Community Health Improvement Plan

- Mercy Hospital Oklahoma City
- Fiscal Year 2026

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

Contents

Introduction

Mercy Hospital Oklahoma City is a leading full-service hospital with a capacity of 344 licensed beds, supported by a dedicated team of over 3,700 caregivers. The hospital operates more than 60 clinic locations, including 32 dedicated primary care facilities, ensuring comprehensive access to healthcare services for the community.

On our campus, we provide a wide range of health services, including a Women's Health Center, a Cancer and Breast Health Center, a Neurosciences Center, and an upcoming Gastroenterology Center. These facilities are designed to meet the diverse health needs of our patients.

Mercy Clinic, a physician-governed practice, consists of over 200 board-certified and board-eligible primary care physicians and advanced practice providers serving the Oklahoma City area. Patients utilizing Mercy primary care services benefit from seamless access to specialty services and the latest medical technology, tailored to their individual health needs. Our physicians utilize an integrated electronic health record system, shared across Mercy facilities in four states, enabling comprehensive care coordination. Patients are empowered to engage actively in their healthcare journeys through My Mercy, which allows them to access their health records and connect with their healthcare teams from anywhere with internet access.

The service area of Mercy Hospital Oklahoma City spans seven counties—Oklahoma, Canadian, Cleveland, Kingfisher, Blaine, Logan, and Lincoln—encompassing a population of approximately 1,471,463 residents. For the purposes of this Community Health Needs Assessment (CHNA), these seven counties will define the community served by Mercy Hospital Oklahoma City.

Introduction *(continued)*

At Mercy Hospital Oklahoma City, our mission is to deliver “compassionate care and exceptional service” to every member of our community. In alignment with this mission, we have dedicated the past year to developing a Community Health Needs Assessment (CHNA) in collaboration with three other health systems in central Oklahoma—SSM Health, Integris Health, and OU Health—alongside various community stakeholders.

Mercy Hospital Oklahoma City actively participates in community-building initiatives aimed at promoting the health of the populations we serve. Through involvement in community boards, partnerships with community-based organizations, and participation in local events, we demonstrate our unwavering commitment to the residents of our community. These efforts not only enhance community engagement but also empower our caregivers to extend their care beyond the walls of our facilities.

The Community Health Needs Assessment (CHNA) and the Community Health Improvement Plan (CHIP) processes utilize both quantitative and qualitative data to comprehensively understand community health needs. This summary serves as documentation that Mercy Hospital Oklahoma City adheres to IRS requirements for conducting the CHNA and CHIP.

Introduction *(continued)*

The CHNA identified five top-priorities. We will strive diligently to address these needs with a Health Equity lens over the next three years:

- Access to Healthcare
- Education
- Access to Healthy Food
- Housing
- Employment

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 vital links between health care providers, community organizations, and social services. They identify and address needs related to the social drivers of health, facilitate access to essential resources, and promote culturally competent, high-quality care. CHWs work one-on-one with at-risk patients and community members, acting as advocates, assisting with applications for insurance, Medicaid, and financial assistance, and connecting individuals to community-based resources and support. CHWs also connect patients to primary care and help patients understand appropriate use of the emergency room; therefore, reducing the unnecessary utilization of the emergency room in non-emergent situations.

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

- Confirm completion of SDOH screenings across emergency, inpatient, and clinic settings to identify social risk factors.
- Conduct outreach to patients with identified social risks.
- Educate and assist with Medicaid, financial aid, and enrollment as needed.
- Inform underinsured patients about health plan benefits and available resources.
- Provide care navigation to Mercy services and community-based programs, including medication assistance.
- Assist patients in establishing care with a Mercy primary care provider.
- Develop follow-up plans for priority populations.
- Ensure closed-loop communication with referring providers.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Reduce 72-hour return rate (all payor).
- Reducing readmission rates for focused populations.

Prioritized Need #1: Access to Care

Program 1 of 2: Community Health Worker Expansion

PLAN TO EVALUATE THE IMPACT:

- Track total patients screened positive for HRSNs.
- Track HRSN screening rate.
- Track number consults orders to CHWs.
- Track turnaround time between referral received and CHW initial outreach.
- Track number of unduplicated patients served.
- Track number of patient encounters.
- Track number of patients successfully enrolled in Mercy financial assistance and Medicaid.
- Track number of patients achieved access to community resource.
- Track number of patients achieved access to medication assistance.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Compensation and benefits for Community Health Workers.
- Mileage and travel expenses required for CHW work.
- Office space and indirect expenses dedicated to CHW work.
- CHW Training-Offered by Ministry (or through community partnership).
- Electronic health record with referral mechanism.

COLLABORATIVE PARTNERS:

- Mercy Clinics
- OK Managed Medicaid partners
- Community based partners working in social care settings

Prioritized Need #1: Access to Care

Program 2 of 2: Mercy Behavioral Health Programs

PROGRAM DESCRIPTION:

Supporting 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:

- Continue training and educating providers on the use of the care approach.
- Identify gaps in care.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Increase patient referrals by 5% each year.
- Increase patient satisfaction assessment participation by 10% from previous CHIP cycle.

Prioritized Need #1: Access to Care

Program 2 of 2: Mercy Behavioral Health Programs

PLAN TO EVALUATE THE IMPACT:

- Track number of primary care physicians participating in program.
- Track number of referrals to Collaborative Care per month.
- Track percentage of patients referred to Collaborative Care who enroll in program (conversion rate).
- Track number of referrals of uninsured and Medicaid patients per month.

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.
- Operational budgeted support as appropriate.
- Indirect expenses related to EMR and clinic operations.

COLLABORATIVE PARTNERS:

- Mercy Behavioral Health Service Line Leadership
- Mercy Virtual Behavioral Health (vBH)
- Substance Abuse Recovery Program (SURP)

Prioritized Need #2: Access to Healthy Food

GOAL 1

Increase access to healthy food for at-risk patients facing food insecurity.

Prioritized Need #2: Access to Healthy Food

Program 1 of 2: Community Garden Partnership

PROGRAM DESCRIPTION:

The Community Garden Partnership at Mercy OKC is a collaboration with the Lynn Institute, a nonprofit organization dedicated to fostering healthy and hopeful communities across Oklahoma. The Lynn Institute leases and manages a 65-bed garden owned by a local oil and gas company, where crops are grown and harvested to support communities facing food insecurity. Mercy OKC receives a portion of this fresh produce each month. A caregiver volunteers to pick up and deliver the produce to Mercy's Good Samaritan Clinic, which provides care to uninsured patients. Individuals who screen positive for food insecurity during their health-related social needs assessment receive fresh produce along with a box of shelf-stable food, or a food bag containing at least one meal in each bag.

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

- Screen patients for health-related social needs including food insecurity.
- Review patient comorbidities to determine if there is a greater need for fresh produce.
- Refer patients to fresh produce pick up at the Good Samaritan Clinic once a month and connect them to another option for sustainable fresh produce.
- Collaborate with internal and external partners to receive weekly/monthly food products and produce for patients.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Provide at least 50% of patients needing access to fresh produce due to a chronic condition with an option to pick up fresh produce at least once/month.
- Connect 80% of patients screening positive for food insecurity with a food pantry, or other community-based resource.
- Promote healthy eating with patients visiting the fresh produce pantry.

Prioritized Need #2: Access to Healthy Food

Program 1 of 2: Community Garden Partnership

PLAN TO EVALUATE THE IMPACT:

- Track number of referrals to CHWs for food insecurity.
- Track number of gap closures for patients facing food insecurity.
- Track number of patients utilizing fresh produce services through Mercy.

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
- Mercy 340B Committee
- Mercy Hospital team
- The Lynn Institute

Prioritized Need #2: Access to Healthy Food

Program 2 of 2: Community Pantry at Mercy

PROGRAM DESCRIPTION:

During the previous Community Health Improvement Plan cycle, Mercy Hospital OKC established a food pantry at the Good Samaritan Clinic, our free and charitable clinic. In recent years, the demand for food assistance among emergency department patients and those being discharged from the hospital has grown significantly. The Integrated Health and Social Care team, in collaboration with Care Management, frequently connects patients to local food pantries and provides meals through the hospital cafeteria. The new Community Pantry will further support these efforts by offering shelf-stable meals and food boxes immediately to patients who screen positive for food insecurity.

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

- Screen patients for food insecurity.
- Ensure patients do not leave without a meal if they screen positive for food insecurity.
- Connect patients with food related community-based resources.
- Follow up with patients to ensure food insecurity gap is closed.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Provide at least 80% of patients screening positive for food insecurity with a food box, fresh produce, or food bag.
- Connect at least 70% of patients screening positive for food insecurity with a community-based resource or program.

Prioritized Need #2: Access to Healthy Food

Program 2 of 2: Community Pantry at Mercy

PLAN TO EVALUATE IMPACT:

- Track number of referrals to CHWs for food insecurity.
- Track number of gap closures for patients facing food insecurity.
- Track number of patients given a food bag, or food box prior to discharge.

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:

- Community based organizations
- Mercy caregivers donating food

Prioritized Need #3: Access to Meaningful Employment

GOAL #1

Increase access to employment for at-risk patients and patients with disabilities.

Prioritized Need #3: Access to Meaningful Employment

Program 1 of 1: Employment Connections For Patients with Disabilities

PROGRAM DESCRIPTION:

Several state and community-based organizations provide opportunities for training and employment for Oklahomans with disabilities. Mercy Hospital OKC connects patients screening positive for financial hardship and identifying as an unemployed or underemployed person with a disability to the most appropriate organization to meet their needs. These organizations include the Oklahoma Department of Rehabilitation Services, Dale Rogers Training Center, and WorkQuest Oklahoma.

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

- Screen patients for financial hardship as part of the health-related social needs screening.
- Refer patients screening positive for financial hardship to a Mercy CHW to assess contributing factors such as unemployment, underemployment, or disability and provide appropriate support.
- Collaborate with the Oklahoma Department of Rehabilitation Services, Dale Rogers Training Center, and WorkQuest Oklahoma to accept referrals for patients needing services.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Connect 80% of patients who have a disability and screen positive for financial hardship with resources for training and employment.
- Improve the dignity, health, well being, financial independence, and social integration, and confidence for unemployed or underemployed patients living with disabilities.

Prioritized Need #3: Access to Meaningful Employment

Program 1 of 1: Employment Connections For Patients with Disabilities

PLAN TO EVALUATE IMPACT:

- Track number of referrals from CHWs to programs.
- Track number of patients completing programs.
- Track employment opportunity gained through program completion and connection.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Partnership with local community resources.
- Basic training on how to find the appropriate resource to help a person with disabilities who is unemployed or underemployed.

COLLABORATIVE PARTNERS:

- Dale Rogers Training Center
- Oklahoma Department of Rehabilitation Services
- WorkQuest Oklahoma
- Mercy Disability Resource Council

Prioritized Need #4: Access to Education

GOAL 1

Increase access to educational opportunities and health education for at- risk patients.

Prioritized Need #4: Access to Education

Program 1 of 2: Total Wellness at Mercy OKC

PROGRAM DESCRIPTION:

Mercy OKC partners with the Oklahoma City County Health Department to provide Total Wellness classes to Mercy patients and the community. Total Wellness is a free 8-week comprehensive weight loss program to help prevent diabetes and heart disease. Participants also learn how to be more health literate, appropriately read food labels, be more active, and make healthier choices overall.

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

- Share course availability with Mercy Clinics to refer patients to Total Wellness program.
- Connect complex patients needing primary care or additional support after class graduation with Mercy Primary Care and Mercy specialists.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Increase referred patients' health literacy and basic understanding of heart disease and diabetes.
- Improve physical health and reduce risk factors that can lead to cardiovascular diseases and weight control issues.

Prioritized Need #4: Access to Education

Program 1 of 2: Total Wellness at Mercy OKC

PLAN TO EVALUATE THE IMPACT:

- Track number of patients from Mercy enrolling in the program.
- Track before and after class biometric data for Mercy patients and provide data to Mercy Primary Care providers.
- Track any complex patient referrals to Mercy specialists.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Classroom space within the Mercy OKC Hospital Conference Center.
- Referrals to the Total Wellness program from Mercy CHWs or Mercy Clinic providers.
- Resources on how to access a Mercy primary care provider for those in need of a PCP.

COLLABORATIVE PARTNERS:

- Oklahoma City County Health Department
- Mercy Clinics

Prioritized Need #4: Access to Education

Program 2 of 2: Community Literacy Centers

PROGRAM DESCRIPTION:

Community Literacy Centers of Oklahoma offer free adult basic education, English language learning, U.S. citizenship preparation, and high school equivalency classes for individuals ages 18 and older. Mercy patients who screen positive for financial hardship during a health-related social needs assessment will be asked about potential barriers related to literacy or education. Patients expressing interest or need will be referred to Community Literacy Centers for enrollment. Both in-person and online class options are available to ensure accessibility and convenience

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

- Conduct health related social needs screening and refer any patients screening positive for financial hardship to a Mercy CHW.
- Support literacy class implementation through 340B fund utilization.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Help Mercy patients referred to the CLC program to reach their personal and professional goals.
- Support the community in improving reading, writing, speaking, and comprehension skills.
- Empower families by improving overall economic opportunities and boosting parents' skills and confidence

Prioritized Need #4: Access to Education

Program 2 of 2: Community Literacy Centers

PLAN TO EVALUATE THE IMPACT:

- Track number of patients from Mercy enrolling and completing the program.
- Follow up with referred patients to determine if a better employment opportunity was gained from program participation.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Funding for additional programs utilizing 340B funding.
- Program referrals from Mercy CHWs and/or Mercy social workers.
- CHW for follow up on patient progress after program completion.

COLLABORATIVE PARTNERS:

- Community Literacy Centers of Oklahoma
- Mercy 340B Committee

Prioritized Need #5: Access to Housing

GOAL 1

Increase access to stable housing and streamline discharge planning for the unhoused.

Prioritized Need #5: Access to Affordable Housing

Program 1 of 2: Discharge Coordination for the Unhoused

PROGRAM DESCRIPTION:

Since 2024, Mercy Oklahoma City has partnered with the Cardinal Community House, a low-acuity medical respite shelter providing case management and wraparound services for unhoused patients. To date, 226 patients have benefited from this partnership.

Mercy will continue this work through new collaborations with City Care, which emphasizes housing access and placement during recovery, and Paseo Avenues, which offers transitional housing following respite care. Together, these partnerships enhance Mercy's efforts to improve health and housing stability for vulnerable patients.

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

- Sponsor bed or room space for qualifying patients for up to 30 days.
- Connect patients housed at any of the three facilities with primary and specialty care services as needed.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Continuity of care, decreasing the likelihood of readmission, complications, or deteriorating health.
- Access to stable housing options making it easier for patients to maintain the necessary lifestyle changes or adhering to protocols for a healthier life.

Prioritized Need #5: Access to Affordable Housing

Program 1 of 2: Discharge Coordination for the Unhoused

PLAN TO EVALUATE THE IMPACT:

- Track the number of patients admitted to each facility,
- Track readmission of patients admitted to each facility.
- Track housing placement and gap closure of other health related social needs.
- Track length of stay for those discharged to each facility.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Care management, interdisciplinary team support, and CHW support for discharged patients housed at any of the three facilities.
- Assistance with applying for Medicaid, Mercy Financial Assistance, and other assistance programs.

COLLABORATIVE PARTNERS:

- Cardinal Community House
- City Care Medical Respite
- Paseo Avenues
- Mercy 340B Committee

Prioritized Need #5: Access to Affordable Housing

Program 2 of 2: Share unhoused patient data across systems and sectors

PROGRAM DESCRIPTION:

Health systems collect data on emergency department visits and hospital admissions, including information on unhoused patients through shared electronic health records. However, community-based organizations that support the unhoused population often lack consistent access to this data to inform their programs. Establishing data-sharing processes between health systems and community partners will strengthen cross-sector collaboration, guide resource allocation, and improve service planning for unhoused individuals with complex health needs.

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

- Gather and share data with other health systems and community based organizations serving unhoused community members.
- Have ongoing stakeholder and partner discussions to learn more about what data is needed and how to refine data.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

- Better collaboration and trust with community-based organizations serving unhoused community members.
- Enhanced support from community-based organizations serving unhoused community members.

Prioritized Need #5: Access to Affordable Housing

Program 2 of 2: Share unhoused patient data across systems and sectors

PLAN TO EVALUATE THE IMPACT:

- Track the number of unduplicated, unhoused patients admitted to the emergency room and hospital each fiscal year. Track readmission of unduplicated, unhoused patients admitted to the emergency room and hospital each fiscal year.
- Track housing placement and gap closure of other health related social needs.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Data tracking mechanism to extract deidentified patient data on unhoused community members.
- Collaboration and stakeholder meetings to share data and have further discussions on areas of opportunity.

COLLABORATIVE PARTNERS:

- The Homeless Alliance
- City Care
- Oklahoma City Key to Home
- Pivot
- Mercy Care Management and Integrated Health and Social Care

Other Community Health Programs

Mercy Hospital Oklahoma City 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.

Other Community Health Programs (Continued)

Community Benefit Category	Program	Outcomes Tracked
Community Health Improvement Services		
	Free and Charitable Clinic Care	2,400 persons served
	Community Health Fairs & Screenings	3283 persons served
Health Professions Education		
	Health professions student education nursing, imaging, therapy, pharmacy, medical student, lab, emergency medical technician and advanced practice nursing	303 students

Other Community Health Programs (Continued)

Community Benefit Category	Program	Outcomes Tracked
Financial & In-Kind Contributions	Community Building -Cash/In-kind Contributions	$348,660
	Flu Shots For Uninsured/Underinsured Patients	2,000 Vaccines
	Meals on Wheels Nutrition Services	3600 meals served
Community Building	Coalition Building/Board Memberships	1500 hours spent
Health Care Support Services	340B Program	$1,935,231

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 Hospital Oklahoma City has limited resources, not every community need will be addressed at this time. Throughout the CHNA process, the following needs arose as community concerns:

- Financial Education
- Transportation
- Grocery Store Availability

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

Your life is our life's work.