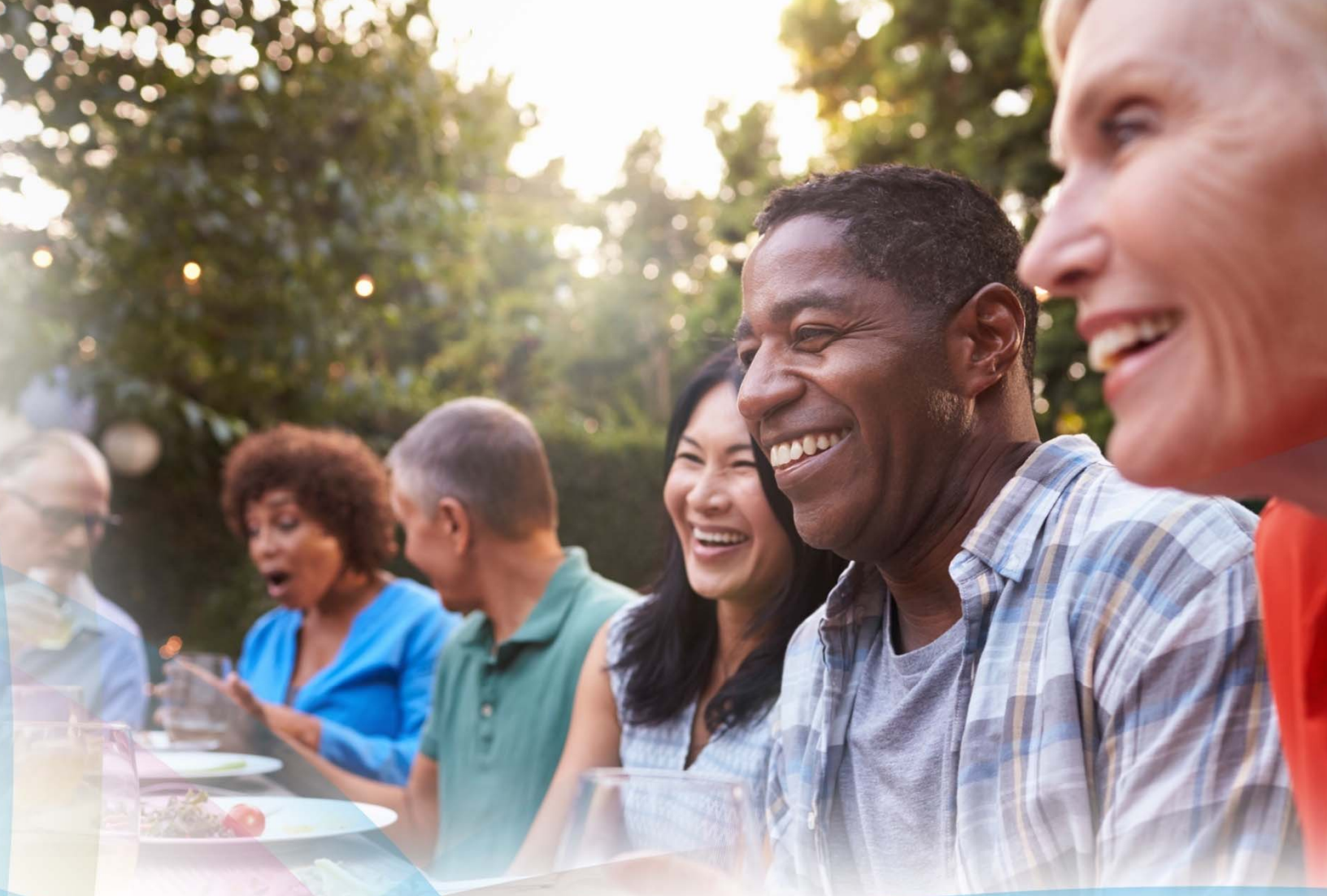

Community Health Improvement Plan

Mercy Hospital Ardmore

Fiscal Year 2019 - 2021

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.

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I. Introduction

Mercy Hospital Ardmore is a full-service hospital with 190 licensed beds, more than 800 coworkers and 7 primary care clinic locations. Mercy Clinic is a physician-governed group practice comprised of more than 40 board-certified and board-eligible primary care physicians and 7 advanced practice providers serving the Ardmore area. This provider partnership gives patients access to the best quality care in the country with access to an entire health care team and advanced services. Mercy Clinic physicians have access to an electronic health record that is shared at Mercy facilities in four states, and patients may connect to their own health record and health teams anywhere they connect to the internet through MyMercy. The service area of Mercy Hospital, Ardmore is comprised of six counties (Carter, Jefferson, Johnston, Love, Marshall and Murray) with a population of 106,451. The main campus includes the hospital and four medical buildings. The community health needs assessment process (CHNA) 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 Oklahoma Ardmore is in compliance with IRS requirements for conduction community health needs assessments

This three-year Community Health Improvement Plan (CHIP), aimed at addressing the prioritized health needs identified in the CHNA, will guide the coordination and targeting of resources, and the planning, implementation and evaluation of both new and existing programs and interventions. The 2019 CHNA and this resulting CHIP will provide the framework for Mercy Ardmore as it works in collaboration with community partners to advance the health and quality of life for the community members it serves.

II. Implementation Plan by Prioritized Health Need

Prioritized Need #1: Access to Care

Goal 1: Increase access to health care for uninsured and at-risk persons.

PROGRAM 1: Mercy Pop-Up Clinic
PROGRAM DESCRIPTION: While conducting local community chats with our underserved population we discovered that most of them did not have access to care. There is a significant amount of the underserved population who do not have access to transportation, insurance, and preventative care. We decided to work with a local community center in an underserved area to put a free clinic in their space once a month. This clinic will offer our uninsured patients the opportunity to be seen by a provider that will ultimately keep them healthier.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Meet with Mercy Clinic and Physicians to volunteer at the clinic. 2. Meet with community partners to get their support for the clinic. (Good Shepherd Community Clinic, Carter County Health Department, Grace Center, HFV Wilson Community Center, Food and Resource Center) 3. Establish a financial support system for the clinic for needs.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. Provide a physical for 100% of patients seen in Clinic. 2. Connect 20% of uninsured patients to local CHW or Financial Counselor. ***Medium-Term Outcomes:*** 1. Establish a proper SDoH screening tool to be used at the clinic 2. Screen 75% of patients for SDoH needs 3. Lower the uninsured patient use of Emergency Department for unnecessary visits by 20% 4. Increase insurance coverage of uninsured patient population in the clinic by 10% ***Long-Term Outcomes:*** 1. Establish a long-term free clinic 5. Increase chronic disease management.
PLAN TO EVALUATE THE IMPACT: 1. Track patient encounters 2. Track patient referrals healthcare services 3. Track patient referrals to community resources 4. Track patient establishments of insurance. (Financial Assistance or Medicaid/Medicare
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Physician Volunteers

2. Free Clinic Coordinator
3. Financial resources
4. Exam Beds
5. EPIC Access

COLLABORATIVE PARTNERS:

1. HFV Wilson Community Center
2. Grace Center of Southern Oklahoma
3. Southern Oklahoma Food and Resource Center
4. Carter County Health Department
5. Family Shelter
6. Good Shepherd Community Clinic

GOAL 2: Increase access to health care for uninsured and at-risk persons.

PROGRAM 2: **Community Health Worker Program**

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:

1. Identify uninsured and at-risk patients and community members in need of assistance in Mercy clinics, emergency department, inpatient settings, community events, and through the use of reports and dashboards.
2. Assist uninsured patients apply for Mercy financial assistance, Medicaid programs, and Marketplace insurance plans.
3. Assist patients without an established primary care provider in establishing care with a primary care clinic or provider.
4. Screen patients for needs related to social determinants of health and connect patients to community resources to meet identified needs.
5. Connect patients with other community resources, including medication resources, as needed.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. By the end of each month, each CHW will have recorded 20 new and 20 ongoing encounters.
2. By the end of each fiscal year for the next three years, each CHW will enroll 30 patients in Mercy financial assistance, 20 in Medicaid, and 10 in Marketplace insurance plans.

3. CHWs will assist patients without a current primary care provider to establish care with a PCP at a Mercy clinic, FQHC, free clinic, or other clinic.
4. Each CHW will assist at least 50 patients per year with community and medication assistance resources.

Medium-Term Outcomes:

1. Patients enrolling in CHW program will demonstrate reduced ED utilization and reduced inpatient admissions by 20%
2. Patients enrolling in CHW program will demonstrate a reduction in their total bad debt by 10%

Long-Term Outcomes:

1. Patients enrolling in CHW program will have improved health outcomes, improved well-being, and demonstrate improvement in measures of social determinants of health.

PLAN TO EVALUATE THE IMPACT:

1. Track number of new and ongoing encounters conducted by each CHW. (Output)
2. Track number of patients successfully enrolled in Mercy financial assistance, Medicaid, and Marketplace insurance plans. (Short-term)
3. Measure number of patients successfully establishing a primary care home. (Short-term)
4. Record number of patients receiving community resource and medication assistance. (Short-term)
5. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing CHW services. (Medium-term)
6. Analyze pre and post intervention bad debt for cohort of patients utilizing CHW services. (Medium-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

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

COLLABORATIVE PARTNERS:

1. Grace Center of Southern Oklahoma
2. United Way of Southern Oklahoma
3. Good Shepherd Community Clinic
4. Carter County Health Department
5. Mercy Good Samaritan Clinic
6. Food and Resource Center of Southern Oklahoma
7. Ardmore Family Shelter
8. Ardmore Behavioral Health Collaborative
9. Ardmore Children's Shelter

Prioritized Need #2: Behavioral Health

Goal 1: To implement an Integrated Care Model approach to behavioral health care in the primary care setting.

PROGRAM 1: Integrate a Clinical Social Worker in the Mercy Ardmore Primary Care Clinic and Mercy Pop-up Clinic

PROGRAM DESCRIPTION: The integrated care model approach will place a licensed clinical social worker into the Mercy Hospital Ardmore Primary Care Clinic setting. The LCSW/OTHER LICENCED MENTAL HEALTH PROFESSIONAL will be available at the request of the provider to address a variety of issues common to primary care which incudes but is not limited to affective conditions such as depression / anxiety, response to physical illness or pain, substance use and abuse, health behavior changes related to obesity, smoking, sleep, medication adherence, and self-management of chronic conditions, as well as, engaging the patient in prevention activities. Primary care provider referral to the LCSW/OTHER LICENCED MENTAL HEALTH PROFESSIONAL will likely occur when the condition exists that the patient and / or family is experiencing difficulties coping with personal, family and / or work life; highly conflictual and / or safety issues are evident in the home; difficulties adapting to medical and chronic health problems including end of life care; inadequate resources, knowledge of formal supports or ability to negotiate services systems. The implementation of this program will depend on securing adequate funding.

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

1. Discuss the Integrated Care Model with Mercy Ardmore Primary Care Providers to obtain their input and needs they have identified related to behavioral health in their practice.
2. Identify a medical director for the program.
3. Secure adequate funding from Catherine's fund of Mercy and other funding sources.
4. Determine billing and documentation requirements and build into charge master / Epic.
5. Hire a Licensed Clinical Social Worker.
6. Identify professional competencies and training needs for the LCSW/OTHER LICENCED MENTAL HEALTH PROFESSIONAL related to integrated behavioral health in primary care.
7. Develop standard work-flow for provision of integrated care.
8. Develop and / or adopt evidence-based screening tools for depression, anxiety, PTSD, alcohol abuse, substance abuse, and domestic violence.
9. Introduce the Trauma-Informed Care model to providers and nurses at the primary care clinic.
10. Primary care provider to provide on-site referral to LCSW/OTHER LICENCED MENTAL HEALTH PROFESSIONAL as patient behavioral health needs are identified.

PLAN TO EVALUATE THE IMPACT:

Short-Term Outcomes:

1. Provide behavioral health services to patients presenting to primary care who are at risk of impending or exacerbation of behavioral health symptoms by 10%
2. Provide various behavioral health screenings for 90% of primary care patients enrolled in the program.
3. Provide 20 on-site counseling sessions for patients in the primary care clinic.

Medium-Term Outcomes:

1. Measurable reduction in ER admissions related to physical symptoms and co-occurring behavioral health disorders, as well as, behavioral health crisis by 10%
2. Promote changes in unhealthy behaviors such as smoking, drinking, substance use, or overeating which will ultimately reduce long term health care costs by 10%.

Long-Term Outcomes:

1. Patient population begins to recognize responsibility for their own personal health and "total wellness" of their physical and mental well-being.
2. Patient population chooses healthier lifestyles resulting in better overall health.
3. Patient population learns coping skills such as relaxation techniques, etc. for reduction of stress / anxiety and other behavioral health issues.
4. Reduction in stigma of "behavioral health" in the community.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- The services of a licensed clinical social work to collaborate with physicians, mid-level providers, and nurses in order to provide integrated care in the primary care setting...
- Materials needed for specific behavioral health screenings, e.g., depression, anxiety, PTSD, alcohol abuse, substance abuse, domestic violence.
- Training / Competencies related to the integrated care model.

COLLABORATIVE PARTNERS:

1. Lighthouse Behavioral Wellness
2. Ardmore Behavioral Health Collaborative

PROGRAM 2: Mental Health Services Inventory/Assessment/Pilot

PROGRAM DESCRIPTION: The hospital will collaborate with community partners to conduct a current assessment of behavioral health services offered, identify any existing gaps and pilot creative collaborative approaches to meet community behavioral health needs.

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

1. Conduct an internal inventory of existing Mercy behavioral health services (i.e. Inpatient, Outpatient, Intensive Outpatient Programs (IOP), Counseling Services, Classes, Support Groups, Regional Access Center services, Virtual Care Center (VCC) for Primary Care Integration.
2. Conduct an external inventory of existing local community services offered by other health systems, non- profit and for-profit agencies.
3. Review data from any existing documents/community assessments, resource list inventories and focus group reports.
4. Identify gaps in service, explore Mercy VCC solutions and other best practice options (for example, intensive outpatient programs (IOPs), and develop a plan to pilot a minimum of one initiative.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. By the end of FY20, the internal and external assessments will be completed.

Medium-Term Outcomes:

1. By the end of FY21, community need gaps will be identified and a plan, including funding support, will be presented for pilot initiative(s).

Long-Term Outcomes:

1. By the end of FY22, the pilot will be implemented and initial outcome data presented

PLAN TO EVALUATE THE IMPACT:

Impact evaluation approach will be dependent on program piloted. Measurement tools will include, but are not limited to:

1. Number of Internal Behavioral Health Programs
2. Numbers of patients and community members served.
3. Analyses of available outcomes data, for example, utilization, readmission, and contribution margin.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

- Cost of coworker time
- Operational budgeted support as appropriate
- Philanthropy support as needed

COLLABORATIVE PARTNERS (Align with Your Community – Examples here are St Louis):

1. Ardmore Behavioral Health Collaborative

III. Other Community Health Programs

Mercy Ardmore 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 below.

Community Benefit Category	**Program**	**Outcomes Tracked**
Community Health Improvement Services	Turning Point Coalition	Persons served
	Diabetes Support Group	Persons served
	Home Health Coalition	Persons served
	Ardmore Behavioral Health Collaborative	Persons served
	Good Shepard Community Clinic Support	Persons served, cost of services
	Community Health Fairs & Screenings	Persons served
	Community health education talks	Persons served
	United Way of Southern Oklahoma	Persons served
	Hospital medication assistance program	Persons served
	Diabetes Prevention Program	Persons served, cost of services
	Patient Family Meals	Persons served, cost of services
	The Landing Teen Recovery	Persons Served
Health Professions Education	Internal Medicine Residency Program	Number of residents
	Health professions student education – nursing, imaging, therapy, pharmacy, medical student, lab, emergency medical technician, and advanced practice nursing,	Numbers of students
Financial and In-Kind Contributions	Mental Health Services Crisis Unit, Victory Life Church, Legal Aid Services, Girls on the Run First Aid Kits	Cost of services, Persons Served

Community Building Activities – Workforce Development	Carter County College Fair	Number of students
	High School Career Day	Number of students
	Teen Shadow Program	Number of students
Community Building Activities – Environmental Improvements		Cost of project

IV. Significant Health Needs Not Being Addressed

Diabetes

After working on diabetes for the last six years we decided that the efforts we have underway on this topic are very well established. Our Diabetes Prevention Program is fully recognized by the CDC. Our Diabetes education team has created a diabetes prevention conference as well as established a great diabetes support group. Mercy Ardmore will continue to fund these programs, but our focus now is turning towards access to care and behavioral health efforts.

NOTES: