Mercy

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Community Health Improvement Plan

Mercy Hospital Berryville

Fiscal Year 2019 - 2021

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.

Table of Contents

I. Introduction

Mercy Hospital Berryville (Mercy Berryville) completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors in May 2019. The CHNA took into account input from the county health department, community members, members of medically underserved, low-income, and minority populations and various community organizations representing the broad interests of the community of Carroll County, Arkansas. The CHNA identified two prioritized health needs the hospital plans to focus on addressing during the next three years: Access to Care and Obesity & Overweight. The complete CHNA report is available electronically at mercy.net/about/community-benefits.

Mercy Berryville is affiliated with Mercy, one of the largest Catholic health systems in the United States. Located in Carroll County, Arkansas, the critical-access hospital has 25 licensed beds, and includes a variety of specialty clinics, an outpatient surgery center, sleep center, physical therapy services, and emergency department. Mercy Berryville is a large employer in the area with over 220 co-workers. Carroll County is considered to be part of the larger Northwest Arkansas metropolitan area, which includes Benton, Carroll, Madison, and Washington Counties in Arkansas, as well as, Barry and McDonald Counties in Missouri.

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 Berryville 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 and community resources for uninsured and at-risk persons.

PROGRAM 1: **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 15 new and 15 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 patient 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. 2. Patients enrolling in CHW program will demonstrate a reduction in their total bad debt.

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)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Salary and benefits for full-time Community Health Worker.
2. Mileage and travel expenses required for CHW work.
3. Office space and indirect expenses dedicated to CHW work.

COLLABORATIVE PARTNERS:

1. A Cup of Love Ministry
2. Tyson Foods, Inc.
3. Area churches

PROGRAM 2: School-Based Clinic: The Learning Center of North Arkansas

PROGRAM DESCRIPTION: The Learning Center of North Arkansas (TLCNA) is a nonprofit organization serving children with developmental and other disabilities in Carroll and Boone Counties. TLCNA provides early intervention day treatment services to preschool-aged children, most of whom are of low socioeconomic status. The purpose of the school-based clinic is to provide access to primary care to these children and their families.

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

1. Operate a primary care clinic ½ - 1 day per week on site at TLCNA utilizing an employed nurse practitioner.
2. Assist families in applying for Medicaid or ARKids first programs as needed.
3. Mercy Community Health Worker will assist families in need to connect to community resources and social services.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. The clinic will begin operating by October 1, 2019, seeing patients ½ - 1 day per week.
2. At least 5 patients will be seen per ½ day in the first year.

Medium-Term Outcomes:

1. Patients will obtain needed primary care and paperwork related to initiating therapy services in a timely manner.
2. TLCNA will be able to serve a greater number of children for therapy services

Long-Term Outcomes:

1. Children with developmental disabilities will benefit from early intervention and improved access to healthcare and therapy services.

PLAN TO EVALUATE THE IMPACT:

1. Track number of patients seen per month in the clinic. (Short-term)
2. Track number of referrals to community health worker per month from clinic (Short-term)
3. Develop other appropriate tracking and evaluating metrics once clinic is operational.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Cost of nurse practitioner, clinic manager, and Community Health Worker time.
2. Cost of installation of technology at clinic site.

COLLABORATIVE PARTNERS:

1. The Learning Center of North Arkansas

Goal 2: Increase access to behavioral health care for elderly and at-risk persons.

PROGRAM: Senior Life Solutions

PROGRAM DESCRIPTION: Senior Life Solutions (SLS) is an intensive outpatient geriatric behavioral health program focused on meeting the unique needs of adults age 65 and over who are struggling with trauma, stress, grief, sleep disorders, and/or other age-related factors contributing to behavioral health issues by providing screening, education, and group therapy.

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

1. Promote the SLS program to Mercy and community providers, as well as, other partners to achieve and maintain maximum capacity for current track.
2. Provide mental/behavioral health education including related risk factors and prevention strategies.
3. Promote and support mental and behavioral health programs, services and treatments within the Mercy system and the community at large.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Monthly: A minimum of 40 contacts will be made with community partners and providers to provide mental/behavioral health education and promote the SLS program.
2. Monthly: A minimum of 5 patient referrals will be made by Mercy PCPs and Mercy departments to the SLS program.
3. Annually: A minimum of 60 seniors will receive mental/behavior health assessments and referral to a PCP or other source, as appropriate
4. An Alzheimer/dementia and care giver support group meeting will be provided each month, providing related education, resources, and referrals.

Medium-Term Outcomes:

1. Patients participating in SLS program will have improved health outcomes and health literacy to be better engaged in their health care decisions.

PLAN TO EVALUATE THE IMPACT:

1. Track number and source of community contacts each month. (Short-term)
2. Track total number of PCP referrals. (Short-term)
3. Track number of related assessments provided. (Short-term)

4. Track number of support groups provided and attendance. (Short-term)
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Cost of program director time. 2. Indirect expenses needed to deliver care.
COLLABORATIVE PARTNERS: 1. Area Agency on Aging 2. Carroll County Senior Citizens Center 3. Local healthcare providers

Prioritized Need #2: Access to Care

Goal: Decrease/maintain obesity rates in Carroll County.

PROGRAM: Health Fairs
PROGRAM DESCRIPTION: Participate in the annual Tyson employee health fair located at Berryville and Green Forest plants by providing screenings and health education related to obesity & overweight and co-morbidities, including cardiovascular disease and diabetes. Tyson employs approximately 3,000 team members at these plants, including many Hispanic and Marshallese individuals. Mercy will also participate in the annual Carroll County Senior Health Fair by providing screenings and health education related to obesity & overweight and co-morbidities, including cardiovascular disease and diabetes. Approximately 75 seniors attend the fair each year.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Perform free blood pressure and pulse oximetry screenings for individuals and provide interpretation of results. 2. Refer and assist individuals, as needed, in establishing care with a primary care clinic or provider. 3. Provide health education regarding such issues as obesity & overweight and co-morbidities, related risk factors, and prevention strategies, including promotion of good nutrition and physical activity. 4. Promote and support evidence-based obesity and related co-morbidities programs, services and treatments within the Mercy system and the community at large.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. 200 individuals will receive screenings, interpretation, and referral, as needed at the annual Tyson employee health fair events. 2. 200 Tyson employees will receive health education regarding obesity & overweight, co-morbidities, and/or healthy lifestyles 3. 40 seniors will receive screenings, interpretation, and referral, as needed at the Carroll County Senior Health Fair. 4. 40 seniors will receive health education regarding obesity & overweight, co-morbidities, and/or healthy lifestyles ***Medium-Term Outcomes:*** 1. Health fair participants will make lifestyle changes to reduce their risk of overweight and obesity.
PLAN TO EVALUATE THE IMPACT: 1. Track number of individuals receiving screenings. (Short-term) 2. Track number of educational materials distributed. (Short-term) 3. Record number of individuals for whom referrals to primary care clinics and/or providers were made. (Short-term)
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Cost of staff and community health worker time. 2. Cost of educational materials provided.
COLLABORATIVE PARTNERS:

4. Tyson Foods, Inc.
5. Carroll County Senior Center

III. Other Community Health Programs

Mercy Berryville 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	Alzheimer's Support Group	Persons served
	Diabetes Support Group	Persons served
	People Helping People pharmacy assistance program	Persons served
	Lab and imaging vouchers for ECHO free clinic patients	Persons served
Health Professions Education	Health professions student education – radiology technician students	Numbers of students
Financial and In-Kind Contributions	Loaves and Fishes Food Bank support	Cost of contributions
	Meeting space donations	Cost of contributions
	First aid for community sporting events	Cost of services
	Ozarks AIDS Resources and Services Support	Cost of contributions
Community Building Activities – Community Support	Adopt a Highway	Hours contributed

IV. Significant Community Health Needs Not Being Addressed

A complete description of the health needs prioritization process is available in the CHNA report. Two health issues identified in the 2019 CHNA process—mental/behavioral health and stroke—were not chosen as priority focus areas for development of the current Community Health Improvement Plan due Mercy's current lack of resources available to address these needs and the intention to focus on the two prioritized health needs. These issues will be addressed indirectly in implementation strategies developed to meet the prioritized needs in areas that may overlap. For example, the Senior Life Solutions program described under access to care also increases access to behavioral health services for seniors. Additionally, related community partnerships, evidence-based programming, and sources of financial and other resources will be explored during the next three-year CHIP cycle. Mercy Berryville will consider focusing on these issues should resources become available. Until then, Mercy Berryville will support, as able, the efforts of partner agencies and organizations currently working to address these needs within the community.

NOTES:

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