



Community Health Improvement Plan

Mercy Hospital
Fort Smith

Fiscal Year 2019 - 2021



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.

Table of Contents

I.	Introduction	4
II.	Implementation Plan by Prioritized Health Need	5
	Prioritized Need #1: Access to Care	
	Prioritized Need #2: Behavioral Health	
	Prioritized Need #3: Nutrition	
III.	Other Community Health Programs Conducted by the Hospital	13
IV.	Significant Community Health Needs Not Being Addressed	15

I. Introduction

Mercy Hospital Fort Smith completed a comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Board of Directors in May 2019. The CHNA measured 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 Sebastian County. The CHNA identified three prioritized health needs the hospital plans to focus on addressing during the next three years: Access to Care, Behavioral Health, and Nutrition. The complete CHNA report is available electronically at mercy.net/about/community-benefits.

Mercy Hospital Fort Smith is affiliated with Mercy, one of the largest Catholic health systems in the United States. Located in Fort Smith, Arkansas, the extended service area spans fourteen counties across the River Valley and Eastern Oklahoma. Which includes both rural and urban settings; however, this stands as the main acute care facility within the region drawing from each of the counties served. The CHIP report will focus on Sebastian County, where the acute care facility sits. The acute-care hospital has 336 licensed beds, and includes a heart and vascular center, orthopedic hospital, a twenty-five bed Level IIIA neonatal intensive care unit, and emergency department, while having primary care and specialty care clinics. Mercy Hospital Fort Smith is one of two 300+ bed acute care hospitals located in Fort Smith.

Sebastian County holds the city of Fort Smith, the hub of a diverse economy, a rich history, and the second largest city in Arkansas. The U.S. Army established the Fort Smith military outpost in 1817 and to this day operates an active military presence, with the Fort Chaffee Maneuver Training Center, operated by the Arkansas National Guard. Home to the University of Arkansas Fort Smith (UAFS) since 1928, the university continues to provide unique and ever-expanding educational opportunities to its community. In 2017, Arkansas Colleges of Health Education brought medical students and other health professions students, which brings new talent of health professionals and mentorship relationships into the community. Fort Smith offers a water park as well as miles of scenic bike and walking trails and two baseball fields and a softball field.

Growth through renovation and construction of a Rehab Hospital, Obstetrical Emergency Department, and Neurosurgery Clinic advancements will improve access to excellence in health care, increase economic development, and enhance quality of life throughout the primary service area.

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 Fort Smith 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.

<p>PROGRAM 1: Community Health Worker Program</p>
<p>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>
<p>ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ol style="list-style-type: none"> 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.
<p>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</p> <p>Short-Term Outcomes:</p> <ol style="list-style-type: none"> 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 and 25 in Medicaid. 3. Each CHW will assist 50 patient per year with community and medication assistance resources. <p>Medium-Term Outcomes:</p> <ol style="list-style-type: none"> 1. Patients enrolling in CHW program will demonstrate a 25% reduction in ED utilization and reduction inpatient admissions. 2. Patients enrolling in CHW program will demonstrate a 30% reduction in their total bad debt. 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 another clinic. <p>Long-Term Outcomes:</p> <ol style="list-style-type: none"> 1. 40% of Mercy patients enrolled saw reduction of malnutrition. 2. 20% of Mercy patients enrolled received housing assistance.
<p>PLAN TO EVALUATE THE IMPACT:</p>

<ol style="list-style-type: none"> 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)
<p>PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:</p> <ol style="list-style-type: none"> 1. Salary and benefits for full-time Community Health Worker. 2. Office space and indirect expenses dedicated to CHW work.
<p>COLLABORATIVE PARTNERS:</p> <ol style="list-style-type: none"> 1. Hope Campus 2. Fort Smith Community Health Council 3. River Valley Primary Care Services 4. Arkansas Department of Health 5. Good Samaritan Clinic

<p>PROGRAM 2: Mercy Charitable Pharmacy</p>
<p>PROGRAM DESCRIPTION: The Mercy Charitable Pharmacy will help un-insured patients receive medications for chronic illnesses, acute illnesses, and others as medications become available through the Dispensary of Hope.</p>
<p>ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ol style="list-style-type: none"> 1. Identify uninsured patients that meet the guidelines for the pharmacy to provide medications per case if we have medications on-hand. 2. Refer patients that come to the pharmacy to a CHW to connect them with health insurance and other resources as needed per patient.
<p>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</p> <p>Short-Term Outcomes:</p> <ol style="list-style-type: none"> 1. By the end of the fiscal year, an informational sheet will be distributed to remind Mercy co-workers about the program. 2. By the end of the fiscal year, 50 prescriptions will be distributed to patients by the pharmacy by outreach, informational sheet, meetings, and medication email list. <p>Medium-Term Outcomes:</p> <ol style="list-style-type: none"> 1. Patients receiving medications from the pharmacy will demonstrate a 10% reduction in ED utilization and reduction inpatient admissions. 2. Patients receiving medications from the pharmacy will demonstrate a 5% reduction in their total bad debt. <p>Long-Term Outcomes:</p>

<ol style="list-style-type: none"> 1. 10% of patients seen at the Mercy Charitable Pharmacy will be referred to the Community Health Worker program.
<p>PLAN TO EVALUATE THE IMPACT:</p> <ol style="list-style-type: none"> 1. Track number of co-workers on email list for medication list (Short-term) 2. Track number of patients served. (Output) 3. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing pharmacy services. (Medium-term) 4. Analyze pre and post intervention bad debt for cohort of patients utilizing pharmacy services. (Medium-term)
<p>PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:</p> <ol style="list-style-type: none"> 1. Salary and benefits for part-time pharmacist. 2. Yearly membership to Dispensary of Hope for medications. 3. Office space and indirect expenses dedicated to pharmacist work.
<p>COLLABORATIVE PARTNERS:</p> <ol style="list-style-type: none"> 1. Hope Campus 2. Dispensary of Hope 3. Arkansas Department of Health 4. Mercy Case Management

<p>PROGRAM 3: Catherine’s Light</p>
<p>PROGRAM DESCRIPTION: Catherine’s Light is program is focused on connecting new and expectant moms in our community with the resources they need to better care for themselves and their families. This program will allow the patients to receive timely care, excellent service, unique to their needs.</p>
<p>ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ol style="list-style-type: none"> 1. Provide pregnancy and postpartum evaluations. 2. Provide the new families with education and support with community resources. 3. Provide the new mom and/or families with short-term counseling or support groups as needed by patient(s).
<p>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</p> <p>Short-Term Outcomes:</p> <ol style="list-style-type: none"> 1. 20 patients referred to Community Health Worker by Catherine’s Light clinic. <p>Medium-Term Outcomes:</p> <ol style="list-style-type: none"> 1. Patients receiving services from the program will demonstrate a 25% reduction ED utilization and reduction inpatient admissions. <p>Long-Term Outcomes:</p> <ol style="list-style-type: none"> 1. 20% reduction in low birth rates.
<p>PLAN TO EVALUATE THE IMPACT:</p> <ol style="list-style-type: none"> 1. Track number of patients referred from OB/GYN and Labor and Delivery to Catherine’s Light. (Short-term) 2. Track number of patients referred to Community Health Worker. (Output) 3. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing the program. (Medium-term)

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Cost of practice manager, behavioral health clinician, and community health worker time.
2. Indirect expenses of clinic.

COLLABORATIVE PARTNERS:

1. McAuley Clinic
2. Mercy Foundation Fort Smith
3. Hope Campus

Prioritized Need #2: Behavioral Health

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

PROGRAM 1: Behavioral Health Strategic Plan

PROGRAM DESCRIPTION: Mercy Fort Smith will collaborate with community partners to conduct a current assessment of behavioral health services offered, identify any existing gaps and develop a plan to 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.
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 community assessments, resource list inventories and other reports.
4. Identify gaps in service, explore Mercy ministry solutions and other best practice options, 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 proposed for pilot initiative(s).

Long-Term Outcomes:

1. By the end of FY22, the pilot plan, if adopted, 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 change in contribution margin.

PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:

1. Cost of coworker time.

<ol style="list-style-type: none"> 2. Operational budgeted support as appropriate. 3. Grant funding as possible.
COLLABORATIVE PARTNERS: <ol style="list-style-type: none"> 1. To be determined based on pilot program(s) proposed.

Goal 2: Increase services to families in the foster care system.

PROGRAM 2: Baggot Street House
PROGRAM DESCRIPTION: Baggot Street House is a collaborative program that provides training for prospective foster and adopting families. As well as providing safe, hospitable space for family visitation.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED: <ol style="list-style-type: none"> 1. Create a friendly, safe environment that can be utilized by families during supervised visits.
ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES): Short-Term Outcomes: <ol style="list-style-type: none"> 1. Support The CALL, by spreading the word about their initiative to the community through quarterly update given to Fort Smith leadership. Medium-Term Outcomes: <ol style="list-style-type: none"> 1. Increase the number of families that foster or adopt children in the primary service area by 10%. Long-Term Outcomes: <ol style="list-style-type: none"> 1. By creating a friendly, safe environment we hope that this will help give the families a sense of purpose to reconnect and have less children in the foster care system with 5% of families reconnecting.
PLAN TO EVALUATE THE IMPACT: <ol style="list-style-type: none"> 1. Track the number of supervised visits at the house. (Short-term) 2. Track the number of families going through the foster care and adoptive families training program. (Output)
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: <ol style="list-style-type: none"> 1. Direct and indirect expenses of maintenance. 2. Pays utilities and upkeep of the house.
COLLABORATIVE PARTNERS: <ol style="list-style-type: none"> 1. The CALL 2. Department of Children and Family Services

Prioritized Need #3: Nutrition

Goal 1: Increase healthy habits for at-risk persons.

PROGRAM 1: Health Seminars
PROGRAM DESCRIPTION: Educational classes for uninsured, at-risk patients, and community members. Classes will vary on topics that are relevant for target audience. There may be a hands-on component to some of the courses as well.
ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:

<ol style="list-style-type: none"> 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 patients with connecting them to educational materials and resources, as needed. 3. Educate patients on health topics relevant to their life and help create a plan towards better habits.
<p>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</p> <p>Short-Term Outcomes:</p> <ol style="list-style-type: none"> 1. By the end of FY20, create a calendar of health seminars. 2. Connect 10% of attendees with Mercy and community resources. <p>Medium-Term Outcomes:</p> <ol style="list-style-type: none"> 1. 20% increase in knowledge of subject matter based on pre and post tests. <p>Long-Term Outcomes:</p> <ol style="list-style-type: none"> 1. Increase attendance to health seminars by 20%.
<p>PLAN TO EVALUATE THE IMPACT:</p> <ol style="list-style-type: none"> 1. Track number of patients attending each seminar. (Output) 2. Track number of patients referred to CHW from each seminar. (short-term) 3. Analyze ED utilization and inpatient admissions data for cohort of patients utilizing health seminars. (Medium-term)
<p>PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT:</p> <ol style="list-style-type: none"> 1. Cost of coworker's time 2. Equipment, space, and materials for meetings to be successful
<p>COLLABORATIVE PARTNERS:</p> <ol style="list-style-type: none"> 1. Fort Smith Health Community Health Council 2. Arkansas Department of Health 3. Local schools and churches

<p>PROGRAM 2: Physical Fitness Initiative</p>
<p>PROGRAM DESCRIPTION: Create healthy habits to encourage community members and patients to lose weight, increase cardio, and increase strength training.</p>
<p>ACTIONS THE HOSPITAL INTENDS TO TAKE TO ADDRESS THE HEALTH NEED:</p> <ol style="list-style-type: none"> 1. Assist patients with physical fitness challenges. 2. Identify patients who might benefit from being encouraged to lose weight. 3. Educate patients on the benefits of physical fitness and healthy weight loss. 4. Assist patients create a plan towards better habits.
<p>ANTICIPATED IMPACT OF THESE ACTIONS (OBJECTIVES):</p> <p>Short-Term Outcomes:</p> <ol style="list-style-type: none"> 1. By the end of FY20, create a physical fitness initiative plan. <p>Medium-Term Outcomes:</p> <ol style="list-style-type: none"> 1. By the end of FY21, community needs will be identified and a plan, including funding support, will be proposed for pilot initiative(s). <p>Long-Term Outcomes:</p>

1. By the end of FY22, the pilot plan, if adopted, will be implemented and initial outcome data presented.
PLAN TO EVALUATE THE IMPACT: 1. Number of physical fitness initiatives. 2. Number of patients and community members served. 3. Analyses of available outcomes data, for example, utilization, readmission, and change in contribution margin.
PROGRAMS AND RESOURCES THE HOSPITAL PLANS TO COMMIT: 1. Cost of coworker time. 2. Operational budgeted support as appropriate. 3. Grant funding as possible.
COLLABORATIVE PARTNERS: 1. To be determined based on pilot program(s) proposed.

Goal 2: Decrease the prevalence of prediabetes/diabetes

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. Look into developing a pilot program in Fort Smith area.
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. Get at least one person trained to be a life-style coach. 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. By end of FY20, DPP will be developed. Medium-Term Outcomes: 1. 2 classes will be held by end of FY21. 2. 5 new participants will enroll in each cohort and complete the first 4 sessions. Long-Term Outcomes: 1. Retention rate for participants attending at least 4 sessions will be 60%. 2. Average weight loss for participants completing the program will be 5%. 3. Percent of participants completing program who have achieved at least 150 minutes of physical activity/week will be 70%.
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 NWA 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 or already funded person).
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. Arkansas Department of Health
2. Mercy Northwest Arkansas

III. Other Community Health Programs

Mercy Fort Smith 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	Back-to-School Physicals	Persons served, Number of residents
	Flu Shot Clinics	Persons served, cost of services
	Fort Smith Family Literacy Hospital Tour	Persons served, Staff hours
	Mercy Transport Van	Persons served, Staff hours
	Mobile Mammography Van	Persons served, Staff hours
	Prenatal and Childbirth Classes	Persons served, Staff hours
	McAuley Assistance Program	Persons served
Health Professions Education	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	Donald W. Reynolds Care Support House	Cost of services
	Ronald McDonald House	Cost of services
	Hamilton House	Cost of services
	Good Samaritan Clinic	Cost of services
	United Way	Cost of services

Community Building Activities – Workforce Development	Project Search	Number of students
	M.A.S.H. program for high school students	Number of students
	Teen and college student volunteer programs	Number of students

IV. Significant Health Needs Not Being Addressed

A complete description of the health needs prioritization process is available in the CHNA report. Three assessed health issues identified in the 2019 CHNA process—cancer, housing, and unemployment—were not chosen as priority focus areas for development of implementation strategies due to Mercy’s current lack of resources available to address these needs. These issues will be addressed indirectly in implementation strategies developed to meet the prioritized needs in areas that may overlap. For example, efforts to reduce the incidence of obesity in the community may also reduce the incidence of cancer. 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 Fort Smith will consider focusing on these issues should resources become available. Until then, Mercy Fort Smith will support, as able, the efforts of partner agencies and organizations currently working to address these needs within the community.

