Community Health Improvement Plan

Mercy Hospital Ada

Fiscal Year 2026

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.

Our Values

Dignity
Excellence
Justice
Service
Stewardship

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Introduction

Mercy Hospital Ada is a full-service hospital with 159 licensed beds, acute-care facility serving Pontotoc County and the surrounding areas in south-central Oklahoma. The service area of Mercy Hospital Ada is comprised of five counties: Garvin, Hughes, Johnston, Pontotoc, and Seminole, with a population of 120,223. For the purposes of this Community Health Improvement Plan (CHIP), these five counties will define the community served by Mercy Hospital Ada.

The hospital is a full-service tertiary hospital and Mercy Clinic is a physician-governed group practice comprised of primary care physicians, including specialists and mid-level practitioners. This provider partnership gives patients access to an expanded health care team and advanced services. Mercy clinic providers also have access to an electronic health record that is shared at Mercy facilities in four states. Patients may connect to their health record and health teams anywhere they have access to the internet through the MyMercy patient portal.

Introduction *(continued)*

Mercy's mission is to deliver "compassionate care and exceptional service" to every community member. In dedication to this mission, our work includes the development of a Community Health Needs Assessment (CHNA) during the last year, in partnership with the Pontotoc County Health Department, The Clinic, The Chickasaw Nation, and in cooperation with stakeholders throughout the community.

Mercy Hospital Ada contributes to community building activities to promote the health of the communities in which they serve. Through active participation in community boards, neighborhood community meetings and involvement in community-based events, Mercy Hospital Ada demonstrates its ongoing commitment to the residents it serves. These activities serve as a link to engage Mercy coworkers to look beyond the walls of the facilities in which they serve.

The Community Health Needs Assessment (CHNA) and Community Health Improvement Plan (CHIP) process involved review of both quantitative and qualitative data to attain the full scope of the community needs as they relate to health. This summary is documentation that Mercy Hospital Ada follows IRS requirements for conduction of the CHNA and CHIP.

Introduction *(continued)*

The CHNA identified six top-priorities and of the six, **three have been chosen as health needs for the Mercy Hospital Ada community**. We will strive diligently to address these needs with a Health Equity lens over the next three years:

- Access to Care
- Behavioral Health
- Food Insecurity

As always, we seek to develop a rich and rewarding network of partnerships with our neighbors. We welcome any thoughts you may have on ways to achieve our goal for a healthier community.

Improvement Plan by Prioritized Health Need

Prioritized Need #1: Access to Care

GOAL 1

Increase access to health care for uninsured and at-risk persons.

Prioritized Need #1: Access to Care

Program 1 of 2: Community Health Worker Expansion

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:

- Identify uninsured and at-risk patients in need of assistance in Mercy clinics, emergency department, inpatient settings, as well as using reports and dashboards.
- Assist uninsured patients in applying for Mercy Financial Assistance, Medicaid programs, and connect to Marketplace insurance plans.
- Assist patients without an established primary care provider in establishing care with a primary care clinic or provider.
- Screen patients for needs related to social determinants of health and connect patients to community resources to meet identified needs.
- Connect patients with other community resources, including medication, as needed.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Each CHW will assist at least 50 patient per month with community and medication assistance resources.
- 80% of patients referred to CHW (within their scope) will be screened for social drivers of health (SDOH).
- 50% of new patients to each CHW without a primary care provider will establish care with a PCP at a Mercy clinic or other clinic within 6 months.
- Patients enrolling in CHW program will demonstrate reduced ED utilization by 10%.

Prioritized Need #1: Access to Care

Program 1 of 2: Community Health Worker

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

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

COLLABORATIVE PARTNERS:

- Mercy Clinics
- Pontotoc County Health Department
- OK Managed Medicaid partners

Prioritized Need #1: Access to Care

Program 2 of 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:

- In contract with the Dispensary of Hope, Mercy Pharmacy will manage charitable formularies within participating pharmacies, including maintaining inventory and making weekly orders.
- 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.
- Mercy will communicate with community partners, including other healthcare providers, to promote the use of the formulary for patients in need.
- Mercy will work to connect qualifying patients with Mercy Financial Assistance and Medicaid and Medicare as applicable.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Increase/maintain number of patients served / month
- Increase/maintain number of patient encounters / month
- Each year, 5% reduction in ED visits
- Each year, 5% reduction in total cost of care.

Prioritized Need #1: Access to Care

Program 2 of 2: Dispensary of Hope

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Annual contract fees to Dispensary of Hope for formulary access ($12,500 per year per pharmacy)
- Pharmacist support for formulary management
- Marketing and communications support, in the form of flyers, rack cards, enrollment cards, etc.
- Training for co-workers to understand enrollment process for Dispensary of Hope

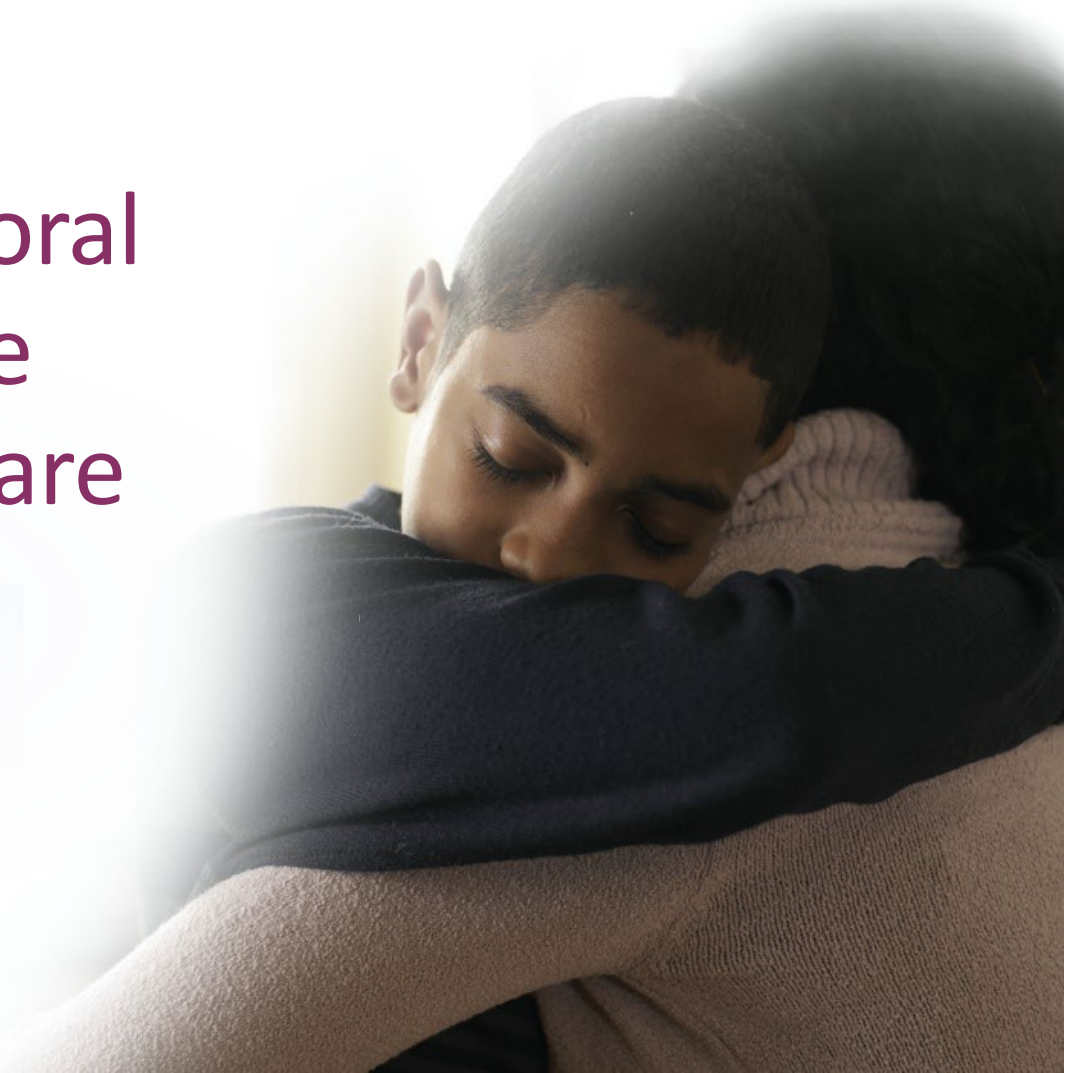
COLLABORATIVE PARTNERS:

- Dispensary of Hope
- Mercy Pharmacy Ada, Integrated Health and Social Care, Care Management, Hospitalists, Mercy Clinics West

Prioritized Need #2: Behavioral Health

GOAL 1

Increase access to behavioral health services in both the emergency and primary care setting.



Prioritized Need #2: Behavioral Health

Program 1 of 3: 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:

- 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.
- Collaborate with external partners and behavioral health service providers such as Lighthouse Behavioral to ensure a strong regional network for care coordination and social service navigation.
- 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.
- 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):

- Each year, the vBH program will increase the number of patient assessments completed by 20% Ministry-Wide.
- Across the Ministry, the vBH program will maintain a 70% connection to treatment rate.
- Over three-year period (FY23-FY25), patients who participated in vBH program will demonstrate a 10% decrease in hospital readmissions and ED visits.

Prioritized Need #2: Behavioral Health

Program 1 of 3: Virtual Behavioral Health

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

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

COLLABORATIVE PARTNERS:

- Mercy Clinics
- Mercy Behavioral Health Leadership
- Mercy Virtual Behavioral Health (vBH)
- Lighthouse Behavioral

Prioritized Need #2: Behavioral Health

Program 2 of 3: Collaborative Care with Concert Health for Primary Care

PROGRAM DESCRIPTION:

Mercy Hospital Ada & 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 HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

- Consistent with the Behavioral Health Service Line model of care, Mercy Hospital Ada will implement the Concert Health Collaboration in Primary Care Clinics.
- Train providers in use of the care approach.
- Promote the initiative.
- Identify gaps in care.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Establish baseline of patients referred and converted to program.
- Increase patient referrals and conversions to program by 10% each fiscal year.
- Increase access to community resources through referrals to Community Health Workers.

Prioritized Need #2: Behavioral Health

Program 2 of 3: Concert Health Collaborative Care for Primary Care

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Cost of coworker and physician time.
- Operational budgeted support as appropriate.
- Indirect expenses related to EMR and clinic operations

COLLABORATIVE PARTNERS:

- Mercy Clinics
- Mercy Behavioral Health Service Line Leadership
- Mercy Virtual Behavioral Health (vBH)
- Concert Health

Prioritized Need #2: Behavioral Health

Program 3 of 3: Virtual Substance Use Recovery Program (vSURP)

PROGRAM DESCRIPTION:

Mercy's Virtual Substance Use Recovery Program (vSURP) is an integrated, mission-driven, patient-centric approach to Opioid Use Disorder. vSURP will ensure that any patient seeking care through Mercy will be connected to ongoing care for Opioid Use Disorder regardless of geography, clinical setting, or ability to pay. vSURP provides Medication-Assisted Therapy (MAT), primarily through buprenorphine, for patients with Opioid Use Disorder. Patients who participate in SURP are also connected to support services, including counseling, behavioral therapies and general primary care, to implement a holistic harm-reduction care model.

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

•Consistent with Mercy's care model, clinicians will refer patients identified with Opioid Use Disorder to vSURP program.
•vSURP LCSWs will outreach and engage with patients, providing necessary direct support as well as referrals and care coordination for treatment and primary care provision
•vSURP clinicians will facilitate MAT for patients, managing MAT medication prescription and adherence
•Community Health Leaders will maintain ongoing relationship with vBH team and facilitate reporting of outcomes to relevant hospital stakeholders.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Establish baseline number of referrals of ED patients to vSURP.
- To increase the number of referrals of ED patients to vSURP program by 10% each year.
- Maintain engagement of 10% of patients that engage through a six-month period.
- Over three-year period (FY26-FY29), patients who participated in vSURP program will demonstrate a 5% decrease in hospital readmissions and ED visits.

Prioritized Need #2: Behavioral Health

Program 3 of 3: Virtual Substance Use Recovery Program (vSURP)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Support and education for clinicians in primary care, inpatient settings, and ED to identify and facilitate patient referrals.
- Operational budgeted support as appropriate.
- Indirect expenses related to EMR and clinic operations

COLLABORATIVE PARTNERS:

- Mercy Clinics
- Mercy Behavioral Health Leadership
- Mercy Virtual Behavioral Health (vBH)

Prioritized Need #3: Food Insecurity

GOAL #1

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

Prioritized Need #3: Food Insecurity

Program 1 of 2: Pantry Food Box Program

PROGRAM DESCRIPTION:

The Pantry Food Box Program is a partnership between Mercy Hospital Ada, Mercy Clinics, and the Regional Food Bank of 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 its 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:

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

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- By the end of each fiscal year, at least 75% of patients identified as food insecure will be given food pantry items and referred to the local food bank.
- Increase new patients in receiving food boxes and referrals from baseline by 20%.
- Patient connections to available food resources in the community.

Prioritized Need #3: Food Insecurity

Program 1 of 2: Pantry Food Box Program

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

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

COLLABORATIVE PARTNERS:

- Mercy Clinics
- Care Management
- Regional Food Bank of Oklahoma

Prioritized Need #3: Food Insecurity

Program 2 of 2: Medically Tailored Meals

PROGRAM DESCRIPTION:

The Medically Tailored Meals pilot program, in collaboration with the Regional Food Bank of Oklahoma (RFBO), will provide frozen meals to qualifying patients with an aim to assist with disease management, improve health outcomes, lower cost of care and increase patient satisfaction. Food insecurity is an emerging factor for chronic disease, and although food insecurity on its 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:

- Identify patients to participate by screening for for food insecurity as well as having a diagnosis of diabetes and/or heart disease.
- Distribute meals to participating patients consistently throughout the duration of the program.
- Identify centric area within the hospital and/or clinic to safely maintain food items.
- Track pilot data via MTM Data Tracker spreadsheet and share de-identified program data with RFBO.
- Ensure patient labs are collected within 90 days of Initial Assessment completion and within 45 days of the final month of the program.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- At least 30 patients with qualifying chronic conditions will be identified and be provided Medically Tailored Meals to assist with disease management.
- Increase new patients in receiving MTMs and referrals to food resources from baseline by 20%.
- Reduction in patient ED visits and readmissions by 10% at the end of the program.

Prioritized Need #3: Food Insecurity

Program 2 of 2: Medically Tailored Meals

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Appropriate storage space for food items.
- Partnership with local community resources.
- Indirect expenses related to organization of food items.

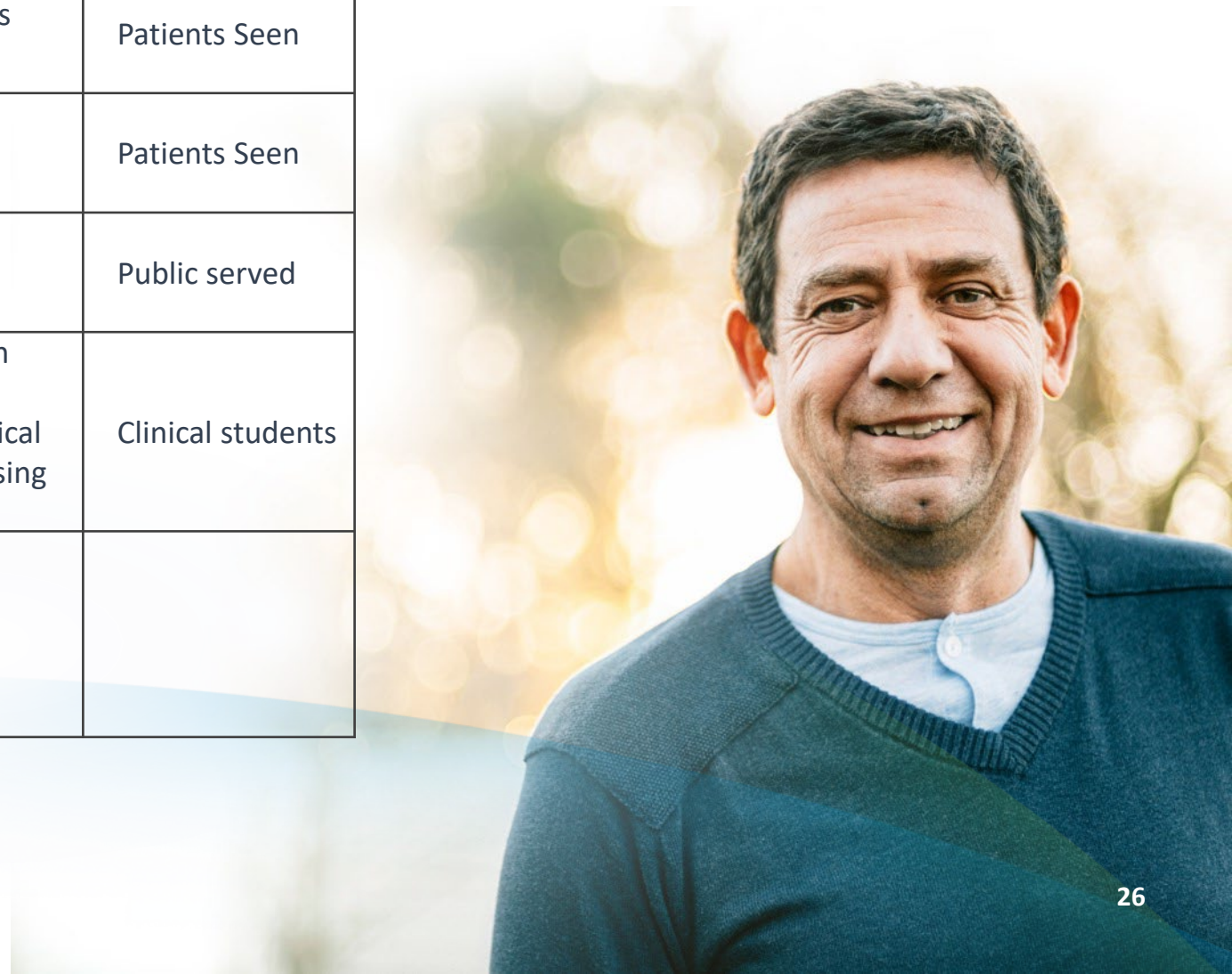
COLLABORATIVE PARTNERS:

- Mercy Clinics
- Regional Food Bank of Oklahoma

Other Community Health Programs

Mercy Hospital Ada 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 on the next page.

Community Benefit Category	Program	Outcomes Tracked
Community Health Improvement Services	Community Health Fairs & Screenings	Patients Seen
	Compassion Outreach Free Clinic	Patients Seen
	Pontotoc County Community Events	Public served
Health Professions Education	Health professions student education nursing, imaging, therapy, pharmacy, medical student, lab, emergency medical technician and advanced practice nursing	Clinical students
Financial & In-Kind Contributions	Community Building- Cash/In-kind Contributions	



Other Community Health Programs (Continued)

Community Benefit Category	Program	Outcomes Tracked
Financial & In-Kind Contributions (continued)	Community Event Sponsorships	Financial contributions
	Guest trays	Meals served
	Meals on Wheels Nutrition Services	Meals served
	Blood Drives	In-kind
	Abbas Table Food Kitchen	Hours served

Other Community Health Programs (Continued)

Community Benefit Category	Program	Outcomes Tracked
Health Care Support Services	Mercy EMS	Patients served
	340B Program	Program funding
Community Building	Coalition Building/Board Memberships	
	TLC Therapeutic Riding Board	In-kind
	Lions Club of Ada	In-kind

Community Benefit Category	Program	Outcomes Tracked
Community Building (continued)	ECU Foundation Board	In-kind
	Ada Homeless Services Board	In-kind
	City of Ada- Call A Ride Committee	In-kind
	Pontotoc County Drug Coalition	In-kind
	Pontotoc Community Coalition	In-kind

Significant Health Needs Not Being Addressed

In any case of prioritization, there will be some areas of needs that are identified that are not chosen as a priority. Because Mercy Ada has limited resources, not every community need will be addressed. Throughout the CHNA process, the following needs arose as a community concern. However, they will not be addressed as top priorities because other organizations are more appropriate to address these needs.

- Transportation
- Housing

While these needs listed will not be specifically addressed in our priorities, they will most likely be impacted through the work in our other community outreach priorities. Mercy Hospital Ada is currently working on partnerships with community organizations to address these significant community needs collaboratively.

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