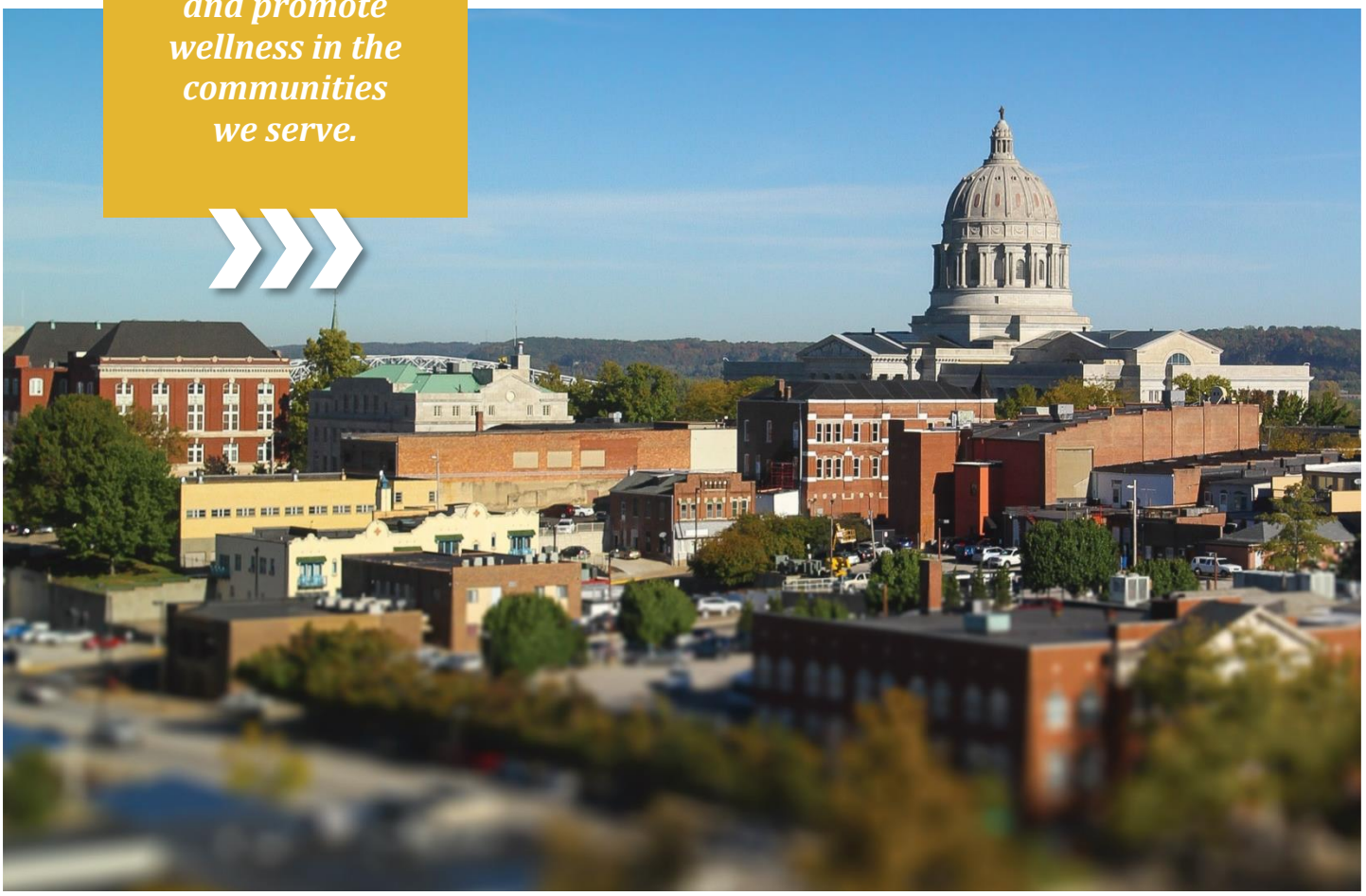
Our Mission:

To improve health and promote wellness in the communities we serve.



Community Health Needs Assessment Action Plan

2022-2024

Capital Region®
MEDICAL CENTER
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Executive Summary

As a community-based hospital, Capital Region Medical Center has a long-standing history of working with service agencies and health care partners to improve the health and wellness in the communities we serve. Through a collaboration with Professional Research Consultants (PRC), a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994, a Community Health Needs Assessment (CHNA) was conducted to determine strategies to improve the health of those living in our surrounding counties of Callaway, Cole, Miller, Moniteau and Osage counties.

The CHNA incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for comparison to benchmark data at the state and national levels. The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Capital Region Medical Center and PRC.

After collecting and analyzing the data, Prioritization of the health needs identified in the CHNA was determined based on a prioritization exercise conducted among community stakeholders (representing a cross-section of community-based agencies and organizations) in conjunction with the administration of the Online Key Informant Survey. Their ranking of these issues informed the following priorities:

1. Mental Health
2. Substance Abuse
3. Diabetes, Disability & Chronic Pain
4. Heart Disease & Stroke
5. Nutrition, Physical Activity & Weight

While the five areas of greatest need are indicated above, this does not discount other health and wellness concerns facing our communities.

Development of implementation strategies were completed with consideration of available resources, the need for policy change, reimbursement and feasibility of greatest impact.

All the supporting data used to generate the areas of greatest need can be found in the Community Health Needs Assessment at www.crmc.org.

2022-2024 Identified Priority Needs

The Community Health Needs Assessment is intended to be a tool in identifying and pursuing collaborative goals and actions to address the identified prioritized needs, based on the prioritization process, wherein key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following top five identified priority needs:

- Mental Health
- Substance Abuse
- Diabetes, Disability & Chronic Pain
- Heart Disease and Stroke
- Nutrition, Physical Activity and Weight

Prioritized Health Issue #1:

Mental Health

There are limited mental health providers in the area in general but especially noted was the gap in providers for youth and families in distress. Long wait lists for treatment or counseling were often noted. Additionally, many feel that mental health is intertwined with other key health issues such as substance abuse, addiction, and overall good physical health.

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.
– Healthy People 2030 (https://health.gov/healthypeople)

A total of 24.9% of Total Service Area adults have been diagnosed by a physician as having a depressive disorder (such as depression, dysthymia, or minor depression).

Miller and Moniteau counties have a disproportionately lower number of mental health providers.

Among those rating mental health issues as a "major problem," reasons related to the following:

- Access to care/Services
- Covid-19
- Impact on Quality of Life
- Transportation
- Follow-up/Support

Action Plan:

Mental Health

- Coordinate Mental Health First Aid training in our communities
- Continue evaluating post-discharge case management for mental health patients in emergency department
- Collaborate with Missouri Rural Health Association on Healthtran to assist those with transportation issues to access medical appointments free of charge
- Continue utilizing technology to track and refer patients to appropriate mental wellness providers on a timely basis
- Continually assess community needs and increase provider capacity at Center for Mental Wellness as needed to improve access
- Promotion of Patient Assistance Medication Program
- Research model/best practice for educating community on stigma of mental wellness
- Continue Real-Time Psychiatric Evaluation in the ER to evaluate the appropriateness of inpatient psychiatric needs.
    - Measurements: Length of hold in ER, length of stay in ICU and admissions to ICU
- Continue depression screenings at Capital Region physicians clinics locations annually
    - Measurement: Rate per month, dashboard metric
- Quarterly education in the News Tribune and other publications focusing on mental health
- Center for Mental Wellness provides physician education centered on the depression screening and referral process if needed
- Continue providing Living in Recovery Support Group which focuses on relapse prevention and evaluate need for additional support groups
- Evaluate expansion of embedded behavioral health model currently in four clinics
    - Measurement: Visits
- Increase promotion of and collaborate with organizations to implement Mindwise, a mental wellness screening tool that connects users with resources.

Prioritized Health Issue #2:

Substance Abuse

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

A total of 24.5% of area adults are excessive drinkers (heavy and/or binge drinkers).

A total of 17.8% of Total Service Area adults report using a prescription opioid drug in the past year (higher than the national percentage).

Among those rating this issue as a "major problem," reasons related to the following:

- Access to Care/Services
  - Availability of treatment centers, resources and transportation
- Awareness/Education
  - Lack of awareness in regards to programs, stigma, expenses
- Affordable Care/Services
- Income/Poverty
- Lack of providers

Action Plan:

Substance Abuse

- Offer and promote tobacco cessation education to the community
- Provide tobacco cessation resources to inpatient population
- Explore additional smoking cessation programs to implement, ex. Auriculotherapy, Freedom from Smoking
- Continue educating medical staff, management team, clinic physicians and nurses on prescription drug abuse particularly in opioids inpatient and ambulatory population
- Implementation and education of chronic pain medication agreement at primary care level
- Collaborate with Council for Drug Free Youth to provide education to schools and communities
- Continue promotion and awareness of drop box for unused or expired medication through Capital Care Pharmacy. Evaluate expansion in Versailles clinic
- Continue Blue Sight Control Substance Surveillance program implemented to evaluate risk among those prescribing and administering control substances
- Enrolled and continue partnership with the Prescription Drug Monitoring Program
- Education of health care providers on drug use to include policies and procedures for ordering pain medication and chronic pain medication agreements
- Evaluate implementation of Chronic Pain Self-Management workshops
- Provide opioid use disorder treatment in PCP clinic
- Continue Living in Recovery Support group for those focusing on relapse prevention and evaluate need for further support groups and expansion to outlying clinics

Prioritized Health Issue #3:

Diabetes, Disability & Chronic Pain

More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

Between 2017 and 2019, there was an annual average age-adjusted diabetes mortality rate of 40.2 deaths per 100,000 population in the Total Service Area (less favorable than found across the state and nation).

Among total Service Area survey respondents, over 80% report currently having at least one chronic health condition. 36.8% of Total Service Area adults report having three or more chronic conditions (more often reported among women and adults age 45 and older).
Among those rating this issue as a "major problem," reasons related to the following:

- Contributing factors
  - Cost of supplies for individuals with a low income.
  - Elderly individuals who cannot care for themselves properly or have transportation
  - Homeless individuals having low access to health foods.
  - Knowledge to create nutritional meals
- Prevention/Screenings
- Cost of medication

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030 (https://health.gov/healthypeople)

A total of 27.9% of Total Service Area adults are limited in some way in some activities due to a physical, mental, or emotional problem.

A total of 21.8% of Total Service Area adults experience high-impact chronic pain, meaning physical pain that has limited their life or work activities "every day" or "most days" during the past six months (higher than US percentage).

Among those rating this issue as a "major problem," reasons related to the following:

- Aging population, expanding number of people who have disabilities
- Addiction
- Incidence, prevalence

Action Plan:

Diabetes, Disability & Chronic Pain

- Evaluate recruiting Certified Diabetes Educator who would assist in providing diabetes and chronic disease education to the community
- Evaluate implementing Diabetes Prevention Program (DPP) and Diabetes Self-Management Training (DSMT) and Diabetes Self-Management Program at no cost to the community
- Support of local farmer's market and community education on recipes for and teaching cooking techniques for fresh vegetables and fruit
- Evaluate perform Hemoglobin A1C testing and diabetes education at clinic screening events
- Quarterly healthy cooking classes for the community at the Sam B. Cook Healthplex and other accessible community organizations
- Continue body mass index (BMI) measurements at CRP clinics and provide appropriate education. Evaluate developing and educating physicians on electronic referral process to potential prevention programs such as Fitness Center at Sam B Cook Healthplex, weight management services/bariatric program, Diabetes Prevention Program (DPP), Diabetes Self-Management Program (DSMP), and Chronic Disease Self-Management Program (CDSMP)
    - Measurement: Rate per month-dashboard metric
- Evaluate offering community-based health screenings including options for Lipid profile, comprehensive metabolic panel, total cholesterol
    - Measurement: Lives screen and educated
- Provide nurse calls for high-level abnormal screenings as well as 30-day follow up letter to encourage patient to seek care of primary care physician for all community health screenings
- Collaborate with Missouri Rural Health Association on Healthtran to assist those with transportation issues to access medical appointments free of charge
- Continue program for lung cancer screenings through Goldschmidt Cancer Center

- Continue Rock Steady Boxing for Parkinson patients
- Evaluate need for scholarship program for Fitness Center for those with limited funds
- Utilize the cardiovascular service line to improve care of patients
    - Measurement: Tobacco use, code STEMI, AMI, stroke, statins, completion of cardiac rehab, CHF readmission rates

Prioritized Health Issue #4:

Heart Disease and Stroke

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Between 2017 and 2019, there was an annual average age-adjusted heart disease mortality rate of 161.6 deaths per 100,000 population in the Total Service Area (fails to satisfy the Health People 2030 target of 127.4 or lower).

A total of 46.4% of Total Service Area adults have been told by a health professional at some point that their blood pressure was higher (higher than state and national findings).

A total of 32.6% of adults have been told by a health professional that their cholesterol level was high.

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

- High blood pressure
- High blood cholesterol
- Cigarette smoking
- Physical inactivity
- Overweight/obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

A total of 88.4% of Total Service Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol (worse than the US percentage; higher among men and adults age 45 to 64).

Among those rating this issue as a "major problem," reasons related to the following:

- Incidence/Prevalence
- Contributing factors
    - Poor general health and community health initiatives
    - Poor knowledge of nutritional meals

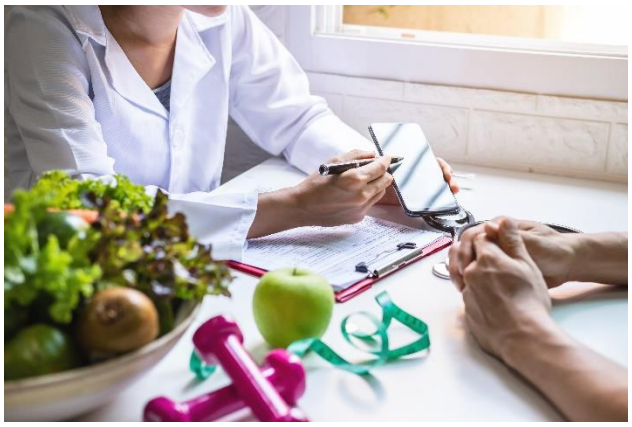
Action Plan:

Heart Disease and Stroke

- Through Capital Region Physicians increase the number of BMI assessments and give appropriate plan of care for our patients
- Support of local farmer's markets and community gardens, providing education on healthy recipes and offering cooking demonstrations
- Collaborate with Missouri Rural Health Association on Healthtran to assist those with transportation issues to access medical appointments free of charge
- Evaluate re-implementing annual clinic outreach screenings and quarterly community screenings
    - Measurement: Lives screen and educated
- Collaborate with Catholic Charities on the Healthy Heart Ambassador – Blood Pressure Self-Monitoring Program
- Evaluate re-implementing screenings for Lipid, CMP, Hemoglobin A1C and waist circumference twice per year at clinic screenings
    - Measurement: Lives screen and educated
- Educate community on heart disease and obesity prevention in publications and via Lunch and Learns
- Evaluate re-implementing Chronic Disease Self-Management courses at no cost to community. Identify ways to increase referrals to the program in order to increase participation
- Provide CPR courses available for all members of the community at a low cost
- Continue providing support groups such as Happy Achiever's Stroke Support Group and Heart-to-Heart. Evaluate expanding groups to outlying clinics and implementing further groups
- Continue body mass index (BMI) measurements at CRP clinics and provide appropriate education. Evaluate developing and educating physicians on electronic referral process to potential prevention programs such as Fitness Center at Sam B Cook Healthplex, weight management services/bariatric program, Diabetes Prevention Program (DPP), Diabetes Self-Management Program (DSMP), and Chronic Disease Self-Management Program (CDSMP)

Prioritized Health Issue #5:

Nutrition, Physical Activity and Weight



Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

A total of 35.7% of Total Service Area adults report eating five or more servings of fruits and/or vegetables per day (lower than was found across the US, lowest among male respondents).

12.1% of Total Service Area adults find it "very" or "somewhat" difficult to access affordable fresh fruits and vegetables.

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

A total of 22.7% of Total Service Area adults report no leisure-time physical activity in the past month.

A total of 19% of Total Service Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity and recommendations).

74.9% of Total Service Area adults are overweight (worse than state and national findings).

The overweight prevalence above includes 49.9% of Total Service Area adults who are obese (much worse than state and national findings).

24.6% of Total Service Area children age 5 to 17 are overweight or obese.

Among those rating this issue as a "major problem," reasons related to the following:

- Contributing factors
  - Cost of quality food and motivation to work on physical activities
  - Healthy meals take time to prepare
  - Small rural community where gyms are not a common event.
  - Obesity

Action Plan:

Nutrition, Physical Activity and Weight

- Continue partnership with local schools to provide low and/or no cost sports physicals
- Provide free Lunch and Learns and other presentations with CRMC Dietitians and athletic trainers
- Dietitians will provide free cooking demonstrations at various community locations, and in collaboration with local food banks to educate on cooking healthy on a fixed income
- Create and provide educational materials on nutrition, including a monthly article on nutrition provided to local media
- Collaborate with organizations, such as Boys and Girls Club, to provide cooking demonstrations, healthy snack ideas and other nutritional topics to a younger demographic
- Provide free exercise classes for the community
- Continue body mass index (BMI) measurements at CRP clinics and provide appropriate education. Evaluate developing and educating physicians on electronic referral process to potential prevention programs such as Fitness Center at Sam B Cook Healthplex, weight management services/bariatric program, Diabetes Prevention Program (DPP), Diabetes Self-Management Program (DSMP), and Chronic Disease Self-Management Program (CDSMP)
- Support of local farmer's markets and community gardens, providing education on healthy recipes and offering cooking demonstrations
- Evaluate providing functional movement developmental screenings at local pre-schools
- Evaluate implementing quarterly full-body screenings at Healthplex including: heart risk assessment, balance screenings, body composition, cholesterol, Lipid profile, metabolic panel, Mindwise for mental wellness resources, etc.
- Collaborate with MU Health Care to provide outreach for bariatric and weight management support
- Evaluate need for scholarship program for Fitness Center for those with limited funds

Comparison to 2019-2021 Identified Priority Needs

1. Improve Access to Health Care and Support Services

Access to health care and support services was the number one health priority in the 2018 CMCHAP report. The lower rate of access to health care and support services was influenced by many health factors including insurance coverage and the ability to afford services, long waits for appointments or treatments, availability and hours of operation of health care providers, an understanding of where to find services when needed, a lack of providers accepting new Medicaid patients and a lack of reliable personal or public transportation.

2. Mental Health Disorders and Substance Abuse

Mental health disorders were rated as the second health priority in the 2018 CMCHAP report for reasons that include: lack of mental health providers and substance abuse services, gap in providers for youth and families in distress, long wait lists for treatment or counseling, and social stigmas. Local public health data showed deaths and ER visits due to opioid overdoses increased in the community from 2012 to 2017.

3. Chronic Disease and Health Risks Prevention

Chronic diseases, specifically diabetes, heart/cardiovascular, cancer and lung/COPD, were ranked as a number three priority in the 2018 CMCHAP report for reasons that included nutrition and diet, low physical activity and exercise levels, and access to healthy food. The cost and accessibility of healthy food was a contributing factor. Alzheimer's disease and dementia were of primary concern for the elderly, including availability of in-home services, respite care, health literacy, and other social and emotional support services. The Heart Disease mortality age-adjusted death rate per 100,000 population was 186.8 for the five-county report area, which was more than two times the Missouri rate of 85.63 per 1000,000 population.

4. Improve Health Literacy

Health literacy, including chronic disease self-management, preventative care, and life skills education, stress management and coping, was ranked as a number four priority in the 2018 CMCHAP report as a result of frequent mentions as a serious issue by discussion group participants. It was noted that health literacy is a concern that cuts across the other priority areas as well, income and educational disparities, language barriers, lack of insurance and/or understanding of how to use the health care system.

5. Address Social Determinants of Health

Addressing social determinants of health, the conditions in the social and physical environment in which people are born, live, work, and age which has a significant influence on health outcomes, was ranked a fifth priority in the 2018 CMCHAP report as a result of discussion group participants sharing concern for increased poverty in some areas and multigenerational effects of poverty on families in their communities. Poverty/unemployment/working poor, affordable housing as well as inadequate social and emotional support systems for victims of abuse or neglect, individuals and

families in distress affected by substance abuse or suicide, and those who experience rural isolation, such as the elderly and working poor in our communities, were mentioned as social issues that needed to be addressed.

Capital Region Medical Center strives to address the needs of the communities we serve by staying abreast of the ever-changing health care landscape. While Capital Region is poised to bridge the gaps to health care for so many, one organization can't do it alone. Partnerships with a variety of service organizations are vital to creating a sustainable health care environment. Capital Region, along with another local hospital, community health centers, county health departments, law enforcement agencies, mental health groups and service organizations have committed to work together to improve the health and wellness of the communities we serve. Through the Community Health Needs Assessment and Action Plan we can achieve our goals to provide greater access to services, educate our populations and give hope for a healthier future.

The action plan has been developed and will require ongoing support and collaboration among various groups in the region. The data included in the CHNA serves as a baseline and will be used to benchmark the plan's effectiveness. Measuring effectiveness of programs and services will be completed by:

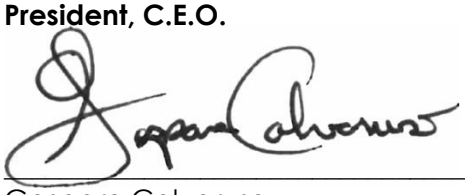
- Utilizing annual community outreach meetings to educate and receive feedback on CHNA Action Plan
- Utilizing Capital Region Medical Center's strategic plan dashboard metrics to monitor progress
- Utilizing feedback obtained from community partners and Board of Directors to drive future strategies for addressing community needs
- Share community benefit and outcomes of CHNA Action Plan via Board of Governors report

Approval

This Community Health Needs Assessment and Capital Region Medical Center's Action Plan will provide a foundation in which to continue the organization's mission to "improve the health and promote wellness in the communities we serve."

Approved by the Board of Directors:

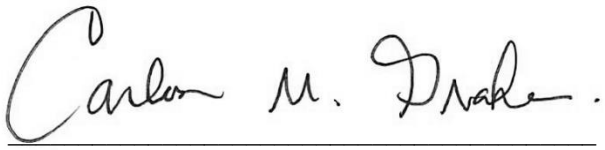
Capital Region Medical Center
President, C.E.O.



Gaspare Calvaruso

July 19, 2022
Date

Capital Region Medical Center
Board of Directors, Chair



Carlos Graham

July 19, 2022
Date