Community Health Improvement Plan

Mercy Hospital Oklahoma City

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 Oklahoma City, INTEGRIS, and SSM Health St. Anthony, in partnership with the Oklahoma City-County Health Department, the Oklahoma State Department of Health and the United Way of Central Oklahoma, are pleased to present the 2019-2021 Community Health Needs Assessment (CHNA). This CHNA report provides an overview of the health needs and priorities associated within Oklahoma County. The goal of this report is to provide residents with a deeper understanding of the health needs in their community, as well as help guide the hospitals in their community benefit planning efforts and development of an implementation strategy to address assessed needs. The CHNA involved review of both quantitative and qualitative data to attain the full scope of the community needs as they relate to health with a focus on the economically poor and underserved populations.

This summary is documentation that Mercy Hospital Oklahoma City is in compliance with IRS requirements for conducting a community health needs assessment. The Mercy Hospital Oklahoma City board approved this CHNA on January 29, 2019. Mercy Hospital Oklahoma City last conducted a CHNA in 2015.

The Affordable Care Act (ACA) requires 501(c)(3), tax-exempt hospitals to conduct a CHNA every three tax years and adopt a strategic implementation plan for addressing identified needs.

Identified priorities for the next three years include: access to care, food access/insecurity, mental/behavioral health, obesity, and tobacco. Many of the initiatives identified and implemented in the previous Community Health Needs Assessment will be continued along with new programs.

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: **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 fiscal year for the next three years, each CHW will enroll patients in Mercy financial assistance, Medicaid, Marketplace insurance plan, or free clinic 2. 90% of new patients without a primary care provider will establish care with a PCP at a Mercy clinic, FQHC, free clinic, or other clinic within 6 months. 3. 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)
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:

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

PLAN TO EVALUATE THE IMPACT:

1. Number of patients seen in clinic
2. Number of providers working in clinic
3. Number of prescriptions
4. Number of referrals given for community resources

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Time, resources, funds, indirect expenses

COLLABORATIVE PARTNERS:

1. Mercy Good Samaritan Free Clinic
2. Mercy Clinic
3. Oklahoma County Pharmacy
4. RX for Oklahoma
5. Heartline 211
6. Regional Food Bank of Oklahoma
7. Embark

Prioritized Need #2: Behavioral Health

Goal 1: Provide mental/behavioral health support for students and families experiencing crisis

PROGRAM 1: Call SAM (Student Assistance by Mercy)
PROGRAM DESCRIPTION: Call SAM is a program that assist students, staff, and families in mental/behavioral health education, referral to services, and crisis support for the Edmond, Oklahoma school district and Catholic Schools in the Archdiocese of Oklahoma City.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Present education on mental health topics through teacher inservice meetings at the schools 2. Send monthly newsletter to counselors and principals of schools served 3. Provide 24/7 support to students and families in crisis via a dedicated call line 4. Design a data collection model of persons and schools served 5. Design and implement survey of those served for effectiveness
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. Analyze data on a quarterly basis to provide a baseline for future reports ***Medium-Term Outcomes:*** 1. Data collected will demonstrate effectiveness and allow for changes in the programming to occur 2. Requests from other school districts will be considered ***Long-Term Outcomes:*** 1. Improved mental health status of students and families served
PLAN TO EVALUATE THE IMPACT: 1. Analyze all data collected from surveys and tracking spreadsheet.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Staff, hours/time 2. Resources and supplies 3. Mileage expenses
COLLABORATIVE PARTNERS: 1. Edmond Public Schools 2. Catholic Schools in the Oklahoma City area 3. Mercy Call Center 4. Heartline 211

Prioritized Need #3: Food Access/Insecurity

Goal 1: Address food insecurity for patients of Mercy Hospital and Mercy Clinic

PROGRAM 1: Food for Health
PROGRAM DESCRIPTION: Food for Health provides patients that have been screened positive for food insecurity. Each patient will receive a pantry box (four meals) upon discharge or checkout. Data will be collected for improved overall wellness which includes physical and mental health, nutrition education and fitness promotion.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: 1. Coordinate planning meeting with Mercy leaders and Regional Food Bank of Oklahoma 2. Design Food for Health pilot and the logistics involved 3. Collaborate with the Regional Food Bank on food items and community resources for the pantry boxes 4. Determine pilot locations and start date to screen patients and provide food boxes 5. Create data collection for each location 6. Create survey for evaluation of pantry boxes
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): ***Short-Term Outcomes:*** 1. Pilot data will be analyzed after six months 2. Changes in pilot plans will be implemented if needed ***Medium-Term Outcomes:*** 1. If changes to pilot need to occur, pilot will extend to another six months 2. If trend continues to show positive outcomes of the pilot, a funding plan will be created 3. Education and awareness of community food resources will demonstrate success ***Long-Term Outcomes:*** 1. Food for Health will become a permanent program for expansion for hospital inpatients and other clinic locations.
PLAN TO EVALUATE THE IMPACT: 1. Number of boxes distributed, and patients served 2. Number of patients that reached out to other food pantries/resources 3. Satisfaction of pantry boxes 4. Patient perception of improved health
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Time, resources, indirect expenses, and funds for pantry boxes
COLLABORATIVE PARTNERS: 1. Regional Food Bank of Oklahoma 2. Food pantries near pilot locations

Prioritized Need #4: Obesity/Diabetes

GOAL: Decrease the prevalence of prediabetes/diabetes in Oklahoma City area.

PROGRAM: Diabetes Prevention Program

PROGRAM DESCRIPTION: The Diabetes Prevention Program (DPP) is a CDC evidence-based lifestyle change program, led by a trained lifestyle coach, to reduce the risk of developing type 2 diabetes in adults with prediabetes or who are at risk for diabetes. Program is schedule to begin November 2019.

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

1. Conduct the year-long program consisting of 26 class sessions, offering various class times and meeting locations to meet the needs of the participants.
2. Maintain a roster of trained lifestyle coaches to offer the program.
3. Publicize the program to primary care physicians and community members.
4. Maintain a fully recognized DPP program by ensuring that participants meet program goals and data is submitted to CDC as required.

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. At least 50 new participants per fiscal year will enroll in the program and complete the first 4 sessions.
2. Retention rate for participants attending at least 4 sessions will be greater than 60%.
3. Average weight loss for participants completing the program will be at least 5%.
4. Percent of participants completing program who have achieved at least 150 minutes of physical activity/week will be at least 70%

Medium-Term Outcomes:

1. At least 60% of participants completing the program will reduce their HbA1C or fasting glucose levels to normal.

Long-Term Outcomes:

1. Rates of diabetes and prediabetes will be reduced in Oklahoma City area.

PLAN TO EVALUATE THE IMPACT:

1. Track number of new participants who enroll in the program and complete the first 4 sessions in each fiscal year and cumulative total since program inception. (Output)
2. Track number of participants who have completed their first of year of the program in each fiscal year and cumulative total since program inception. (Output)
3. Track the program cumulative retention rate for participants completing the first 4 sessions. (Short-term)
4. Track the percent of participants annually receiving partial or full financial assistance to cover program costs. (Short-term)
5. Calculate and record the average weight loss for all participants under the Oklahoma City area DPRP recognition code completing the program who have attended at least 3 or more sessions and had a time span between the 1st and last session of at least 9 months (consistent with CDC-reported program data). Report this outcome in December and June of each year (number of participants included in measure and % weight loss). (Short-term)

6. Record the percent of participants completing their first year of the program in the fiscal year who have achieved at least 150 minutes of physical activity/week. (Short-term)
7. Record the percent of participants completing their first year of the program each fiscal year who have reduced their HbA1C or fasting glucose to normal levels. (Medium-term)
8. Calculate changes in HbA1C levels for participants completing their first year of the program each fiscal year (Medium-term):
    a. Average beginning HbA1C
    b. Average ending HbA1C
    c. Average percent change in HbA1C
9. Calculate changes in fasting glucose levels for participants completing their first year of the program each fiscal year (Medium-term):
    a. Average beginning fasting glucose
    b. Average ending fasting glucose
    c. Average percent change in fasting glucose

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Cost of program coordinator time (grant offset).
2. Financial assistance for participants unable to afford the cost of the program.
3. Indirect expenses related to meeting space and overhead.

COLLABORATIVE PARTNERS:

1. Oklahoma Department of Health
2. Center for Disease Control
3. Mercy Hospital Ardmore
4. Oklahoma Diabetes Caucus members

Prioritized Need #5: Tobacco

GOAL: Decrease tobacco use in Oklahoma County to 17% by 2020 in collaboration with community partners

PROGRAM 1: Active and engaged participation in the Tobacco Use Prevention workgroup of Wellness Now coalition of the OCCHD

PROGRAM DESCRIPTION: The Tobacco Use Prevention Workgroup is dedicated to improving health outcomes by ensuring clean indoor/outdoor air, strengthening policies for limiting youth access to all tobacco products, and providing cessation support services.

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

1. Serve as an active participant of the OK2Quit campaign
2. Host annual campus Clean Up Day at Mercy sites
3. Host/participate in Great American Smoke Out events

ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Community tobacco prevention efforts will experience higher participation over last year events

Medium-Term Outcomes:

1. Year end data and group discussions will determine future programming
2. Anecdotal data will be used for demonstration of changes in behavior and decision-making findings

Long-Term Outcomes:

1. Increase membership in Tobacco Workgroup
2. Improved health status and life conditions

PLAN TO EVALUATE THE IMPACT:

1. Successful community events and efforts will result in increased workgroup membership and impact
2. Data collection of all efforts will be analyzed for impact

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Staff attend Tobacco Use Prevention workgroup meetings
2. Provide resources/supply for the Clean Up Day at Mercy sites

COLLABORATIVE PARTNERS:

Community partners:

1. Oklahoma City/County Health Department, Wellness Now
2. Oklahoma State Health Department
3. Oklahoma Tobacco Settlement Endowment Trust (TSET)
4. American Lung Association in Oklahoma
5. State of Tobacco Control Coalition
6. Oklahoma Tobacco Helpline

III. Other Community Health Programs

Mercy Hospital Oklahoma City conducts other community programs not linked to a specific health need. These programs do 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, relieve government burden to improve health. The need for these programs was identified through documentation of demonstrated community needs or a request from a public health agency of community group. Activities or programs carried out for the purpose of improving community health and which involve an unrelated, collaborative tax-exempt partner are also included. Although this is not an exhaustive list, several programs are listed below.

Community Benefit Category	**Program**	**Outcomes Tracked**
Community Health Improvement Services And Support	Good Samaritan Free Clinic Ministries of Jesus Clinic Lighthouse Ministries Clinic Cross and Crown Clinic St. Charles Clinic	Persons served Cost of services
	Support groups for Diabetes, Better Breathers, Stroke, Cancer, Grief	Persons served
	Project Early Detection breast health services for the uninsured	Persons served, Cost of services
	Mercy In Schools	Persons served
	Community health education talks	Persons served
	Hospital medication assistance program and transportation assistance program	Persons served Cost of services
Health Professions Education	Health professions student education – nursing, imaging, therapy, pharmacy, lab,	Number of students and hours
Financial and In-Kind Contributions	Health Alliance for the Uninsured	Salary support
	Archdiocese Priest Wellness Nurse	Salary Support
	Friday Mercy Meals	Persons served, cost of services
	Blood Drives	Persons served
	Flu Shots	Cost of services
	Good Shepherd School at Mercy (autism school)	Cost of services
Community Building Activities – Workforce Development	High School Career Days	Number of students Cost of supplies

Community Building Activities – Coalition Building & Board Membership	Wellness Coalition of OCCHD, Public Health Institute of Oklahoma, Compassionate Care Group, Oklahoma Diabetes Caucus, Wellness Alliance of Central Ok., NE OKC Healthy Collaborative, HAU,	Cost of services

IV. Significant Health Needs Not Being Addressed

Due to limited resources, not every health indicator which has an identified need for improvement will be directly addressed. Those community needs identified, but not "prioritized" for improvement included the following:

EDUCATION
Data collection occurred at the same time as the 2018 Oklahoma legislative session when teacher pay raises, education funding crises, and a teacher walkout were trending current events. This most likely impacted the high rate of responses showing education as a need.

Health education programs including physical activity and prevention and wellness were mentioned numerous times in community chat feedback. It is believed that through the focus of obesity, tobacco, food access, mental health and healthcare access, these needs will be indirectly addressed.

HEALTH INSURANCE AND PRESCRIPTION MEDICATIONS
The hospitals attempt to alleviate these economic constraints on a regular basis through the provision of charity care and the foundation programs.

POVERTY
Although poverty as a standalone item was not chosen as a priority, the hospitals believe the selected priorities will positively impact poverty through improved food, healthcare access, and mental health.

SOCIAL
This variable includes, but is not limited to, the following comments from chat questionnaires: classes for adults; community gathering spaces; affordable housing; political representation; employment; funding, systems and government; infrastructure, parks and recreation; environment; social support; respect and tolerance; transportation issues; elder care; safety; and intrinsic factors. The hospitals are not prepared to address these needs, and rely on federal, state, and local government-based programs to address and improve these issues.

TEEN PREGNANCY
There are Ethical and Religious Directives for Catholic healthcare entities (SSM Health St. Anthony and Mercy Hospital OKC) that limit the ability and capacity to intervene on this issue. There are several organizations in Oklahoma County that are addressing teen pregnancy in the community including THRIVE, Variety Care, and the Oklahoma City-County Health Department.

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