2022 IMPLEMENTATION PLAN

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Introduction

Many factors influence health and well-being in the communities we serve, and many entities and individuals in the community have a role to play in responding to community health needs. SoutheastHEALTH and the community partnerships established see the need and requirement for a framework within which our communities can take a comprehensive approach to maintaining and improving health: assessing its health needs, determining its resources and assets for promoting health, developing and implementing a strategy for action, and establishing where responsibility should lie for specific results.

This document describes the action plan and framework for the SoutheastHEALTH System *community health improvement process*. Critical to this process are performance monitoring activities to ensure that appropriate steps are being taken by responsible parties and that those actions are having the intended impact on health in the community. This document also includes a description of the current resources available to meet the needed support services and performance monitoring of the recommended health improvement activities.

In developing a health improvement program, every community will have to consider its own particular circumstances, including factors such as health concerns, resources and capacities, social and political perspectives, and competing needs. The community coalitions cannot prescribe what actions a community should take to address its health concerns or who should be responsible for what, but they do believe that communities need to address these issues and that a systematic approach to health improvement that makes use of performance monitoring tools will help all constituents achieve their goals.

SoutheastHEALTH's Mission and Vision

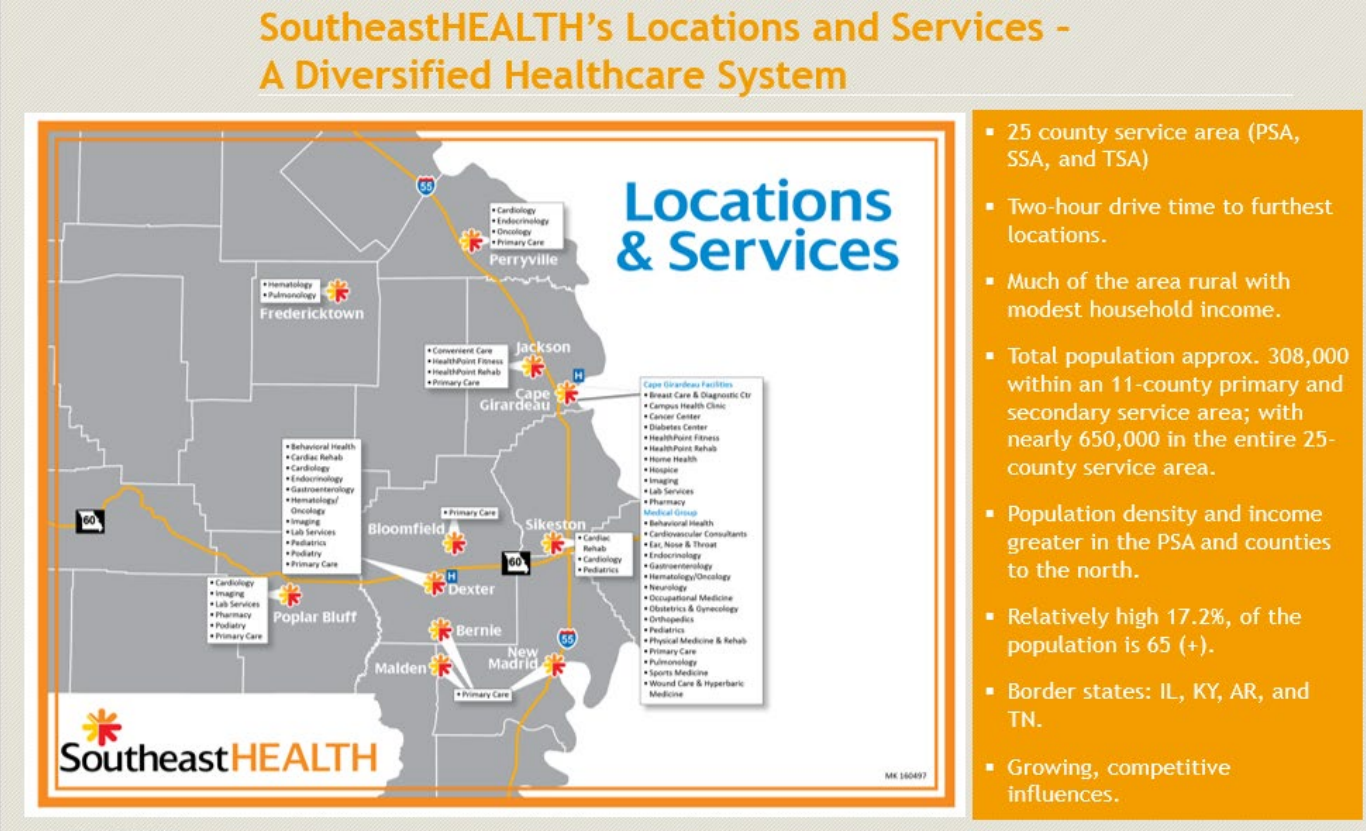
Mission

Together we will evolve healthcare through innovation, compassion and partnerships.

Vision

With our collective expertise, we strive to be the best in patient experience and outcomes, instilling confidence within our community and empowerment among our employees.

Target Area/Population



Community Health Priorities

Members of the CHNA Team analyzed survey data, focus group data, and secondary data in the report to prioritize the community health needs for each county. The priority needs were first identified by the primary research or what the community finds most important. These high priority needs were then validated by the secondary research – looking at the community's statistics and trends against the state, region and nation's statistics and trends. The following table lists the priority health needs of the community:

	Health Need
1	Substance Abuse/Mental Health (drug and alcohol, anxiety, depression and suicide)
2	Health Care Affordability (uninsured/underinsured, cost)
3	Healthcare Access (Wait times, available providers and services, transportation)
4	Smoking and vaping
5	Obesity (diet and exercise)
6	Chronic Disease (Cancer, Heart Disease, Diabetes, and Stroke)

Approach to Implementation

In response to the Community Health Needs Assessment, the SoutheastHEALTH CHNA Team reviewed and compiled a list of resources and services already available in the community that address the priority needs that surfaced. The Team then met with the Transitions of Care Committee which is comprised of individuals from various departments throughout SoutheastHEALTH, including:

Quality Management, Case Management, Education, Home Health, Patient Experience, and clinical areas such as the Emergency Department, Cardiovascular Services, Perioperative Services, Behavioral Health Services, to determine what additional actions should take place to address these issues. From those discussions, the following improvement strategies and actions were developed.

This Community Health Needs Assessment was presented to the Executive Team, Hospital Board of Directors on Thursday, October 27 and the Regional Board of Directors on Monday, November 21, 2022, which received final approval.

Improvement Strategies

Priority: Increase Access to Mental Health Services and Resources

Key Strategies	Key Actions
Assess and Screen	1. Offer an online Health Risk Assessment that will provide an evaluation of current health and quality of life 2. Work to integrate behavioral health screening protocols into primary care visits 3. Identify and work to understand health inequities with access to Mental Health services by **c**ollecting patient data to establish baselines, monitor trends over time, and ensure strategies account for the needs and barriers encountered by populations experiencing health inequities. ***Anticipated Outcome(s):*** • Increase the knowledge and awareness of those who suffer from behavioral health disorders • Identification of an individual's risk for chronic disease and other illnesses • Work to eliminate health inequities by improving access to care
Access to Care	1. Open a 102-bed Behavioral Health Hospital in Cape Girardeau, MO. which opened in the fall of 2020. Services are available for both adults and youth. 2. Continue collaboration with local providers to reduce barriers to care by building referral relationships with those providers and assisting patient with access to care. 3. Work with patient populations most directly affected by inequities through partnerships and coalitions with diverse skills and expertise. ***Anticipated Outcome(s):*** • An increase in the number of behavioral healthcare access points will encourage greater utilization and accessibility
Education	• Integrate behavioral health education protocols into primary care visits • Hospital involvement in the Substance Use Prevention Education and Resources (SUPER) community coalition which provides education at various community events and collaboration/info-sharing between numerous community organizations • Offer free community educational seminars on behavioral health-related topics

	Anticipated Outcome(s): • Increase the knowledge and awareness of the community about the stigma associated with behavioral health issues and current resources for care. • Increase the knowledge of those suffering with substance use disorders about available resources. • Work to eliminate health inequities by improving access to behavioral health care

Resource Inventory:

SoutheastHEALTH

- Inpatient psychiatry services relocated to renovated unit at the Southeast Health Center of Stoddard County facility in Dexter, Missouri

Tender Hearts Child Therapy Center

Heartland Counseling Center

Community Counseling Center

Family Counseling Center

New Vision Counseling

Associated Counseling Services

Great Oak Counseling

The Hancock Center

4-Sight Counseling

Louis E. Masterman Center Gibson Recovery Center

Teen Challenge

Cross Trails Medical Center

- Mental health services and counseling

Bootheel Counseling

Ferguson Medical Group

Mission Missouri

- Faith-based substance abuse treatment home

Southeast Missouri Behavioral Health

Priority: Ensure Health Care Affordability & Accessibility

Key Strategies	Key Actions
Access to Care	1. Expand primary care services in the existing Cape Girardeau and Dexter facilities to accommodate additional family practice providers 2. Expand primary care into Sikeston and Jackson with new facilities 3. Continue to grow and expand the First Option Health Plan (narrow network) that is offered to area employers 4. Offer extended hours for primary care which offers patients a lower cost, convenient option for those seeking care after hours 5. Patient assistance funds, which assist with health care expenses and transportation, are available through the hospital's Foundation for those that qualify 6. Look into developing partnerships with local Federally Qualified Health Centers, community paramedic programs, and pharmacies to make referrals and help with accessibility 7. Explore more opportunities for expanding patient access to telemedicine services 8. Continue work with 1st Option Narrow Network connecting employers to high quality affordable health plans for employees have access to the right care at the right setting when they need it. 9. Work with patient populations identified and most directly affected by inequities through partnerships and coalitions with diverse skills and expertise. ***Anticipated Outcome(s):*** • Increasing the number of primary healthcare access points will ease accessibility
Education	1. Provide education about preventive health and wellness in order to reduce healthcare service utilization, through classes, seminars, providers, health fairs, etc. 2. Provide education through free community education seminars and case management about navigating insurance 3. Provide ongoing education at the community events and screenings when populations with health coverage needs are identified 4. Provide education to patients in the Emergency Department about the right setting for care ***Anticipated Outcome(s):*** • A healthier population with reduced healthcare utilization • An educated population regarding when and where to seek care and why having that knowledge is important

Transitions of Care	• Assist patients with getting insurance if they are uninsured and finding the most appropriate setting for care ***Anticipated Outcome(s):*** • An insured patient population seeking care in the most appropriate setting • Work to eliminate health inequities in populations that have limited access

Priority: Healthcare Access (Wait times, available providers, services and transportation)

Key Strategies	Key Actions
Assess and Screen	1. Provide free or low-cost screening services to the community: mammograms, prostate-specific antigen (PSA) test, skin cancer screenings, colonoscopies, low-dose CT lung screenings, etc. 2. Offer an online Health Risk Assessment that will provide an evaluation of current health and quality of life. 3. Provide community education information regarding online and hotline health information for connecting community to the right care settings 4. Connect patients needing transportation services to Foundation's patient care fund. Empower staff at all Southeast facilities to access transportation resources when need is identified. ***Anticipated Outcome(s):*** • Grow volume of participation in ongoing preventive screening programs • Identification of an individual's risk for chronic disease and other illnesses
Access to Care	1. Continue to offer outpatient services through outreach clinics in Dexter, Perryville, and via Telemedicine in southeast secondary region 2. Patient assistance funds, which assist with health care expenses and transportation, are available through the hospital's Foundation for those that qualify 3. Work with patient populations most directly affected by inequities through partnerships and coalitions with diverse skills and expertise to connect to the right care setting.

	Anticipated Outcome(s): • Increasing the number of healthcare access points will encourage greater accessibility and patient experience
<u>Education</u>	1. Work with the Healthy Communities Coalition to enhance chronic disease prevention education in the community regarding smoking cessation, healthy eating, physical activity, preventive screenings, etc. 2. Work with the SUPER Coalition to provide education about the dangers of smoking and vaping and encourage participation in smoking cessation programs 3. Provide free community education seminars on various chronic disease topics ***Anticipated Outcome(s):*** • Increased knowledge and awareness about preventative risks factors and screenings

Resource Inventory:

SoutheastHEALTH

- Support groups for Breast Cancer
- We Can Weekend event for survivors and their families
- Smoking Cessation Informational Sessions and One-on-One Support

East Missouri Action Agency

- Show Me Healthy Women program – provides free breast and cervical cancer screenings to women ages 35-64 who qualify

Cross Trails Medical Center

- Show Me Healthy Women program – provides free breast and cervical cancer screenings to women ages 35-64 who qualify

Cape Girardeau County Public Health Center

- Show Me Healthy Women program – provides free breast and cervical cancer screenings to women ages 35-64 who qualify

Bollinger County Public Health Center

- Show Me Healthy Women program – provides free breast and cervical cancer screenings to women ages 35-64 who qualify
- Tobacco Free Missouri Youth – helps provide training opportunities and assistance for these programs in schools which educates their schools and communities about dangers of smoking and secondhand smoke

Scott County Health Department

- Show Me Healthy Women program – provides free breast and cervical cancer screenings to women ages 35-64 who qualify

Stoddard County Health Center

- Show Me Healthy Women program – provides free breast and cervical cancer screenings to women ages 35-64 who qualify

SEMO Health Network

- Well-woman exams – pap smears, pelvic and breast exams

- Well-Women's Care – pelvic exam and cancer screenings
- Freedom from Smoking – smoking cessation program

Priority: Reduce the Percentage of Obesity

Key Strategies	Key Actions
Assess and Screen	1. Offer an online Health Risk Assessment that will provide an evaluation of current health and quality of life 2. Work with the Healthy Communities Coalition to collect Body Mass Index (BMI) at various community events/health fairs ***Anticipated Outcome(s):*** • Increase awareness of unhealthy weight and associated health risks • Identification of an individual's risk for chronic disease and other illnesses
Access to Care	1. Expand primary care services in the existing Cape Girardeau and Dexter facilities to accommodate additional family practice providers 2. Expand primary care into Sikeston and Jackson with new facilities ***Anticipated Outcome(s):*** • Increased collaboration with providers will help drive healthy lifestyles • Better access to primary care providers will allow for more consistent care
Education	1. Work with the Healthy Communities Coalition to enhance education in the community regarding healthy eating and physical activity through: a. Healthy Cooking classes b. Gardening classes c. Promotion and involvement with community gardens d. Community health fairs e. Annual school health fair 2. Work with the Occupational Medicine/Business Development liaison to provide improved wellness and health programs in workplaces with better outcomes in employee populations ***Anticipated Outcome(s):*** • Additional coalition efforts will improve the knowledge of the community regarding nutrition and physical activity • SoutheastHEALTH clinical resources accessible in the workplace will encourage employers and employees to make use of SoutheastHEALTH facilities to keep workers well

Resource Inventory:

SoutheastHEALTH

- HealthPoint Fitness
  - For Adults:
    - Group Fitness Classes
    - Aquatic Fitness Classes
    - Crossfit
    - Dance
    - Cycling
    - High Intensity classes
    - Low Impact classes
    - Strength Training
    - Personal Training
    - Yoga/Pilates
    - Barre Fusion
    - REBOOT
  - For Children:
    - Kids' Bee Fit
    - Dolphins Swim Club
    - Fit Kids/Boot Camp
    - Power Club
    - Warriors
- HealthPoint - Nutrition
  - Starting Point – Weight Management program
  - Launch Pre-Surgery Weight Management
  - Healthy Cooking Classes
  - Nutritional Coaching
  - PHIT (Promoting Health in Teens)
  - Reclaim Program
  - Biometrics
  - Weight Management First Steps Seminars

Healthy Communities Coalition

- Community Gardens
- School Health Fairs
- Storybook Trail
- Vendor events – displays, education, collect BMIs, provide info about available free screenings, classes, and events

Bollinger County Health Center

- Nutrition and health education services

Stoddard County Health Center

- Nutrition and health education services

Regional Healthcare Foundation

- Fitness Challenge

Scott County Health Center

- Nutrition and health education services

Priority: Reduce the Rates of Chronic Disease (Cancer, Heart Disease, Diabetes, Stroke)

Key Strategies	Key Actions
Assess and Screen	1. Offer an online Health Risk Assessment that will provide an evaluation of current health and quality of life 2. Continue to offer free screenings for chronic disease diagnosis (i.e. Peripheral Artery Disease, Blood Pressure, Diabetes A1c, Low Dose CT) 3. Develop a Cardiovascular Risk tool to determine a risk score for patients that is interactive and connects the patients to a primary care provider based on the score. 4. Identify and work to understand Health Inequities in effort to reduce the rates of chronic disease through preventive screenings & early detection. Assess by **c**ollecting patient data to establish baselines, monitor trends over time, and ensure strategies account for the needs and barriers encountered by populations experiencing health inequities of chronic disease populations. ***Anticipated Outcome(s):*** • Identification of an individual's risk for chronic disease and other illnesses • Increase the knowledge and awareness of those who suffer from chronic disease
Access to Care	1. Continue to expand primary care services in the existing Cape Girardeau and Dexter facilities to accommodate additional family practice providers 2. Expand primary care patients into Sikeston and Jackson with new facilities 3. Connect patients who meet the criteria to Southeast's Food Insecurity Program ***Anticipated Outcome(s):*** • Increased collaboration with providers that will help drive healthy lifestyles • Better access to primary care providers will allow for more consistent care and boost efforts for prevention and early detection
Education	1. Tobacco Cessation Counseling 2. Continue to offer free educational seminars to the community – Stroke, Heart, etc. 3. Work with the Healthy Communities Coalition to enhance education in the community regarding healthy eating and physical activity through: a. Healthy Cooking classes b. Connect patients to Southeast's Food Insecurity Program c. Promotion and involvement with free community health resources d. Community health fairs

	4. Work with the Occupational Medicine/Business Development liaison to provide improved wellness and health programs in workplaces with better outcomes in employee populations ***Anticipated Outcome(s):*** • Increase the knowledge of those suffering with chronic disease about available resources
<u>Transition of Care</u>	1. Work toward alignment with home care, skilled nursing facilities, and various clinics/services throughout the hospital 2. Identify needs of the primary care providers in order to partner in the care of discharged patients 3. Partner with other community resources to meet patients' needs 4. Incorporate pharmacy and nutrition resources and processes into patient discharge ***Anticipated Outcome(s):*** • A program that is focused on patient and family navigation, education, resources, and collaboration that will improve patients' outcomes and experience

Resource Inventory:

SoutheastHEALTH

- Vascular screenings
- Mended Hearts – education program
- Free Peripheral Artery Disease (PAD) Screenings
- HealthPoint Healthy Cooking classes
- Diabetes Self-Management Support Group
- Diabetes self-management education program
- Diabetes education center
- Camp DAY (Diabetes and Youth) Break
- Hemoglobin and A1c testing
- Glucose screening
- Diabetes annual assessment
- Diabetes Grandparent/Caregiver workshop
- Individual counseling for Diabetes
- Smoking Cessation Classes & Counseling
- Wound Care Center

Bollinger County Health Center

Cape Girardeau County Public Health Center

- Asthma Case Management

Scott County Health Center

- Chronic disease screening and monitoring

Stoddard County Health Center

- Blood pressure screening
- Cholesterol screening

SEMO Health Network

- Care for chronic disease
- Health screenings for diabetes
- Blood pressure screening

Cross Trails Medical Center

- Diabetes program including education
- Preventative health screenings

East Missouri Action Agency

- Blood pressure screening
- Cholesterol screening
- A1C and Glucose screening
- Diabetes screening for women

Regional Healthcare Foundation

- Chronic Disease Self-Management program

Conclusion

The Community Health Improvement Plan (CHIP) will serve as our guide to policy and program decisions that optimize health and well-being. Analysis of health, social and economic data as well as direct input from the community led to the identification of the top threats to community health and the selection of priorities that will address these threats. The CHIP is a realistic plan that will assist Southeast Health in its role to improve the health for residents of Cape Girardeau, Bollinger, Scott and Stoddard counties. It includes evidence-based strategies that are measurable and appropriate for influencing policies, systems, and environments to bring change to the county. At the same time, the 2020-2023 plan is flexible. It allows for adjustments in timing, leadership, strategy initiation, and tactical planning. Because this plan focuses on a restricted number of priorities, not all health issues or community initiatives are identified in the plan. This does not negate the importance of other public health issues; nor does it imply that resources and services should not continue for other public health needs. Our plan is intended to bring the community together around a limited number of issues with the greatest opportunity for health improvement through collective efforts. We will continue to work with a wide range of community partners to modify this (CHIP) in the months and years ahead in the Counties identified through our CHNA process. This CHIP will be used by partner organizations to complete agency specific reporting of roles and responsibilities (e.g., our health department and local hospitals), as well as informing agency strategic plans across the county where appropriate.

This CHIP will be widely disseminated electronically to partner organizations and used as a community roadmap to monitor and evaluate our collective efforts. Dissemination of this CHIP will also include community presentations, making it publicly available on our website SEHeatlh.org/CHNA and available at the Cape County Health Department website (www.cgcohealthdept.com), and the local libraries.