
- The ratio of mental health providers in Scott County is 10,690:1 and in Franklin County is 5,490:1 which is much higher than the state (520:1) and U.S top performers (370:1).
- Mental health was ranked in the top three barriers/issues identified by the Community Health Council.
- This issue is being addressed in all 13 counties that Mercy serves.

Goal #1: **Mental Health and Emotional Wellbeing** – implement strategies to promote improved mental health and promote emotional well being.

Objective: Identify gaps and promote/develop strategies to evidenced based strategies to close the gap.

- **Activity:** Promote positive early childhood development, to include positive parenting and violence free homes.
- **Activity:** Facilitate social connectedness and community engagement across the lifespan.

- **Activity:** Promote early identification of mental health needs and access to quality services.

Goal #2: Access the current level of services available and identify gaps.

Objective: Services to address mental health needs in the Mercy Booneville Community will expand and/or be enhanced.

- **Activity:** Engage in strategic planning for resources/partners in order to increase service numbers with mental health providers, mental health navigators and use of telemedicine visits.
- **Activity:** Recruit new mental health providers, including Psychiatrists, Counselors, and Nurse Practioners.
- **Activity:** Develop process/policies to implement Telemedicine for psychiatric/counseling visits.
- **Activity:** Advocate for legislation to improve mental health service delivery through our State representatives and legislatures.

Objective: The number of low income/uninsured patients able to access mental health treatment will increase.

- **Activity:** Collaborate with community partners to identify the mental health service gaps in the area.
- **Activity:**

Objective: Educate primary care physicians on diagnosis and care for persons suffering mental illnesses.

- **Activity:** Partner with local Psychiatrists to help educate primary care physicians in the diagnosis and treatment of acute mental health issues.
- **Activity:** Inventory mental health services currently available and partnerships.

Leaders/Departments Involved: Behavioral Health, Mercy Clinics, Quality, Pharmacy, Advocacy, Virtual Care Center and Community Health.

Community Partners: National Alliance on Mental Illness (NAMI), Local public schools, Boys and Girls Clubs, local churches, and local County Health Departments.

Evaluation Plan for Goal
Community Health Council's Mental Health priority committee will establish **baseline data and report 3-year measurable outcomes** to include:

Outputs:

- Inventory and resource manual of mental health services currently available
- Number of mental health providers recruited
- Number of patient's served
- Number of newly formed partnerships/resources

Short-Term Outcomes: TBD

Long-Term Outcomes: TBD

Goal #3: **SUBSTANCE USE** – Increase the number of Mercy Booneville Community members able to **access** appropriate, quality substance use treatment particularly pregnant women and their babies.

Objective: Substance use treatment services in the Mercy Booneville will expand and/or be enhanced.

- **Activity:** Explore potential partnerships, particularly with agencies that have residential detoxification programs, to enhance transitions of care/recovery
- **Activity:** Explore and develop potential programs to assist moms and babies addicted to alcohol and drugs.
- **Activity:** Improve the clinical competency of behavioral health providers in the area of addiction treatment

Leaders/Departments Involved: Behavioral Health, Mercy Clinic, NICU and Labor and Delivery, Quality, Pharmacy, and Community Health

Community Partners: National Alliance on Mental Illness (NAMI), Local County Health Departments, Public schools, Boys and Girls Clubs, Western Arkansas Counseling and Guidance and Valley Behavioral Health

Evaluation Plan for Goal
Community Health Council's Mental Health priority committee will establish **baseline data and report 3-year measurable outcomes** to include:

Outputs:

- Number of patients referred/served

- Number of behavioral health providers who participate in professional development

Short-Term Outcomes: (*Data Source: Mercy)*

- Number of Partnerships Developed

Long-Term Outcomes: *(Data Source: Mercy)*

- Decrease in babies born to moms addicted to alcohol and/or drugs
- Addiction & Death rates from substance use decrease

Priority Area/Community Need: Nutrition

Narrative: As outlined in the 2016 MHBC Community Health Needs Assessment (CHNA), nutrition and obesity is an issue throughout the report area. Access to affordable healthy food was cited by key leaders, and focus group participants as an important community need. Obesity prevention and accessible adequate nutrition were also reported as high needs.

CHNA Findings:

- Food Insecurity rate for the report area is 16.38% with the National rate at 15.94%.
- Children eligible for free/reduced lunch for the report area is 72.01% with the National rate at 51.7%.
- Population in the report area receiving SNAP benefits is 17.09% with the National rate at 12.4%.
- Access to grocery stores in the report area is at 11.77 per 100,000 population with the National rate at 21.2 per 100,000 population.
- Adults with a BMI greater than 30 in the report area is 34.59% with the National rate at 27.14%.
- Obesity rates for children ages 10 - 17 years of age is 18.7% - Arkansas ranks 8th in the Nation for childhood obesity rates.
- Obesity related health issues in the report area:
    - Hypertension 50.18% with the National rate at 55.49%
    - Diabetes 10.83% with the National rate at 9.11%

Goal #1: Promote healthy lifestyles and improve access to nutritious food and physical activity in order to increase the percentage of people living at a healthy weight.

Objective: Increase participation in nutrition and physical activity education in targeted neighborhoods or with priority populations.

- **Activity:** Leverage leaders on community boards, committees and other initiatives to increase collaboration and connectivity.
- **Activity:** Access and build awareness of culturally appropriate resources and tools that are written at an appropriate health literacy level.
- **Activity:** Offer free or reduced cost wellness programs for groups in-need including diabetes education, nutrition and food preparation classes, and exercise classes.

Objective: Improve access to healthy foods and educate on health food choices.

- **Activity:** Explore food systems in the Booneville Community and identify partnership opportunities that increase healthy food choices and access to healthy foods.
- **Activity:** Engage and education Mercy Booneville Community employees to help address food insecurities and obesity rates in the communities they serve.
- **Activity:** Support and collaborate with local community gardens and food pantries to offer healthy food choices in targeted food insecurity areas.
- **Activity:** Provide cooking classes with food prepared from the community gardens and food pantries.

Objective: Establish community health dashboard to measure food insecurities in targeted populations.

- **Activity:** Develop standard work for community health dashboard to provide ongoing support and monitoring of CHIP related activities.
- **Activity:** Collaborate with other healthcare providers and community partners to aggregate health data to establish accurate nutrition and obesity data.

Objective: Increase awareness and disseminate consistent messages among schools, early learning centers, hospitals and senior citizens centers through various education campaigns.

- **Activity:** Provide low cost nutrition education counseling and classes to maintain healthy weight for low income families.

- **Activity:** Encourage local media to support healthier decision making by promoting new and existing healthier food and beverage choices and limiting marketing of unhealthy foods especially for children.

- **Activity:** Disseminate information to schools, early learning centers, hospitals, and senior citizen centers and faith-based partners.

Leaders/Departments Involved: Administration, Mercy Clinics, and Community Health/Community Health Worker

Community Partners: Public schools, Local health departments, local churches, Local Food Banks and Food Pantries.

Evaluation Plan for Goal
Community Health Council's Nutrition priority committee will establish **baseline data and report 3-year measurable outcomes** to include:

Outputs:

- Decrease obesity rates in targeted areas in adults and children

- Increase the consumption of fruits and vegetables in adults and children

- Increase the number of community gardens within the Booneville Community

Short-Term Outcomes: (*Data source)*

- TBD

Long-Term Outcomes: *(Data source)*

- TBD

Community Health Council
Mercy Hospital Fort Smith

Leadership

SPONSOR
Ryan Gehrig, President Mercy Hospital
Cole Goodman, MD, President Mercy Clinic

MEMBERS
Martin Schreiber, VP, Mission Services
Samantha Cole, Dir Community Health & Access
Darla Mortimore, Scott County Health Dpt.
Mike Barr, Mercy Board Member
Carl Geffken, Fort Smith City Administrator
Charlotte Tidwell, Dir Antioch Food Pantry
Deacon Greg Pair, Immaculate Conception Church
Debbie Everly, Dir Hope Campus
Rachel Fiori, MD
Jerry Glidewell, Dir Girls and Boys Club
Jim West, Dir Western Arkansas Counseling & Guidance
Jo Wester, Sebastian County Health Dpt.
Ken Kupchick, Dir River Valley Food Bank
Kenneth Heiles, DO
Mike Roberts, Harps Food
Rosa Salazar, Mercy Hospital Registration
Samantha Minster, AR Department of Health
Sherriff Bill Hollenbeck, Sebastian County
Wittney Jones, University of AR at Fort Smith
Zena Marshall, Fort Smith Public School System
Pat Morris, Mercy Hospital
Cristelyn Roebuck, Mercy Hospital
Keith Brown, Mercy Clinic

Community Health Council
Mercy Hospital Fort Smith

Responsibilities:

1. Approves:
    a. Community health needs assessment every three years
    b. Annual written implementation plan
    c. Annual community impact plan
2. Develops & manages a Community Benefit budget:
    a. Annual Community Benefit amount falls between 5-8%
3. Assures Community Benefit activities:
    a. Meet a prioritized community health need
    b. Make a measurable impact on a community health indicator
    c. Involve collaboration/partnership with key community stakeholders and advocacy with key legislators
    d. Connect programs to service line and community master planning strategies
    e. Develop innovative programs/medical management of charity & Medicaid populations
4. Reports:
    a. Community Benefit activities accurately and thoroughly
    b. Information for 990H/990, especially narrative questions
    c. Community Benefit activities quarterly to local boards and ministry oversight group

To comply with new IRS guidelines, the following timeline will guide Community Benefit program development and reporting.

1. Community Health Needs Assessments (CHNA) are completed (including posting) – **6/30/2016**
2. Community Health Improvement Plans (CHIP) are written and approved by local boards – **11/15/2016**