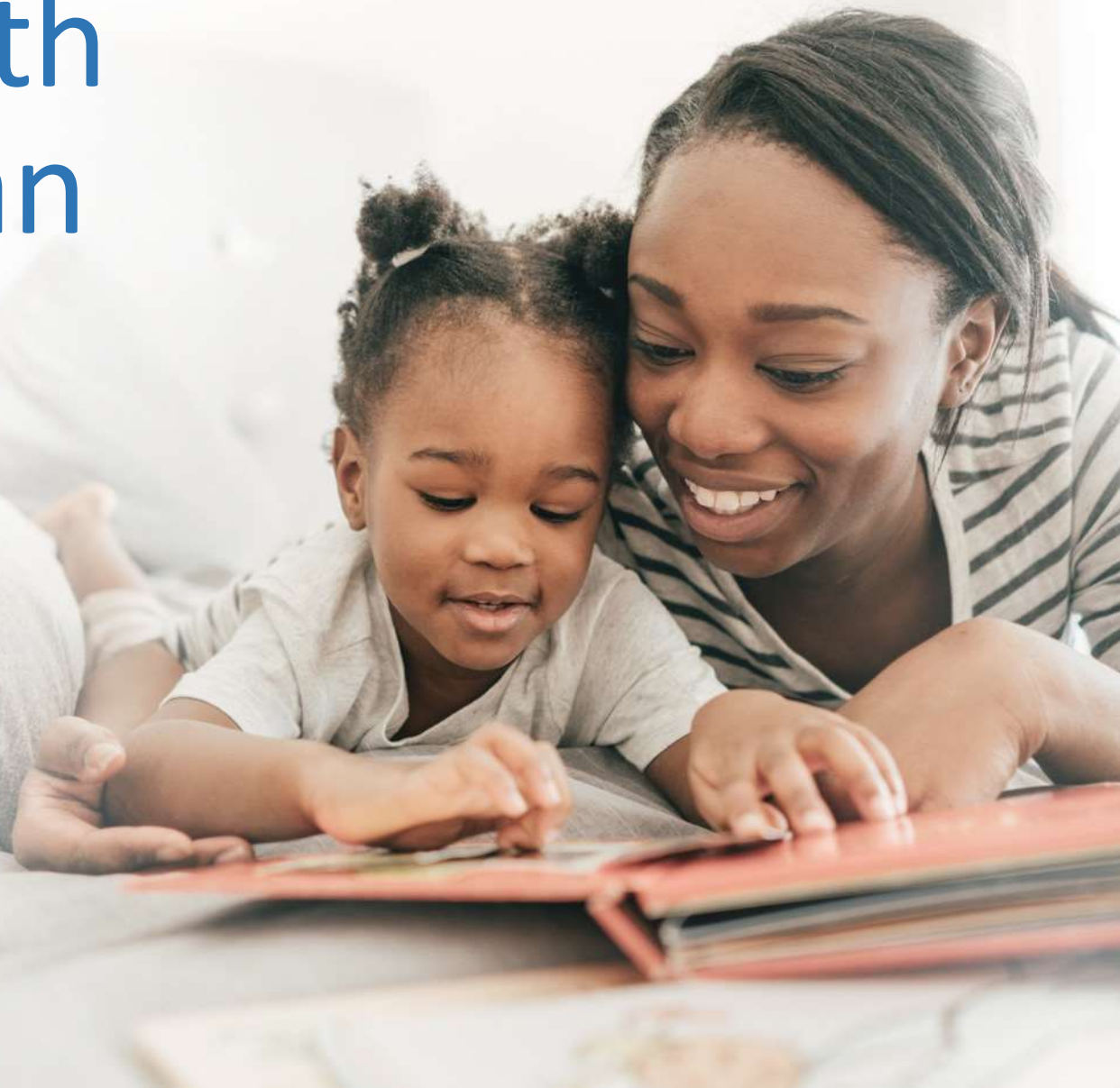
Community Health Improvement Plan

Mercy Hospital Healdton

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

Contents

Introduction

Mercy Hospital Healdton is a 22-bed critical access facility located in Healdton, Oklahoma. It serves rural Carter, Jefferson and Stephens counties in southern Oklahoma, with a population of approximately 64,239. In addition to acute care and swing bed (skilled care) services, our facility is equipped to provide inpatient and outpatient therapy, infusion services, emergency care and other treatments.

As a service to local residents, Mercy Hospital Healdton offers a community education program that provides information on specific medical conditions, healthy living, new medical treatments and other topics.

Mercy Hospital Healdton 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 Healdton 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.

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 Carter County Health Department, Good Shepherd Community Clinic, and in cooperation with stakeholders throughout the community.

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 Healdton 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 Healdton 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 year with community and medication assistance resources.
- All 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.

Prioritized Need #1: Access to Care

Program 1 of 2: Community Health Worker

PLAN TO EVALUATE THE IMPACT:

- Track number of patient encounters.
- Track number of patients screened for Social Drivers of Health (SDOH).
- Track number of patients successfully enrolled in Mercy Financial Assistance and Medicaid.
- Measure number of patients successfully establishing a primary care home.
- Record number of patients receiving community resource and medication assistance.
- Analyze ED utilization and inpatient admissions data for cohort of patients utilizing CHW services.

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
- Carter County Health Department

Prioritized Need #1: Access to Care

Program 2 of 2: Dispensary of Hope- expansion

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):

Short-Term Outcomes:

- Increase/maintain number of patients served / month
- Increase/maintain number of patient encounters / month

Medium-Term Outcomes:

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

Long-Term Outcomes:

- 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

PLAN TO EVALUATE THE IMPACT:

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

- Annual contract fees to Dispensary of Hope for formulary access ($12,500 per year per pharmacy) - covered by Mercy Ardmore
- 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

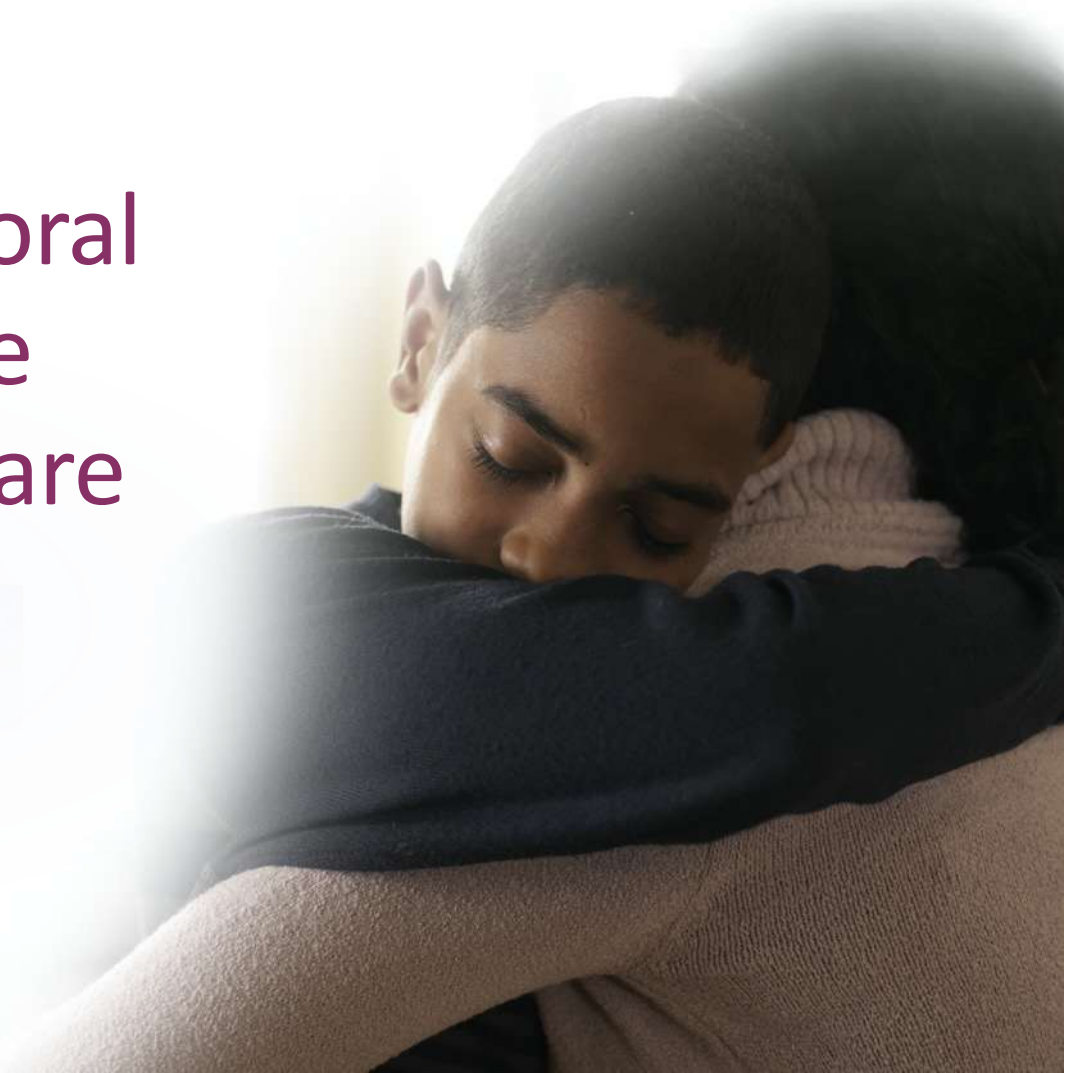
COLLABORATIVE PARTNERS:

- Dispensary of Hope
- Mercy Pharmacy Ardmore, 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):

Short-Term Outcomes:

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

Medium-Term Outcomes:

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

Long-Term Outcomes:

- 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

PLAN TO EVALUATE THE IMPACT:

- Mercy vBH will track assessments and consultations conducted
- Mercy vBH will track number of patients who are referred to BH resources and connected to appropriate treatment
- Mercy will evaluate cost-impact of expanded behavioral health services, including on hospital readmissions.

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: Concert Health Collaborative Care for Primary Care

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 HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

- Consistent with the Behavioral Health Service Line model of care, Mercy Hospital Ardmore 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):

- Set baseline number of referrals and conversions to program by end of FY26
- Increase referral and conversion numbers by 10% at the end of each 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

PLAN TO EVALUATE THE IMPACT:

- Track number of primary care physicians participating in the program.
- Track number of referrals to Concert Health per month.
- Track percentage of patients referred to Concert Health who enroll in program (conversion rate).
- Track number of referrals of uninsured and Medicaid patients per month.
- Track referrals to Community Health Workers for needs related to social determinants of health by Concert Health.

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):

Short-Term Outcomes:

- Establish baseline number of referrals of ED patients to vSURP.

Medium-Term Outcomes:

- 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.

Long-Term Outcomes:

- 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)

PLAN TO EVALUATE THE IMPACT:

- vSURP will track program referrals.
- vSURP will track number of patients who initiate care/engage with program.
- Mercy Healdton track ED utilization rates and readmissions. (Long-term outcome)

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 1: Catherine's Pantry Program

PROGRAM DESCRIPTION:

Catherine's Pantry Program is a partnership between Mercy Hospital Healdton, 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):

Short-Term Outcomes:

- By the end of each fiscal year, at least 50% of patients identified as food insecure will be given food pantry items and/or referred to the local food bank.
- Help connect repeat patients to local food resources.

Medium-Term Outcomes:

- Increase new patients in receiving food boxes and referrals from baseline by 20%.

Long-Term Outcomes:

- Patient connections to available food resources in the community.

Prioritized Need #3: Food Insecurity

Program 1 of 1: Catherine's Pantry Program

PLAN TO EVALUATE THE IMPACT:

- Track number of patients given referrals to local community pantries.
- Track number of food boxes provided to food insecure patients.
- Track number of repeat patients.

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.

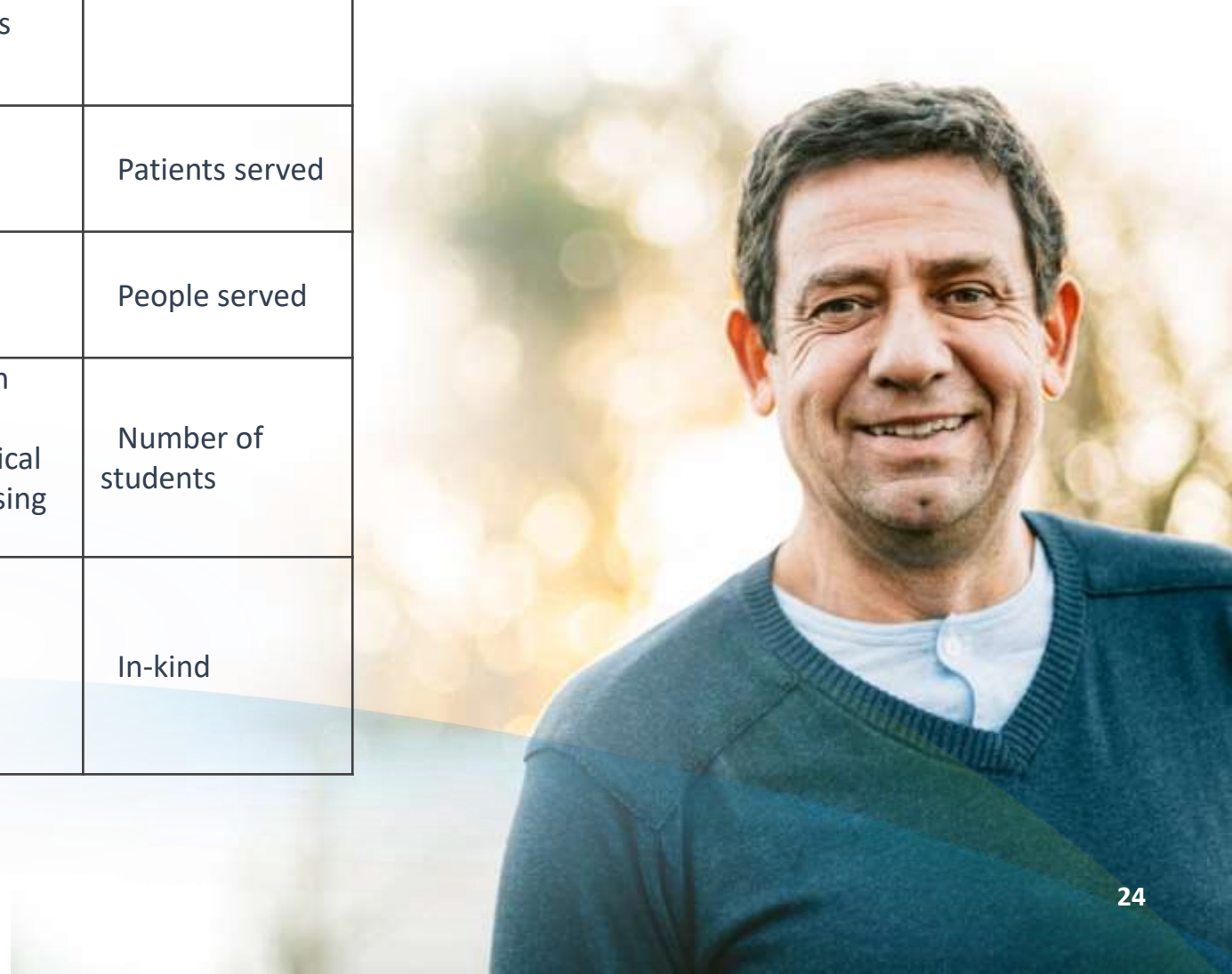
COLLABORATIVE PARTNERS:

- Mercy Clinics
- Regional Food Bank of Oklahoma

Other Community Health Programs

Mercy Hospital Healdton 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	
	Health Education Classes	Patients served
	Blood Drives	People served
Health Professions Education	Health professions student education nursing, imaging, therapy, pharmacy, medical student, lab, emergency medical technician and advanced practice nursing	Number of students
Financial & In-Kind Contributions	Community Building -Cash/In-kind Contributions	In-kind



Other Community Health Programs (Continued)

Community Benefit Category	Program	Outcomes Tracked
	Emergency Food Box Program	Boxes given out
Community Building	Coalition Building/Board Memberships	In-kind
	Lions Club	In-kind
	Healdton Strong Committee	In-kind
	Healdton Chamber of Commerce	In-kind
Health Care Support Services	340B Program	

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 Healdton has limited resources, not every community need will be addressed. Throughout the CHNA process, the following need arose as a community concern. However, it will not be addressed as a top priority because other organizations are more appropriate to address this need.

- **Transportation and Housing**

  While other community organizations are working on increasing transportation and access to low-cost housing, Mercy will not, however, take a lead role on this issue as there are some limitations to the organization's partnerships in this area. 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.

Now What

Next Steps

After carefully reviewing the data and mapping existing resources, Mercy Healdton is developing an implementation plan with evidence-based strategies. The plan will be submitted to a committee of appointed members from Mercy Hospital Healdton, for their approval. The final version of the CHNA and Implementation Plan will be available to the public on the Mercy Hospital Healdton website, **www.mercy.net/communitybenefits**.

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