2022-2024
COMMUNITY HEALTH
IMPLEMENTATION PLAN

MARGARET MARY HEALTH

MMH's Board of Directors approved and adopted the Health Collaborative CHNA 2021 and the MMH CHIP 2022-2024 on September 24, 2022.

OUR COMMUNITY HEALTH IMPROVEMENT PLAN

This plan represents our response to the Community Health Needs Assessment (CHNA) that was conducted in partnership with The Health Collaborative. As partners in a regional effort, Margaret Mary Health will support efforts whenever possible as written in the regional community health improvement plan (CHIP). However, MMH has developed and will adopt a local plan with the primary focus being in our service areas of Franklin and Ripley counties.

ORGANIZATIONAL MISSION, VISION AND VALUES

Located in Batesville, Indiana, MMH is a not-for-profit, critical access hospital providing both inpatient and outpatient services. Employing nearly 850 team members, the hospital has experienced significant growth through the years, adding oncology and rehab centers, as well as expanding access to primary and minor care in nearby communities. In 2022, we are celebrating our 90 years of service to our community.

At MMH, we are proud of our commitment to our community and strive to meet the increasingly complex and ever-changing healthcare needs of those we serve.

SERVICE AREA

MMH serves a population of more than 65,000 residents in Ripley and Franklin counties, as well as surrounding areas. For this plan, our target communities include both of these counties.

IDENTIFIED HEALTH NEEDS

1. Access to services specific to the top health needs identified, including behavioral health, cardiovascular disease, dental and vision care.
2. Healthcare education pipeline and workforce are strong, reflecting the diversity of our community and delivery of equitable care to everyone.
3. Access to healthy, affordable food and quality, affordable housing.

SIGNIFICANT HEALTH NEEDS NOT ADDRESSED

MMH may not be able to focus resources and services on all aspects of the identified needs in the CHNA. We are committed to focusing on those within our resources of time, talent and expertise. We will rely on strong community partners and their efforts to address needs we are not able to deliver.

Regarding the need of access to dental and vision services, MMH efforts are limited in comparison to addressing access to care for behavioral health and cardiovascular disease.

Currently, our healthcare workforce at MMH is as diverse as our community. Primary strategies will focus on our workforce pipeline and professional development.

While we recognize housing is an identified concern, our resources and expertise limit our ability to address quality and affordable housing.

Each of the identified health needs from the CHNA will include the regional goal, desired outcomes, indicators for success and the strategies to address the identified needs. The desired outcomes and strategies are specific to the MMH CHIP for 2022-2024.

1 ACCESS TO CARE

GOAL: Everyone in the region has access to healthcare, when they need it, including services for behavioral health and heart disease.

OUTCOMES

- Increase the use of routine and preventative primary care services.
- Expand access to health insurance coverage.
- Increase access to behavioral health and cardiovascular care.
- Reduce unnecessary emergency department visits for mental health and heart disease issues.
- Reduce preventable hospital admissions and readmissions.
- Improve incidence rates and outcomes for depression, anxiety, suicide, drug overdose and youth drug use.
- Increase the number of physicians and mental health providers.
- Reduce heart disease.

INDICATORS

- Track Social Determinants of Health (SDOH) within Data Link software in partnership with the Indiana Hospital Association.
- Decrease Readmission rates with a goal of 4.4%.
- Decrease frequent ED utilization in the ER by 5% with Care Coordination and Chronic Care Management.
- Decrease no-show rates and cancellations for primary care, behavioral health, and wellness services to less than 8%.
- Increase utilization of transportation to improve access and decrease no-show and cancellation rates to achieve an 8% reduction, as stated above.
- Incrementally recruit 2-3 primary care providers to expand capacity based on need in the next 36 months.
- Decrease rate of percent uninsured with a goal of 8% or below.
- Increase suicide prevention awareness through community education and training opportunities at least once per year.

STRATEGIES

- Partner with the Indiana Hospital Association (IHA) and State Health Insurance Program (SHIP) specific to Social Determinants of Health.
- Assess the social needs and Social Determinants of Health of our patients and provide information about community resources when needed. (Joint Commission element of performance LD.04.03.08)
- Collect social determinants of health via I-pad or health portal prior to visit.
- Linkage of local resources and the HELP app.
- Maintain local resource guide for Ripley County and Franklin County.
- Create and maintain partnerships needed to positively impact Social Determinants of Health.
- Explore feasibility of a comprehensive primary care and emergency department care team to include social workers by strengthening the coordination between all care areas.
- Expand partnerships between established transportation services in the community to increase patient access to and from scheduled appointments.
- Evaluate feasibility of transportation with vouchers for public transit outside of the Batesville area.
- Evaluate optimal care delivery models including telehealth and remote patient monitoring.
- Focus efforts in pre-design and design of potential new hospital to improve efficiencies related to patient care.
- Continue marketing efforts specific to automated mailers for age-appropriate screenings and annual wellness visits.
- Develop opportunities to increase access to primary care through extended hours in physician practices.
- Improve Consumer Engagement through expanded services and utilization of the MMH Patient Portal including results, self-scheduling and ease of payment.
- Improve coordinated efforts of population health including care coordination, annual wellness visits, post-acute care navigation, chronic care management and transitional care.
- Identify patients who are uninsured or under insured and connect them with an MMH financial counselor to decrease bad debt and increase use of charity care options.
- Utilize financial and certified state insurance navigators.
- Focus outreach services related to review of health care coverage and needs.
- Allocate funding for financial assistance program and disperse to those in need.
- Focus patient education programs to ensure alignment with Social Determinant of Health findings for our patient population.
- Support the statewide initiative I-HOPE (Indiana Healthy Opportunities for People Everywhere) in Ripley County.

BEHAVIORAL HEALTH

- Integrate primary care program with behavioral health to improve continuity of care, sharing treatment plans and communicating mental health.
- Implement ACES screening in behavioral health and potentially in pediatric office.
- Increase access to behavioral health in conjunction with IHC, our telehealth/tele-psych partner, at our Osgood Rural Health Clinic.
- Promote the new mental health crisis line "988."
- Partner with Community Mental Health for crisis support, infant mental health, and inpatient admissions for Psych from the ER.
- Utilize CERT (Choice's emergency response team) as a community resource and support for drug-related concerns.
- Educate MMH staff and local employers to help address mental health emergencies (i.e., QPR (Question, Persuade Refer) and Mental Health First Aid trainings).
- Conduct feasibility study of suicide prevention program SOS (Signs of Suicide) or QPR (Question, Persuade, Refer) in partnership with local schools.
- Develop policy and education plan for providers for when a patient presents with psych or suicidal ideations. Policy: Suicidal patient.
- Partner with the State Health Insurance Program (SHIP) efforts related to suicide.
- Engage with the Indiana Suicide and Fatality Review (SAFR) Team to look at lessons from suicide victims to develop recommendations for Ripley and Franklin counties.
- Increase availability of group therapy sessions.
- Continue active involvement in local drug coalition efforts.
- Continue drug prevention education in the schools.

ORAL AND VISION

- Provide fluoride treatments in pediatric office.
- Encourage dental and vision care during a primary care wellness visit.
- Promote dental program at SEIHC.

HEART DISEASE

- Prioritize partnership with The Christ Hospital Health Network ensuring four day a week physician coverage in Batesville with potential expansion of local cardiac services.
- Continue to evaluate cardiac diagnostic testing needs utilizing state-of-the-art equipment.
- Maintain Chest Pain Network accreditation in our ER through our partnership with The Christ Hospital Health Network.
- Maintain Stroke Certification in collaboration with University of Cincinnati.
- Conduct feasibility study to establish National Hypertension (HTN) Control Initiative.
- Explore remote patient monitoring for patients with Hypertension (HTN) through programs supported by the Indiana Primary Health Care Association (IPHCA).
- Support efforts of the Cardiovascular & Diabetes Coalition of Indiana.
- Increase access and evaluate lowering the cost of MMH vascular screenings.
- Increase access to community screenings.
- Increase referrals into programs to address heart disease (including cardiac rehab, Intensive Behavioral Therapy (IBT) and educational programs)
- Develop IBT for cardiovascular disease following CMS guidance.

2 HEALTHCARE WORKFORCE AND PIPELINE DIVERSITY

GOAL: The healthcare education pipeline and workforce are strong, reflect the diversity of our community and deliver equitable care to everyone.

OUTCOMES

- Increase the size of the healthcare education pipeline.
- Reduce vacancy rates for key healthcare positions (physicians, nurses and clinical staff).
- Ensure healthcare workforce diversity for key positions reflective of our community diversity.
- Strengthen culturally and linguistically competent services in healthcare delivery.
- Reduce disparities in patient outcomes and experience.

INDICATORS

- Provide appropriate access for students to participate in healthcare internships, mentoring and shadowing at MMH.
- Maintain turnover rate at MMH of less than 18% annually.
- Maintain vacancy rate at MMH of less than 10% annually.
- Continue to award healthcare scholarships to qualifying students annually.
- Continue to provide tuition reimbursement to qualifying MMH team members.

STRATEGIES

- Collaborate with colleges to serve as a healthcare clinical rotation site (The Christ College of Nursing, IUPUC, Ivy Tech, Marian University).
- Strengthen collaboration with local high schools to increase interest in healthcare fields via clinical and non-clinical mentoring programs.
- Create more opportunities for student shadowing across the organization.
- Support efforts to increase rural healthcare education and employment opportunities (Med scholars, AHEC student participation, medical transport).
- Collaborate with Franklin County Community Foundation and Ripley County Community Foundation to increase awareness of available scholarships for ongoing education, specifically with healthcare related careers.
- Complete annual salary benchmarking and adjust wages accordingly to be competitive in market.
- Promote culture of equity and non-discrimination by complying with MMH Compensation Philosophy to utilize pay ranges to reward based on education and performance.
- Reduce turnover in frontline positions.
- Promote clinical expertise and encourage employees obtain certifications in their field.
- Develop a best practices document on engaging employees at all levels to measure and improve workplace culture in healthcare.
- Promote and build resilience and innovation in the healthcare workforce (RISE workshop event for entire organization, wellness, continuing Lean/PI training).
- Leverage recruitment strategies including referral bonuses, sign-on bonuses, job fairs and advertising on social media and professional resource sites.
- Train and implement the National Culturally and Linguistically Appropriate Services (CLAS) standards.
- Strengthen collaboration with the community (Patient and Family Advisory Council, Feedtrail survey process, LinkedIn).

STRATEGIES

- Solicit ongoing staff feedback (focus groups, surveys, weekly leader rounding).
- Promote communication and transparency throughout the organization (Daily Operations Brief, Leadership meetings, Leader Rounding, MMH Connect app/ platform to share announcements, recognitions, and video updates).
- Increase diversity, cultural competency and empathy training (leadership workshops, Healthstream in-services, new hire orientation, RISE event).

3 ACCESS TO FOOD

GOAL: Everyone in the region has access to healthy food.

OUTCOMES

- Increase the percent of patients screened for health-related social needs.
- Increase referrals to community resources for patients with health-related social needs.
- Increase support for existing food and housing efforts to meet the full scope of community needs.
- Increase enrollment in food assistance safety net programs (SNAP, Produce Perks)
- Decrease food desert areas.
- Decrease household food insecurity.
- Increase the consumption of healthy food.

INDICATORS

- Decrease the percent of population food insecure to a goal of 10%.
- Improve the food environment index to 9.

STRATEGIES

- Expand the availability of nutritious food (therapeutic meals) in clinical care settings.
- Provide produce prescriptions (Rx Food as Medicine).
- Promote farm-to-school programming within schools.
- Develop partnerships with local businesses and churches to support and fund healthy food access points, including farmers' markets, food carts or food cupboards at various locations throughout our communities.
- Support school garden initiatives.
- Promote gardening educational programs in partnership with organizations dedicated to healthy food access and food equity.
- Continue Bounty Box in partnership with the FGA (Food and Growers Association).
- Continue Cooking Matters program with financial support from Indiana Department of Health (IDOH).
- Support efforts of Fresh Local Food Collaborative.
- Support efforts of Indiana Grown.
- Partner with local schools to promote Indiana Food Day efforts.
- Partner with local schools to provide Locally Sourced, a nutritional newsletter for parents.
- Expand food pantry partnership to provide recipes, cooking demos and education.
- Increase the number of food drives to supply local food pantries.