MERCY HOSPITAL FORT SMITH COMMUNITY
COMMUNITY HEALTH IMPROVEMENT PLAN (2016-2019)

An IRS-mandated Community Health Needs Assessment (CHNA) was recently completed for the Fort Smith Community. For the purposes of this Community Health Improvement Plan the Fort Smith Community includes: Crawford County, Franklin County, and Sebastian County in Arkansas and Haskell County, Latimer County, Le Flore County and Sequoyah County in Oklahoma. The Mercy Hospitals that serve these counties are:

- Mercy Hospital Fort Smith
- Mercy Hospital Ozark

The Mercy Hospital Fort Smith 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 Fort Smith Community (MHFSC). The health needs that have been prioritized in this CHIP are:

- Access to Care
  - Community Health 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.
Priority Area/Community Need: ACCESS TO CARE

**Narrative:** As outlined in the 2016 MHFSC Community Health Needs Assessment (CHNA), accessing health care is a challenge for many people in the Fort Smith Community. The uninsured rate for the report area is 28.62% with Haskell and Le Flore Counties in Oklahoma having the highest rates of greater than 31%. 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.

MHFSC 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:**

- For the Fort Smith Community all areas, except Sebastian County are in a Health Professional Shortage Area for primary health care.
- The uninsured rate for the report area is 28.62% for adults with the National rate at 20.76%. The uninsured rate for children in the report area is 9.97% with the National rate 7.54%.
- The population in the report area receiving Medicaid is 26.68% with the National rate at 20.21%.
- 29.28% of the report area self-reported that they do not have at least one person who they think of as their health care provider (the national average 22.07%).

**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, Fort Smith Public Schools, Hope Campus, McAuley Clinic, 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, Boys and Girls Clubs and Hope Campus
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
- MHFSC become educated and aware of community resources.
- MHFSC 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 WELL-BEING

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). Mercy will also advocate and support the development of a Stabilization Unit through the Sebastian County Sheriff’s Department. Currently Sebastian County reports a >60% recidivism rate – Arkansas’s recidivism rate is 57%, with Oklahoma’s recidivism rate at 33%.

These rates for both Arkansas and Oklahoma indicate that most are not receiving the care they need to fully recover from their illnesses.

CHNA findings:
• The Fort Smith 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 Crawford County is 2200:1 and in Franklin County is 17,810:1 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: Mental Health - Increase the number of Mercy Fort Smith Community members able to access appropriate, quality mental health treatment.

Objective: Services to address mental health needs in the Mercy Fort Smith 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 Practitioners.

- **Activity:** Advocate and support the Sebastian County Sheriff’s department for the development of a stabilization unit to divert person’s suffering from mental health crisis and to ensure appropriate level of care is received.

- **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:** Support the Hope Campus to ensure the homeless and underserved receive assistance in obtaining the appropriate level of care.

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:** Sebastian County Sheriff’s Department, local County Health Departments and Hope Campus.
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 Fort Smith Community members able to access appropriate, quality substance use treatment particularly pregnant women and their babies.

**Objective:** Substance use treatment services in the Mercy Fort Smith 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:** Local County Health Departments, Heart to Heart Pregnancy Crisis Center, and other local crisis centers.

**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

**Leaders/Departments Involved:** Behavioral Health, Mercy Clinic, Virtual Care, Finance, and Community Health

**Community Partners:** National Alliance on Mental Illness (NAMI), Local County Health Departments, 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:**
- Inventory of mental health services currently available
- Number of resources added/partnerships formed
- Number of patients served
- Number of mental health providers recruited

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

**Long-Term Outcomes:** *(Data Source:)*
- TBD
**Priority Area/Community Need: Nutrition**

**Narrative:** As outlined in the 2016 MHFSC 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 17.65% with the National rate at 15.94%.
- Children eligible for free/reduced lunch for the report area is 66.9% with the National rate at 51.7%.
- Population in the report area receiving SNAP benefits is 16.43% with the National rate at 12.4%. Disparity index for Latimer County and Sequoyah County in Oklahoma is greater than 67 (National 62)
- Access to grocery stores in the report area is at 15.81 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 36.65% 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 and Oklahoma ranks 9th in the Nation for childhood obesity rates.
- Obesity related health issues in the report area:
  - Hypertension 54.37% with the National rate at 55.49%
  - Diabetes 11.69% 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 Fort Smith Community and identify partnership opportunities that increase healthy food choices and access to healthy foods.

- **Activity:** Engage and education Mercy Fort Smith 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, River Valley Food Bank and Antioch Food Pantry
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 Fort Smith 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
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