MARGARET MARY HEALTH

2025-2027 COMMUNITY HEALTH IMPLEMENTATION PLAN

MMH's Board of Directors approved and adopted the Health Collaborative CHNA 2024 and the MMH CHIP 2025-2027 on March 31, 2025.

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 health system providing both inpatient and outpatient services. 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.

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.

THE NEXT GENERATION OF CARE

NEW HOSPITAL OPENING IN 2026

Progress is underway on the construction of Margaret Mary's new replacement hospital and we couldn't be more excited! Located on State Route 229 just north of the I-74 Batesville interchange, this facility will enhance the patient experience, attract new providers to our community and serve as an anchor for an expanded health and wellness campus.

COLLECTIVE HEALTH FOCUS

GOAL: Everyone in our community has access to care when they need it, including behavioral health and heart disease services.

TARGETED PRIORITIES

MMH will focus on two health priorities identified in the CHNA. These health priorities have overarching outcomes that may impact both areas.

1. Behavioral Health Treatment and Prevention
2. Heart Disease and Stroke Treatment and Prevention

SIGNIFICANT HEALTH NEEDS NOT ADDRESSED

MMH may not be able to focus resources and services on all aspects of the identified needs in the Regional CHNA. We are committed to focusing on those within our resources of time, talent and expertise. While we recognize housing is an identified concern, our resources and expertise limit our ability to address quality and affordable housing. We will rely on strong community partners and their efforts to address needs we are not able to deliver.

COLLECTIVE OUTCOMES

- Track Social Determinants of Health (SDOH) within Data Link software in partnership with the Indiana Hospital Association and in the EHR.
- Increase the percentage of patients screened for health-related social needs.
- Increase referrals to community resources for patients with health-related social needs.
- Increase the use of routine and preventative primary care services.
- Increase access to behavioral health and cardiovascular care.
- Increase utilization of transportation to improve access and decrease no-show and cancellation rates.
- Decrease no-show rates and cancellations for behavioral health.
- Increase awareness of heart disease and stroke.
- Increase awareness of behavioral health conditions.
- Reduce preventable hospital admissions and readmissions related to behavioral health conditions, heart diease and stroke.
- Improve incidence rates and outcomes for depression, anxiety, suicide and drug overdose.
- Increase the number of providers and mental health providers.

COLLECTIVE 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.
- Streamline coding efforts to capture Z-Codes related to SDOH.
- Link local resources.
- 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 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 provider practices or immediate cares.
- 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.
- 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.

1 BEHAVIORAL HEALTH TARGETED STRATEGIES

- Integrate primary care program with behavioral health to improve continuity of care, sharing treatment plans and communicating mental health.
- Utilize ACES screening in behavioral health.
- Increase access to behavioral health in conjunction with Peregrine and SHO, our telehealth/tele-psych partners.
- Promote the mental health crisis line “988.”
- Raise awareness for benefits provided through employer EAP programs.
- Host annual 5K walk, Stop the Stigma, for suicide prevention and awareness.
- 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.
- 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.
- Engage with Southeast Indiana Suicide Prevention Coalition.
- 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.
- Serve on the local efforts of Coalition for a Drug Free Batesville (CDFB) and Stayin Alive.
- Increase availability of group therapy sessions.

2 HEART DISEASE & STROKE TARGETED STRATEGIES

- Prioritize partnership with The Christ Hospital Health Network ensuring four-day-a-week physician coverage in Batesville.
- 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.
- Continue cardiopulmonary rehab services.
- Focus efforts in the MMH primary care practices on blood pressure control.
- 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 to MMH vascular screenings.
- Increase referrals into programs to address heart disease including cardiac rehab, nutrition and preventive programs.
- Expand availability of nutritious food (therapeutic meals) in clinical care settings.
- Provide produce prescriptions (Rx Food as Medicine).
- 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.