



Community Health Improvement Plan

Mercy Hospital
Oklahoma City

Fiscal Year 2022-2025



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

The Central Oklahoma Health Impact Team's FY22 Community Health Needs Assessment (CHNA) was developed under the direction of each nonprofit hospital systems' Community Health leader, along with leadership and facilitation of the collaborative process by the Oklahoma City Community Foundation (OCCF).

Four non-profit hospitals engaged in a joint CHNA: INTEGRIS Health, Mercy Hospital Oklahoma City, OU Health, and SSM Health St. Anthony. This assessment evaluated the health needs of Oklahoma County. As federally required by the Affordable Care Act, the CHNA provides an overview of the methods and processes used to identify and prioritize significant health needs in the service area. The goal of the CHNA is to provide residents with a deeper understanding of the health needs in their community as well as to help guide the hospitals in their community benefit planning efforts and development of an implementation strategy to address assessed needs. In addition, the CHNA aligns local planning efforts with assessments and interventions conducted by the Oklahoma City-County Health Department (OCCHD). Throughout the needs assessment process, we focused on the interconnectedness of social determinants and health outcomes in Oklahoma County. Social determinants of health (SDoH) are the conditions in which people are born, grow, live, work and age that shape health. SDoH are primary drivers of health disparities and include factors like economic stability, education access and quality, health care access and quality, neighborhood and the built environment, and social and community context. The CHNA process was designed to use data to identify those who may not be thriving; use information provided from Community Chats and key stakeholder interviews to help community members and organizations identify systems that perpetuate inequity; recognize potentially replicable bright spots; and test policy and programmatic changes that have the potential to disrupt systems perpetuating inequity. By doing this we hope the long-term outcome will be the creation of conditions where everyone has the opportunity to achieve health and well-being, by addressing the root causes of poor health outcomes.

The team used the following methods to understand the community health needs:

- Stakeholder meetings – assembled a group of 65 community stakeholders representing 45 organizations including those that serve populations experiencing health inequities.
- Secondary data research – information related to the current state of our community's economic, social, and health status published by established sources.
- Community survey – a survey of the general public to better understand what they view as the most significant health issues.
- Community Chats – discussions with community members and community champions to delve deeper into individual experiences with health-related issues.
- Informational interviews – with key community leaders to gain insights into their priorities and plans to address the social determinants of health.

This process led to the identification of four priority areas, which will be discussed in the 2022-2025 Community Health Improvement Plan/Implementation Strategy. Although there is no single factor that predicts a health outcome, the areas identified as priority for Oklahoma County, by the hospital systems and community stakeholders, include: Access to healthcare, Access to education, Access to healthy food and Access to meaningful employment.

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 Community Advisory Board reviewed, provided feedback and approved the CHNA on January 11, 2022. Mercy Oklahoma City Hospital Board approved on August 3, 2022. Mercy Hospital Oklahoma City last conducted a CHNA in 2019.

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.

II. Implementation Plan by Prioritized Health Need

Community Health Driver Diagram:

To create opportunities for multisector collaboration and alignment to improve community health, the Mercy Hospital OKC created a community health driver diagram (Table 1). A driver diagram can be used collaboratively by public health, health care, and other partners to identify the potential primary and secondary drivers that can help to achieve an identified community health objective. Driver diagrams serve as a starting point for discussion among stakeholders and help to create an atmosphere of cooperation by enabling each participant to identify their organization's role in addressing the health challenge.

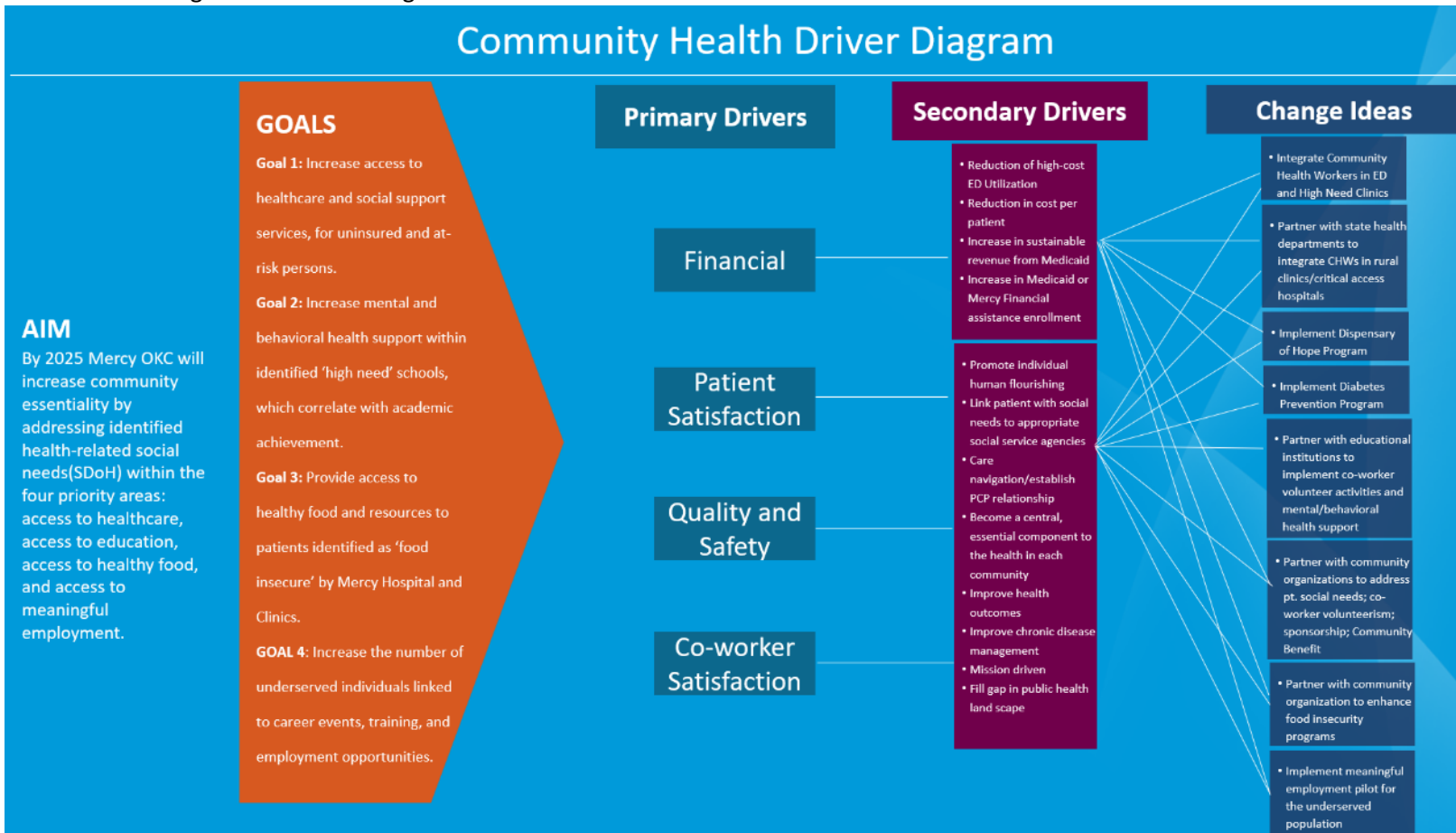


Table 1: Community Health Driver Diagram shows alignment of hospital aim, goals, drivers, and change ideas. Change ideas will be tested using quality improvement techniques (i.e A3 and PDSA), to improve Community Health from 2022-2025.

Prioritized Need #1: Access to Healthcare

Goal 1: Increase access to healthcare and social support services, for uninsured and at-risk persons.

PROGRAM 1: Social Determinants of Health Initiative- Integration of Community Health Workers within Mercy Hospital and 'High Need' Clinics

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.

<p>ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ol style="list-style-type: none"> 1. Community Leadership/ Sponsorship/ Co-worker Kick-off meetings 2. Site Planning Meeting 3. Readiness Assessments for leaders and co-workers 4. eLearning for leaders and co-workers 5. Monthly Sponsor Accountability meetings (CQI) 6. CHL bi-weekly ministry leader meetings 7. CHW bi-weekly meetings (CQI) 8. SDoH Screening (Basic Needs Questionnaire-BNQ)- Identify uninsured, at-risk patients and community members in need of assistance in Mercy clinics, emergency department, inpatient settings, community events, and using reports and dashboards; Screen patients for needs related to SDoH and connect patients to community resources, including medication resources, to meet identified needs. 9. Patient case management- Assist uninsured patients in applying for Mercy financial assistance, Medicaid programs, and Marketplace insurance plans; assist patients without an established primary care provider in establishing care with a primary care clinic or provider. 	<p>COLLABORATIVE PARTNERS:</p> <ol style="list-style-type: none"> 1. Mercy Community Health ministry leaders 2. Health Informatics leader/Team 3. Patient Access Representatives Leader/Team (ED and Clinic) 4. Emergency Department Leaders 5. Clinic Leaders 6. Nursing Leader/Team (ED) 7. Community Health Leader(s)/Team 8. Inpatient Care Management Leader/Team 9. Catholic Charities/Cardinal House Respite Shelter 10. Behavioral Health Leader/Team 11. Mercy Eligibility Leader(s)/Team 12. Pharmacy 13. Oklahoma State Department of Health- Community Health Leader(s)/CHWs 14. Pharmacy 15. Diabetes Prevention Program Leaders 16. Epic Leader/Team 17. Mercy Financial Assistance Leader/Team 18. Health Alliance for the Uninsured 19. Unite Us
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ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes (12 months):

- By the end of each fiscal year for the next three years, CHWs will increase patient enrollment in Medicaid by 20%, from baseline (of the previous year).
- By the end of each fiscal year for the next three years, CHWs will increase patients served by 20%, from baseline.
- 10% of new patients (seen by a CHW) without a primary care provider will establish care with a PCP at a Mercy clinic, FQHC, free clinic, or other clinic within 6 months.

Medium-Term Outcomes (12-36 months):

- Patients enrolling in CHW program will demonstrate reduced ED utilization and reduced inpatient admissions.
- Patients enrolling in CHW program will demonstrate a reduction in their total bad debt.

Long-Term Outcomes (36+ months):

- 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.
2. Track number of patients successfully enrolled in Mercy financial assistance, Medicaid, and Marketplace insurance plans.
3. Measure number of patients successfully establishing a primary care home.
4. Record number of patients receiving community resource and medication assistance.
5. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing CHW services.
6. Analyze pre and post intervention bad debt for cohort of patients utilizing CHW services.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

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

PROGRAM 2: Dispensary of Hope

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:

1. In contract with the Dispensary of Hope, Mercy Pharmacy will manage charitable formularies within participating pharmacies, including maintaining inventory and making weekly orders.
2. 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

COLLABORATIVE PARTNERS:

1. Mercy Community Health ministry leaders
2. Health Informatics leader/Team
3. Clinic Leaders
4. Community Health Leader(s)/CHWs
5. Pharmacy
6. Epic Leader/Team
7. Care Management
8. Hospitalists
9. Mercy Clinics

<ol style="list-style-type: none"> 3. and ED physicians, Care Management, Diabetes Education, Behavioral Health, and Mercy Clinic. 4. Mercy will communicate with community partners, including other healthcare providers, to promote the use of the formulary for patients in need. 5. Mercy will work to connect qualifying patients with Mercy Financial Assistance and Medicaid and Medicare as applicable. 6. Mercy will standardize Dispensary of Hope processes, including Dispensary of Hope renewal processes, across communities to ensure seamless co-worker and patient experience and to improve patient outcomes. 	
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ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes:

1. Set baseline number of 30-day prescriptions filled /month
2. Increase/maintain number of patients served / month
3. Increase/maintain number of patient encounters / month

Medium-Term Outcomes:

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

Long-Term Outcomes:

1. Each year, 10% reduction in ED visits
2. Each year, 10% reduction in total cost of care.

PLAN TO EVALUATE THE IMPACT:

1. Mercy Pharmacy will provide monthly reports on the number of patients served, number of prescriptions filled, and estimated cost savings to patient.
2. 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:

1. Annual contract fees to Dispensary of Hope for formulary access (\$12,500 per year per pharmacy)
2. Pharmacist support for formulary management (responsibilities include: monthly and quarterly reports, ordering medications)
3. Marketing and communications support, in the form of flyers, rack cards, enrollment cards, etc.
4. Training for co-workers to understand enrollment process for Dispensary of Hope

COLLABORATIVE PARTNERS:

1. Dispensary of Hope
2. Mercy Pharmacy, Community Health & Access,

Goal 2: Increase mental and behavioral health support for children and adults, experiencing a mental health crisis or ‘at risk’ for experiencing a mental health problem.

PROGRAM 1: Concert Health Collaborative Care for Primary Care Physicians

PROGRAM DESCRIPTION: Mercy Hospital OKC & Clinics will collaborate with Concert Health to support primary care providers (Primary Care and Women’s Health) 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.

<p>ACTIONS THE HEALTH SYSTEM INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ol style="list-style-type: none"> 1. Consistent with the Behavioral Health Service Line model of care, Mercy OKC will implement the Concert Health Collaboration in Primary Care Clinics. 2. Train providers in use of the care approach. 3. Promote the initiative. 4. Identify gaps in care. 	<p>COLLABORATIVE PARTNERS:</p> <ol style="list-style-type: none"> 1. Mercy Clinic and Population Health Leaders 2. Concert Health
<p>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</p> <ol style="list-style-type: none"> 1. By the end of FY23, the initiative will go live in Mercy Hospital OKC Primary Care Clinics. 2. By the end of FY24, 200 referrals will have been made to Concert Health, and 100 patients will have engaged in collaborative care. 3. Increase access to community resources through referrals to Community Health Workers. 	
<p>PLAN TO EVALUATE THE IMPACT:</p> <ol style="list-style-type: none"> 1. Track number of primary care physicians participating in program. 2. Track number of referrals to Concert Health per month. 3. Track percentage of patients referred to Concert Health who enroll in program (conversion rate). 4. Track number of referrals of uninsured and Medicaid patients per month. 5. Track referrals to Community Health Workers for needs related to social determinants of health by Concert Health. 	
<p>PROGRAMS AND RESOURCES THE HEALTH SYSTEM PLANS TO COMMIT:</p> <ol style="list-style-type: none"> 1. Cost of coworker and physician time. 2. Operational budgeted support as appropriate. 3. Indirect expenses related to EMR and clinic operations 	

PROGRAM 2: Call SAM (Student Assistance by Mercy)

PROGRAM DESCRIPTION:

Mercy partners with local school districts and higher educational institutions to provide Call SAM – a FREE 24-hour call center staffed with counselors who will provide confidential referral services, crisis support and mental/behavioral health education to staff, students and families.

<p>ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ol style="list-style-type: none"> 1. Present education on mental health topics through teacher in-service meetings at the schools 	<p>COLLABORATIVE PARTNERS:</p> <ol style="list-style-type: none"> 1. Local/State Health Departments 2. Clinical Services (Behavioral Health Advisor- School Programs)
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<ol style="list-style-type: none"> 2. Send monthly newsletter to counselors and principals of schools served 3. Provide 24/7 'in the moment' support to students and families in crisis via a dedicated call line 4. Provide education and referrals 	<ol style="list-style-type: none"> 3. Schools Districts/Colleges 4. School counselors 5. Health Informatics Leader 6. UniteUs- referral system 7. Behavioral Health Community Partner Agencies 8. Mercy 24-hour call center(counselors) 9. Heartline 211
<p>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</p> <p>Short-Term Outcomes (12 months):</p> <ul style="list-style-type: none"> • Analyze data and provide monthly report for mental health calls and referrals (potentially implement adult and student well-being survey) <p>Medium-Term Outcomes (12-36 months):</p> <ul style="list-style-type: none"> • Data collected will demonstrate effectiveness and allow for changes in the programming to occur • Requests from other school districts will be considered <p>Long-Term Outcomes (36+ months):</p> <ul style="list-style-type: none"> • Improved mental health status of students and families served 	
<p>PLAN TO EVALUATE THE IMPACT:</p> <ol style="list-style-type: none"> 1. Analyze all data collected from tracking spreadsheet. 	
<p>PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:</p> <ol style="list-style-type: none"> 1. Staff, hours/time 2. Resources and supplies 3. Mileage expenses 	

Prioritized Need #2: Access to Education

Goal 1: Increase life skills and health education opportunities within schools located in zip codes identified as having poor health outcomes or 'trending' in the direction of having poor health outcomes, to intervene early.

PROGRAM 1: Communities and Schools Together (CAST) Initiative

PROGRAM DESCRIPTION

CAST is an initiative for families, community organizations, businesses, and individuals to support Putnam City's public education. The partnerships are dynamic, innovative, mutually beneficial and contribute significantly to educating and preparing our students to be successful in their community, state, and world. Involvement in CAST is an opportunity for the neighborhood, school and local community to unify in a way that enhances the learning environment for students. Resources (volunteers, equipment, materials, and assistance with special projects) offered by partners positively impact student achievement.

<p>ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ol style="list-style-type: none"> 1. Recruit co-worker volunteers 	<p>COLLABORATIVE PARTNERS:</p> <ol style="list-style-type: none"> 1. Mercy Hospital and Clinics co-worker volunteers 2. Mercy Community Health Department
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<ol style="list-style-type: none"> 2. Community mentoring/ community buddies 3. School Beautification Projects 4. Conduct health education activities/presentations for classrooms/school events 5. Participate in annual high school career day 6. Sisterhood Project for each school- (creating feminine hygiene spaces for young girls) 7. Collaborate with school to potentially conduct student well-being survey. 	<ol style="list-style-type: none"> 3. Putnam City Schools Foundation 4. High Needs Schools (PCN H.S, Hefner M.S, Will Rogers Elementary) 5. Health Informatics Leader 6. UniteUs- referral system 7. Behavioral Health Advisor (Call SAM) 8. Catholic Charities 9. Junior Achievement 10. Paradigm Shift
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ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):

Short-Term Outcomes (12 months):

- ***Increase Mercy OKC Co-worker volunteers from baseline, in identified high need schools in PC District.***

Medium-Term Outcomes (12-36+ months):

- ***Increased hope/well-being scores, from baseline(pre-post)***

Long-Term Outcomes (36+ months):

- ***Increase student academic achievement***

PLAN TO EVALUATE THE IMPACT:

1. #co-worker volunteers
2. # presentations conducted per year
3. #referrals mental/behavioral health
4. # Activities coordinated/participated
5. #of students present at school/community coordinated events
6. #surveys completed

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Co-workers, funding and/or supplies for presentations and events

Prioritized Need #3: Access to Healthy Food (Food As Medicine)

Goal 1: Provide access to healthy food and resources to patients identified as ‘food insecure’ by Mercy Hospital and Clinics.

** Food Insecurity, as defined by the U.S. Department of Agriculture (USDA), is the “limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.”*

PROGRAM 1: Catherine’s Food Pantry

PROGRAM DESCRIPTION:

Catherine’s Food Pantry Program, initially known as the Food for Health Program, relaunched FY2019. The Catherine’s Food Pantry Program is a partnership between Mercy Hospital, Mercy Clinics, Mercy Health Foundation and the Regional Food bank, to drive improved health outcomes for patients experiencing food insecurity. Food insecurity is an emerging key factor for chronic disease, and although reducing 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.

<p>ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ol style="list-style-type: none"> 1. Recruit co-worker volunteers 2. Retrieve and pack produce weekly 3. Deliver boxes and/or produce to Mercy Sponsors 4. Screen/refer patients 5. Audit boxes monthly 6. Submit monthly reports 7. Order specialized food products for older adults and homeless population 	<p>COLLABORATIVE PARTNERS:</p> <ol style="list-style-type: none"> 1. Mercy Community Health Department 2. Mercy Clinical Services (Population Health) 3. Regional Food Bank 4. Good Samaritan Clinic (Host/Storage site) 5. Mercy Sponsors (Mercy South-SW, Coletta-SW, Nutritional Services, GS) 6. Health Informatics Leader
<p>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</p> <p>Short-Term Outcomes (12 months):</p> <ul style="list-style-type: none"> • Increase Mercy OKC Co-worker volunteers, from baseline (FY22) • Increase patients provided food boxes and produce, from baseline (FY22) • Increase patients provided specialized food items, from baseline (FY22) <p>Medium-Term Outcomes (12-36+ months):</p> <ul style="list-style-type: none"> • Increased access to healthy food options <p>Long-Term Outcomes (36+ months):</p> <ul style="list-style-type: none"> • Improved health and well-being 	
<p>PLAN TO EVALUATE THE IMPACT:</p> <ol style="list-style-type: none"> 1. #co-worker volunteers 2. # patients received boxes provided 3. #patients received produce 4. # patients received specialized food items 	
<p>PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:</p> <ol style="list-style-type: none"> 1. Co-workers, funding for specialty meals and food items 	

PROGRAM 2: Friday Mercy Meals (Meals on Wheels Partnership)

PROGRAM DESCRIPTION:

In partnership with St. Luke’s United Methodist Church, and Mercy Nutritional Services, Community Health has partnered to prepare and deliver Friday Mercy Meals, weekly, to aging adults who are identified as ‘food insecure’.

<p>ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ol style="list-style-type: none"> 1. Recruit co-worker volunteers 2. Pack meals 3. Deliver meals to seniors 4. Submit reports (quarterly) 	<p>COLLABORATIVE PARTNERS:</p> <ol style="list-style-type: none"> 1. Mercy Community Health Department 2. Mercy Clinical Services(vehicle) 3. Nutritional Services Department 4. St. Luke’s Hunger Free Program
<p>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</p> <p>Short-Term Outcomes (12 months):</p> <ul style="list-style-type: none"> • Increase Mercy OKC Co-worker volunteers, from baseline (FY22) • Increase # Seniors served each week, from baseline (FY22) <p>Medium-Term Outcomes (12-36+ months):</p> <ul style="list-style-type: none"> • Increased access to healthy food options <p>Long-Term Outcomes (36+ months):</p> <ul style="list-style-type: none"> • Improved health and well-being 	
<p>PLAN TO EVALUATE THE IMPACT:</p> <ol style="list-style-type: none"> 1. # co-worker volunteers 2. # Meals prepared quarterly 	
<p>PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:</p> <ul style="list-style-type: none"> • Co-workers, funding for meals, vehicle 	

Prioritized Need #4: Access to Meaningful Employment

GOAL 1: Increase the number of underserved individuals linked to career events, training, and employment opportunities.

PROGRAM 1: Underserved Patient Employment

PROGRAM DESCRIPTION:

This is a pilot program focused a partnership between Community Health and Mercy Talent Selection, to create a pathway for linkage of underserved patients, to receive peer support and coaching with applying for Mercy non-clinical employment opportunities, with which they qualify.

<p>ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ol style="list-style-type: none"> 1. Provide education on opportunities available and expectations 2. Coordinate or provide technical assistance with application, resume, cover letter, interviewing 3. Provide 1:1 peer mentor follow up(if provided the job) 	<p>COLLABORATIVE PARTNERS:</p> <ol style="list-style-type: none"> 1. Community Health Workers 2. Mercy Talent Selection Contact (Katherine Horton) 3. Director of Operations-Patient experience (Margaret Downs) 4. Director of Business Operations (Rebecca Dalke) 5. Health Informatics Leader
<p>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</p> <p>Short-Term Outcomes:</p> <ul style="list-style-type: none"> • Increase # of patients educated about employment options available that meet their need (from baseline). • Increase # of patients linked to employment (from baseline). • Decrease number of patients unemployed (from baseline). <p>Medium-Term Outcomes:</p> <ul style="list-style-type: none"> • Increase access to employment for the underserved population. <p>Long-Term Outcomes:</p> <ul style="list-style-type: none"> • Improve health and well being through access to financial resources. 	
<p>PLAN TO EVALUATE THE IMPACT:</p> <ul style="list-style-type: none"> # patients applied # patients referred # of patients offered the position # of patients accepted the position 	
<p>PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:</p> <p>Co-workers, job opportunities for non-clinical positions, HR support</p>	

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 Compassion Clinic	Persons served Cost of services
	TSET Tobacco Referral Initiative	# referrals provided
	Project Early Detection breast health services for the uninsured	Persons served, Cost of services
	Mercy In Schools	Persons served
	Hospital medication (Mercy Shield) 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
	Tobacco Referral Program	??
Community Building Activities – Workforce Development	High School Career Days	Number of students Cost of supplies
Community Building Activities – Coalition	Wellness Coalition of OCCHD, Oklahoma Public Health Association, Compassionate Care Group, Oklahoma Diabetes Caucus, Wellness Alliance of	Cost of services

Building & Board Membership	Central Ok., Oklahoma Community Health Taskforce(HAU), OCCA, CHW Coalition, COHIT, Homelessness Taskforce with City of OKC	
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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:

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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