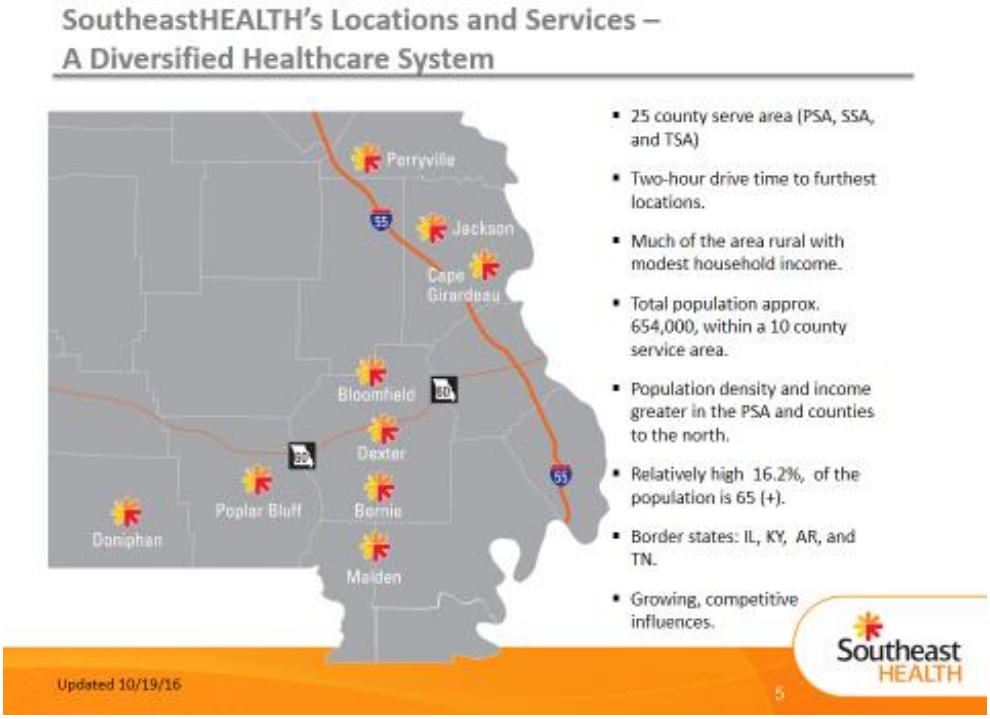
Mission for Implementation

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. The community coalitions we've 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 action planning and a 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.

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's statistics and trends.

	Health Need
1	Obesity (Diet and Exercise)
2	Cancer (Smoking)
3	Chronic Disease (Stroke, Heart Disease, Diabetes, and Chronic Respiratory Disease)
4	Substance Abuse/Mental Health
5	Health Care Affordability & Accessibility (Uninsured/Underinsured)
6	Pre-Conception and Prenatal Health

REDUCTION IN THE PERCENTAGE OF OBESITY – IMPROVEMENT STRATEGY

(Description of major actions)

Major Action(s)	Sub-actions
Collaborate with local providers to reduce barriers to care	1. Continue to build upon referral relationships with Cape Girardeau County Community Health Services 2. Meet with local providers who participated in the Community Health Needs Assessment to prioritize needs and develop strategies for collaboration 3. Hospital will provide discharge follow-up, case management, and referrals to community clinics and providers ***Anticipated Outcome(s):*** • Efficient referral relationships and responsive case management/follow-up will assist patients with finding a medical home. • Increase networking and collaboration with community coalitions and hospital administrative staff in the community to drive healthy lifestyles
Open new access points in areas of need	1. Expand physician services in West Campus facility to accommodate two new family care providers 2. Expand advanced providers in existing outpatient clinics in Dexter, Sikeston, and Jackson, Missouri areas ***Anticipated Outcome(s):*** • Increasing the number of primary care access points in convenient locations will encourage greater utilization.

	• New clinics in areas of need will attract more insured patients seeking covered services, including Medicaid obstetric care and commercially insured patients.
Continue to develop outreach services	1. Work with community coalitions in counties of service area to identify service gaps and develop programs to serve unmet needs 2. Work with 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 and first responder efforts will improve community participation in health fairs and increase capacity to conduct home visits and discharge follow up. • SoutheastHEALTH clinical resources accessible in the workplace will encourage employers and employees to make use of SoutheastHEALTH facilities to keep workers well. • Re-committing to outreach and health plan enrollment efforts will lead to a decrease in the number of uninsured patients seeking care in the hospital.
Address frequent emergency department (ED) use among low-income populations by improving access to appropriate care alternatives	1. Refer more low-income patients to clinics, primary care providers, or other non-emergency care settings more appropriate to their medical situation ***Anticipated Outcome(s):*** • Achieve a 10% reduction in ED visits among the low-income population, and reduce disproportionality in ED revisit rates by race and ethnicity. • As diverse and vulnerable patient populations reduce cyclical ED use and are integrated into a medical home, measurable reductions in health disparities will be observed.

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

Healthy Communities Coalition

- Community Gardens
- School Health Fairs
- Employer Wellness Education
- Storybook Trail
- Marketeers Program
- 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

▪ Barre Fusion ○ For Children: ▪ Kids' Bee Fit ▪ Dolphins Swim Club ▪ Fit Kids/Boot Camp ▪ Power Club ▪ Kids Cycle ▪ Warriors • HealthPoint - Nutrition ○ Starting Point – Weight Management program ○ Healthy Cooking Classes ○ Nutritional Coaching ○ PHIT (Promoting Health in Teens) ○ Reclaim Program ○ Biometrics ○ Weight Management First Steps Seminars	• Eating behavior and nutritional education ***Regional Healthcare Foundation*** • Fitness Challenge • Exercise for Wellness program ***Scott County Health Center*** • Offers nutrition classes in schools/community ***Ripley County Health Center*** • Nutrition education

REDUCTION IN THE NUMBER OF CANCER DEATHS - IMPROVEMENT STRATEGY

(Description of major actions)

Major Action(s)	Sub-actions
Collaborate with local providers to reduce barriers to care	1. Continue to build upon referral relationships with the Cape Girardeau County Community Health Services 2. Meet with local providers who participated in the Community Health Needs Assessment to prioritize needs and develop strategies for collaboration 3. Hospital will provide discharge follow-up, case management, and referrals to community clinics and providers ***Anticipated Outcome(s):*** • Efficient referral relationships and responsive case management/follow-up will assist patients with finding a medical home. • Increased networking and collaboration with providers in the community will drive reductions in duplicated services and improve continuity of care for populations who have traditionally experienced lower access.
Open new access points in areas of need	1. Expand outpatient services by expanding cancer outreach physician clinics in Dexter and Perryville areas 2. Open outreach chemotherapy services in Dexter and Perryville ***Anticipated Outcome(s):***

	• Increasing the number of primary care access points in convenient locations will encourage greater utilization. • New clinics in areas of need will attract more insured patients seeking covered services, including Medicaid care and commercially insured patients.
<u>Continue to develop outreach screening services</u>	1. Work with community coalitions to establish enhanced community screening services in top 4 cancer diagnosis: Breast, Lung, Prostate, Colon 2. Work with community coalition and partners to enhance cancer prevention education in schools and key community events ***Anticipated Outcome(s):*** • Reduction of later stage cancers due to early diagnosis and treatment of cancer cases and consistent and ongoing preventive screening programs • Decrease in the number of uninsured patients seeking care in the hospital.
<u>Address frequent emergency department (ED) use among low-income populations by improving access to appropriate care alternatives</u>	1. Refer more low-income patients to clinics, primary care providers, or other non-emergency care settings more appropriate to their medical situation ***Anticipated Outcome(s):*** • Achieve a 10% reduction in ED visits among the low-income population, and reduce disproportionality in ED revisit rates by race and ethnicity. • As diverse and vulnerable patient populations reduce cyclical ED use and are integrated into a medical home, measurable reductions in health disparities will be observed.

Resource Inventory:

SoutheastHEALTH

- Cancer Screenings
  - Skin Cancer
  - Lung Cancer
  - Mammograms
- Southeast Cancer Center – offers cancer services
- Support groups for Breast Cancer
- We Can Weekend event for survivors and their families
- Online Health Risk Assessments for Colon, Prostate, and Breast Cancer
- Education Seminars with Health Experts for Breast Cancer, Prostate Cancer, and Testicular Cancer

Cape Girardeau County Public Health Center

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

Bollinger County Public Health Center

- Show Me Healthy Women program – offers pap smears, cervical exams, and mammograms
- Skin cancer screening
- Smokebusters – education in schools about dangers of smoking

Stoddard County Health Center

- Show Me Healthy Women program – offers pap smears, cervical exams, and mammograms

- Smoking Cessation Informational Sessions and One-on-One Support

East Missouri Action Agency

- Show Me Healthy Women program – offers pap smears, cervical exams, and mammograms

Cross Trails Medical Center

- Show Me Healthy Women program – offers pap smears, cervical exams, and mammograms

SEMO Health Network

- Health screenings for prostate cancer
- Well-woman exams – pap smears, pelvic and breast exams
- Forget Your Impulses smoking cessation program

Ripley County Health Center

- Show Me Healthy Women program – offers pap smears, cervical exams, and mammograms
- Women's health screening

Missouri Highlands Health Care

- Show Me Healthy Women program – offers pap smears, cervical exams, and mammograms

REDUCTION IN THE RATES OF CHRONIC DISEASE - IMPROVEMENT STRATEGY

(Description of major actions)

Major Action(s)	Sub-actions
Collaborate with local providers to reduce barriers to care	1. Continue to build upon referral relationships with the Cape Girardeau County Community Health Services and Public Health Department 2. Meet with local providers who participated in the Community Health Needs Assessment to prioritize needs and develop strategies for collaboration in reduction of chronic disease rates 3. Hospital will provide discharge follow-up, case management, and referrals to community clinics and providers ***Anticipated Outcome(s):*** • Efficient referral relationships and responsive case management/follow-up will assist patients with finding a medical home. • Increased networking and collaboration with providers in the community will drive reductions in duplicated services and improve continuity of care for populations who have traditionally experienced lower access.
Open new access points in areas of need	1. Expand primary outpatient services by acquiring advanced practitioners for placement in at-risk communities with limited healthcare access ***Anticipated Outcome(s):*** • Increasing the number of primary care access points in convenient locations will encourage greater utilization.

	• New clinics in areas of need will attract more insured patients seeking covered services, including Medicaid care and commercially insured patients.
<u>Continue to develop outreach services</u>	1. Fund community health programs that provide general health and wellness and disease prevention education 2. Collaborate with Occupational Medicine Business Development Liaison for education at workplaces to improve wellness and health outcomes in populations of employees ***Anticipated Outcome(s):*** • Funding a cohort of CHWs will improve community participation in health fairs and increase capacity to conduct home visits and discharge follow up. • A Southeast-affiliated health plan accessible in the workplace will encourage employers and employees to make use of SoutheastHEALTH facilities to keep workers well. • Re-committing to outreach and enrollment efforts will lead to a decrease in the number of uninsured patients seeking care in the hospital.
<u>Address frequent emergency department (ED) use among low-income populations by improving access to appropriate care alternatives</u>	1. Refer more low-income patients to clinics, primary care providers, or other non-emergency care settings more appropriate to their medical situation ***Anticipated Outcome(s):*** • Achieve a 10% reduction in ED visits among the low-income population, and reduce disproportionality in ED revisit rates by race and ethnicity. • As diverse and vulnerable patient populations reduce cyclical ED use and are integrated into a medical home, measurable reductions in health disparities will be observed.

Resource Inventory:

<u>Stroke</u>

SoutheastHEALTH

- Stroke center
- Stroke Educational Seminar
- Integra Wellness screening (AAA, PAD, Stroke/Carotid Artery)

Bollinger County Health Center

- Blood pressure screening
- Cholesterol screening

SEMO Health Network

- Care for chronic disease

<u>Diabetes</u>

SoutheastHEALTH

- Diabetes Self-Management Support Group
- Diabetes Self-Management program
- Camp DAY (Diabetes and Youth) Break
- Diabetes education center
- Wound Care seminar

Cross Trails Medical Center

- Diabetes program including education

East Missouri Action Agency

- Diabetes screening for women

- Blood pressure screening

Stoddard County Health Center

- Blood pressure screening
- Cholesterol screening

Scott County Health Center

- Chronic disease screening and monitoring

Ripley County Health Center

- Blood pressure screening

Heart Disease

SoutheastHEALTH

- Mended Hearts – education program
- Peripheral Artery Disease screening
- Integra Wellness screening (AAA, PAD, Stroke/Carotid Artery)
- Cardiovascular services
- Educational Seminars – CardioMEMs/Heart Failure, Meet & Greet with Heart Experts, Heart Medications and Nutritional Supplements

Bollinger County Health Center

- Blood pressure screening
- Cholesterol screening

Regional Healthcare Foundation

- Chronic Disease program

SEMO Health Network

- Care for chronic disease
- Blood pressure screening

Stoddard County Health Center

- Blood pressure screening
- Cholesterol screening

Scott County Health Center

- Chronic disease screening and monitoring

Ripley County Health Center

- Blood pressure screening

Bollinger County Health Center

- Glucose screening

Regional Healthcare Foundation

- Chronic Disease program

Stoddard County Health Center

- Blood sugar screening

SEMO Health Network

- Health screenings for diabetes
- Care for chronic disease

Scott County Public Health Center

- Chronic disease screening and monitoring

Bollinger County Health Center

- Diabetic screening and education

Chronic Respiratory Disease

SoutheastHEALTH

- Pulmonology services

Cape Girardeau County Public Health Center

- Asthma Case Management

Regional Healthcare Foundation

- Chronic Disease program

Scott County Health Center

- Chronic disease screening and monitoring

INCREASING ACCESS TO MENTAL HEALTH SERVICES - IMPROVEMENT STRATEGY

(Description of major actions)

Major Action(s)	Sub-actions
Collaborate with local providers to reduce barriers to care	1. Continue to build upon referral relationships with the Cape Girardeau County Community Health Services 2. Meet with local providers who participated in the Community Health Needs Assessment to prioritize needs and develop strategies for collaboration 3. Hospital will provide discharge follow-up, case management, and referrals to community clinics and providers ***Anticipated Outcome(s):*** • Efficient referral relationships and responsive case management/follow-up will assist patients with finding a medical home. • Increased networking and collaboration with providers in the community will drive reductions in duplicated services and improve continuity of care for populations who have traditionally experienced lower access.
Open new access points in areas of need	1. Expand inpatient by opening a new large comprehensive facility in Cape Girardeau and inpatient unit in Dexter 2. Open new outpatient clinics in Dexter and Cape Girardeau ***Anticipated Outcome(s):*** • Increasing the number of primary care access points in convenient locations will encourage greater utilization. • New clinics in areas of need will attract more insured patients seeking covered services, including Medicaid care and commercially insured patients.
Continue to develop outreach services	1. Fund and or provide collaborative leadership for community programs with health workers that provide services for this identified risk population 2. Work with community coalition and new facility staff to address unmet needs with at risk populations ***Anticipated Outcome(s):*** • Re-committing to outreach and enrollment efforts will lead to a decrease in the number of uninsured patients seeking care in the hospital.
Address frequent emergency department (ED) use among low-income populations by	1. Refer more low-income patients to new outpatient behavioral health clinics, primary care providers, or other non-emergency care settings more appropriate to their medical situation

improving access to appropriate care alternatives	***Anticipated Outcome(s):*** • Achieve a 10% reduction in ED visits among the low-income population, and reduce disproportionality in ED revisit rates by race and ethnicity. • As diverse and vulnerable patient populations reduce cyclical ED use and are integrated into a medical home, measurable reductions in health disparities will be observed.

Resource Inventory:

SoutheastHEALTH

- Inpatient psychiatry services
- Outpatient services

Tender Hearts Child Therapy Center

Heartland Counseling Center

Community Counseling Center

Family Counseling Center

New Vision Counseling

Associated Counseling Services

Riverview Counseling

4-Sight Counseling

Louis E. Masterman Center

Gibson Recovery Center

Mending Hearts Recovery

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

ENSURING HEALTH CARE AFFORDABILITY & ACCESSIBILITY - IMPROVEMENT STRATEGY

(Description of major actions)

Major Action(s)	Sub-actions
Collaborate with local providers to reduce barriers to care	1. Continue to build upon referral relationships with the Cape Girardeau County Community Health Services 2. Meet with local providers who participated in the Community Health Needs Assessment to prioritize needs and develop strategies for collaboration 3. Hospital will provide discharge follow-up, case management, and referrals to community clinics and providers ***Anticipated Outcome(s):*** • Efficient referral relationships and responsive case management/follow-up will assist patients with finding a medical home. • Increased networking and collaboration with providers in the community will drive reductions in duplicated services and improve

	continuity of care for populations who have traditionally experienced lower access.
Educate population about plan options	1. Work with community coalition partners to educate community resources about the available health plan options for those in need 2. Ongoing education at community events and screenings when identifying populations with health coverage needs ***Anticipated Outcome(s):*** • Increasing the number of primary care access points in convenient locations will encourage greater utilization. • Current clinic expansion in areas of need will attract more insured patients seeking covered services, including Medicaid care and commercially insured patients.
Address frequent emergency department (ED) use among low-income populations by improving access to appropriate care alternatives	1. Refer more low-income patients to clinics, primary care providers, or other non-emergency care settings more appropriate to their medical situation ***Anticipated Outcome(s):*** • Achieve a 10% reduction in ED visits among the low-income population, and reduce disproportionality in ED revisit rates by race and ethnicity. • As diverse and vulnerable patient populations reduce cyclical ED use and are integrated into a medical home, measurable reductions in health disparities will be observed.

Resource Inventory:

SoutheastHEALTH

- Provide general health services and accept Medicaid

Cross Trails Medical Center

- Federally qualified health center

Cape Girardeau County Public Health Center

- Rural Health Clinic

Med-Stop One

Prompt Care

Southeast Health Center of Stoddard County

- Provide general health services and accept Medicaid

SEMO Health Network

- Provide general health services, accepts Medicaid, and offers a Medication Assistance Program

Regional Healthcare Foundation

- Offers a prescription drug assistance program

Missouri Delta Medical Center

- Provide general health services and accept Medicaid

Southeast Health Center of Ripley County

- Provide general health services and accept Medicaid

IMPROVING PRECONCEPTION & PRENATAL HEALTH - IMPROVEMENT STRATEGY

(Description of major actions)

Major Action(s)	Sub-actions
Collaborate with local providers to reduce barriers to care	1. Continue to build upon referral relationships with the Cape Girardeau County Community Health Services that provide additional care services for this at risk population 2. Meet with local providers who participated in the Community Health Needs Assessment to prioritize needs and develop strategies for collaboration 3. Hospital will provide discharge follow-up, case management, and referrals to community clinics and providers ***Anticipated Outcome(s):*** • Efficient referral relationships and responsive case management/follow-up will assist patients with finding a medical home. • Increased networking and collaboration with providers in the community will drive reductions in duplicated services and improve continuity of care for populations who have traditionally experienced lower access.
Open new access points in areas of need	1. Engage Community Coalitions 2. Engage Community Associations, Faith-Based Groups, First Responders about the current resources available to serve this population base ***Anticipated Outcome(s):*** • Increasing the number of primary care access points in convenient locations will encourage greater utilization. • New clinics in areas of need will attract more insured patients seeking covered services, including Medicaid obstetric care and commercially insured patients.
Continue to develop outreach services	• Work with regional health departments and community health improvement coalitions for identifying enhanced services to fulfill unmet needs • Collaborate with workplaces to improve wellness and health outcomes in populations of employees ***Anticipated Outcome(s):*** • Funding and sponsoring community programs that will improve community participation in health fairs and increase capacity to conduct home visits and discharge follow up. • A SoutheastHEALTH Occupational Medicine Business Development liaison accessible to the workplace will encourage employers and employees to make use of facilities to keep workers well.

	• Re-committing to outreach and enrollment efforts will lead to a decrease in the number of uninsured patients seeking care in the hospital.
<u>Address frequent emergency department (ED) use among low-income populations by improving access to appropriate care alternatives</u>	1. Refer more low-income patients to clinics, primary care providers, or other non-emergency care settings more appropriate to their medical situation ***Anticipated Outcome(s):*** • Achieve a 10% reduction in ED visits among the low-income population, and reduce disproportionality in ED revisit rates by race and ethnicity. • As diverse and vulnerable patient populations reduce cyclical ED use and are integrated into a medical home, measurable reductions in health disparities will be observed.

Resource Inventory:

SoutheastHEALTH

- Building Blocks – free prenatal early childhood home visitation service to help mothers:
  - Make healthy choices about diet and pregnancy
  - Prepare for labor and delivery
  - Make the best decisions on feeding the baby
  - Make parenting easier with helpful hints
  - Learn about baby's growth and development
- Childbirth Preparation Classes
- Planning for Baby Educational Seminar
- Obstetrics services

Cape Girardeau County Public Health Center

- Pregnancy testing
- High risk pregnancy assessments
- Case management for high risk pregnancies

Lutheran Family and Children's Services

- WINGS – pregnancy counseling

Birthright of Cape Girardeau

- Pregnancy counseling and services offering alternatives to abortion

Women, Infants, and Children (WIC) program

- Provides nutritious foods, nutrition education and counseling, and screening to pregnant, breastfeeding, and non-breastfeeding postpartum women, infants, and children up to age 5

Stoddard County Health Center

- Prenatal case management
- Breastfeeding education
- Pregnancy testing
- Family planning education
- Prenatal and parenting education

Regional Healthcare Foundation

- Mother to Mother program

Scott County Health Center

- Prenatal case management
- Family planning education

Ripley County Health Center

- High-risk infant follow up
- Case management for prenatals
- High-risk pregnancy counseling
- Pregnancy testing