Our Mission:

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

Community Health Needs Assessment Action Plan

2019-2021

Capital Region®
MEDICAL CENTER
An Affiliate of MU Health Care

Better. Every day.

www.crmc.org

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 an additional local hospital, county health departments, community health centers, mental health agencies, law enforcement, community members, service organizations and health care providers, 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.

To develop the CHNA, community discussion groups were conducted to provide real time insight into the health challenges facing our communities. Coupled with the focus group, data from secondary sources was analyzed and prioritized to determine the areas of greatest need for the communities included in the study. One of the tools utilized for data analysis was the Missouri Department of Health and Senior Services, "Missouri Information for Community Assessment" (MICA) interactive system, Community Commons, and ExploreMOHealth.

After collecting and analyzing the data, the top five areas of need emerged:

1. Access to Health Care
2. Mental Health Disorders and Substance Abuse
3. Chronic Disease and Health Risks Preventions
4. Health Literacy
5. Social Determinants of Health

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

With the assessment completed the collaboration moved to a more in depth discussion to determine how to address the findings. Development of implementation strategies were completed with consideration of available resources, the need for policy change, reimbursement and feasibility that the group as a collaborative can 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.

2019-2021 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 Central Missouri Community Health Assessment Partnership (CMCHAP) prioritization exercise, these top five issues and determining factors were identified as priorities:

- Improve Access to Health Care and Support Services
- Mental Health Disorders and Substance Abuse
- Chronic Disease and Health Risks Prevention
- Improve Health Literacy
- Address Social Determinants of Health

Prioritized Health Issue #1:

Improve Access to Health Care and Support Services

Access to specialty, primary and preventive health care services through a doctor's office, clinic or other appropriate provider is an important element of a community's health care system, and is vital for helping the community's residents to be healthy. The ability to access care is influenced by many factors, including insurance coverage and the ability to afford services, long waits for appointments or treatments, the 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 were frequently mentioned as concerns. For the purposes of this report, "access to care" is more than just access to health insurance. It also encompasses availability and continuity of primary and specialty care for physical and behavioral health, as well as accessibility of health and human services and providers.

Lack of mental health providers and substance abuse services was mentioned most among participants. Community input emphasized the impact of opioid abuse on the community, a lack of detox or substance abuse treatment options, as well as the economic burden it is placing on law enforcement, EMS, and hospital providers. Heroin and opioid use were mentioned more often, however, alcohol, marijuana, and methamphetamines were also mentioned as top concerns.

Language differences and cultural understanding of diseases on the part of providers of care or service organizations was also mentioned as effecting the quality and accessibility to care. Lack of accessible or reliable transportation to health care, especially for low-income individuals and senior citizens who rely on public transportation to get to appointments and elsewhere for care.

Action Plan:

Improve Access to Health Care and Support Services

- Capital Region strategic plan includes adding Endocrinologist, psychiatry, psychology, ENT, physical medicine and rehabilitation, general surgery, OB/GYN, orthopedic group, and several primary care providers.
- Continue Charity Care Program for those who cannot afford health care. In fiscal year 2018, Capital Region provided $3,370,266 in health care services to those who were not insured or underinsured.
- Online scheduling tool currently offered at urgent cares, pediatric clinic, Owensville and Linn. Plan will be to go live with online scheduling in all clinics by 2021.
- Working with SSM Health, United Way of Central Missouri and the City of Jefferson on potential transportation programs to assist residents with reliable personal and public transportation.
- Continue our partnership with New Vision for inpatient drug detox program.
- Developed protocol for emergency department physicians to schedule next day appointments with Capital Region Physicians (CRP) to reduce admissions, decrease health care cost as well as encourage continuum of care.
- Developed protocol for OB department to schedule well baby visits at time of discharge to improve access for clinic visit and compliance of visit.
- Evaluation of need to expand hours of operation to improve access to urgent care, pediatrics and primary care physicians.
- Each primary care clinic location has at least one provider that accepts new Medicaid patients.
- Continued medication assistance in Goldschmidt Cancer Center and specialty drugs through Capital Care Pharmacy. Evaluating opportunities of expansion to other areas.
- Partnering with City of Jefferson, Missouri Foundation of Health- Healthy Schools, Healthy Community Initiative to provide low cost bikes and scooters for transportation.

Prioritized Health Issue #2:

Mental Health Disorders and Substance Abuse

Many discussion group participants and steering team members expressed concern about mental health issues in the community. In particular, mental health issues, such as anxiety, depression and risk of suicide, are prevalent concerns. 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. In regard to substance abuse, it was noted that individuals may be using drugs/alcohol as a mechanism to cope with mental health issues stemming from toxic stress they have experienced. Local public health data shows deaths and ER visits due to opioid overdoses have increased in the community from 2012 to 2017. Poor mental or behavioral health frequently contributes to or exacerbates problems with physical health and illness. An additional concern reported in all discussion groups was related to connecting patients with services needed, especially coordination of care for patients with co-occurring or dual diagnosis conditions. Social stigmas around mental health is widespread in our communities and plays key role in whether someone chooses to seek care.

Action Plan:

Mental Health Disorders and Substance Abuse

- Facilitate local Behavioral Health Resource Partnership meetings that includes SSM, United Way, Compass Health, Department of Mental Health and many other local partners.
- Implementation of 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
- Implement Emergency Room Enhancement Program with Compass Health. This program is a community based holistic case management service of frequent utilizers of healthcare for medical and psychiatric needs.
    - Measurements: Referrals made mental health provider
- Continue depression screenings at Capital Region physicians clinics locations at each visit
    - Measurement: Rate per month, dashboard metric
- Activate drop box for unused or expired medication through Capital Care Pharmacy.
- Blue Sight Control Substance Surveillance program implemented to evaluate risk among those prescribing and administering control substances.
- EAP education provided to Capital Region leadership team as well as sent to local employers quarterly.
- EAP presentations, education and crisis services provided to local business as requested.
- 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.
- 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 contracts.
- Evaluate need for implementing Chronic Pain Self-Management workshops.
- Partner with Miller County Health Center and Morgan County Health Departments and Lake Regional Hospital to implement a 4Mind4Body (mental health awareness) events in 2019.
- Partner with clergy and CRMC Foundation for a mental wellness resource fair in 2019.
- Implement new position of crisis counseling at Capital Region's Center for Mental Wellness.
- Provide mindfulness exercises and mental health screening for local clergy during Clergy Day in 2019.

Prioritized Health Issue #3:

Chronic Disease and Health Risk Prevention

Chronic diseases, specifically diabetes, heart/cardiovascular, cancer and lung/COPD are prevalent health issues. Diabetes and heart disease was the most frequently mentioned chronic disease, and was often linked with discussion about obesity and overweight. The heart disease mortality age-adjusted death rate per 100,000 population is 186.8 for the five-county report area, which is more than two times the Missouri rate of 85.63 per 100,000 population. (CHNA, page 37) Preventing these health issues from occurring is of particular importance through education of children and youth on proper nutrition, fitness and other healthy living habits. Related contributing factors reported were nutrition and diet, low physical activity and exercise levels, and access to healthy food. Access to healthy foods was mentioned as a barrier, including that some cannot afford to purchase fresh produce or would have to travel some distance to access healthy food. There was wide recognition of the toll chronic illness has on health, its impact on the health care system, and the importance of not only treatment but also behavioral change necessary to address the chronic disease, specifically the patient's desire to change and engage in self-management of their chronic disease.

Cancer and lung/chronic obstructive pulmonary disease were reported frequently among the top five diseases for hospitalizations, ER visits and chronic disease deaths in the secondary data and are listed as the number two and three top cause of death, respectively, just behind heart disease (MICA 2016). The cancer mortality age-adjusted death rate per 100,000 population is 167.7 for the five-county report area, which is significantly higher than the Missouri rate of 87.2 per 100,000 population. (CHNA, page 38) The Lung disease mortality, age-adjusted death rate per 100,000 population for the five-county report area is 54.7 compared to the Missouri state rate of 11.5 (CHNA, page 39). Increased awareness of risk factors, cancer services and treatment options, as well as preventative screenings through health promotion is needed in order to increase early detection, and decrease late diagnosis and treatment of cancer and lung diseases.

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. Caring for and coordinating services for persons with Alzheimer's was mentioned as a key issue for family members and caregivers, particularly knowing how and where to obtain proper diagnosis and treatment. Increasing

caregiver and provider knowledge of and connecting patients to available services was noted as an opportunity for improvement.

Overweight/Obesity and Physical Inactivity, Smoking and Tobacco Use

Obesity and physical inactivity are both often pre-cursors to other health issues. Obesity is often the driver of other chronic conditions, such as diabetes, heart disease and cancer. Therefore, many discussion group participants felt obesity prevention is at the core to addressing other health issues by improving community infrastructure for places to walk, exercise, and bike, as well as increasing access to fitness facilities and healthy food sources. Many noted that while improvements are being made in Jefferson City, other communities within the report area are making some, but not enough infrastructure improvements, primarily due to limited funding.

Like obesity, smoking and tobacco use is well-documented to be a risk factor for various forms of cancer, heart disease and other ailments, and pose serious health risks for those exposed to secondhand smoke. The increasing use of e-cigarettes and vapor products, particularly among young people, and the misinformation that they are a healthy alternative to regular cigarette smoking is of major concern. Passage of the Tobacco 21 ordinance in Jefferson City in 2017 was held out as an example of a collaborative community strategy to reduce smoking and tobacco use among young people. Community leaders and elected officials who participated in the discussion groups indicated an interest to work with the medical community to develop a road map for potential future health policies.

Action Plan:

Chronic Disease and Health Risks Prevention

- Continue partnership with Missouri Foundation for Health (MFH) on the Healthy Schools, Healthy Community grant to address childhood obesity in Versailles and Jefferson City Public Schools systems.
- Collaborate with the YMCA, SSM, JCMG on a Community Wellness Expo offering screenings and education.
- Continue Leslie Cam Stop Smoking Auriculotherapy at bi-monthly.
- Continue partnership with Arthritis Foundation on the Show Me Better Health by providing Chronic Disease Self-Management courses at no cost to community. Identify ways to increase referrals to the program in order to increase participation.
- Collaborate with Capital Region Partners to assist with 2019 community initiative related to sleep apnea community education.
- Support of local farmer's market and community education on recipes for and teaching cooking techniques for fresh vegetables and fruit.
- Evaluate opportunity to reflex and perform a hemoglobin A1c all emergency room patients with a glucose over 180 non-fasting/120 fasting. Facilitate referral to diabetes education programs.

- Offer diabetes programs including Diabetes 101 and Diabetes Self-Management Program at no cost to the community. Explore other educational opportunities for pre-diabetic patients.
- Pilot with Missouri Custom on diabetic population to have a pharmacists review all prescriptions through ViPRx, a virtual pharmacy review program.
- Continue body mass index (BMI) measurements at CRP clinics and provide appropriate education. Develop and educate physicians on electronic referral process to prevention programs such as Fitness Center at Sam B Cook Healthplex, wellness navigators and Diabetes 101.
  - Measurement: Rate per month-dashboard metric
- Offer community and corporate based health screenings.
  - Measurement: Lives screen and educated
- Offer bi-monthly low cost lab screenings through Corporate and Community Health Department
- 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 corporate and community health screenings.
  - Develop tracking for scheduled physician visits post call and identify ability to make appointments for individuals at time of call to ensure follow up and access to care partner with Community Health Center to facilitate care for those with limited insurance/financial resources.
- Develop Capital Region intern/resident involvement in community health initiatives.
- Continue program for lung cancer screenings through Goldschmidt Cancer Center.
- Promotion of smoke free campus and continue practice of not hiring those with positive cotinine.
- Implement Rock Steady Boxing for Parkinson patients. Explore development of other diagnosis specific group exercise programs.
- Support and develop employee wellness programs that focus on prevention and lowering of risk factors
- Development of scholarship program for Fitness Center for those with limited funds
- Continue with Chronic Care Management Program for Medicare patients. Through Capital Region Physicians those that have two or more chronic diseases are eligible to work with a nurse to ensure their plan of care is being followed and educational support is offered as needed.
- Evaluate chronic disease care coordination program for inpatients that will facilitate transfer to outpatient Chronic Care Management Program.
- Participate on community boards that support chronic disease, example COSMOS Club, American Cancer Society, etc.
- 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
- Enhance program for individuals with chronic obstructive pulmonary disease (COPD).
  - Measurement: Readmissions, spirometry use, rates of completion of pulmonary rehab

Prioritized Health Issue #4:

Improve Health Literacy

Health literacy, including chronic disease self-management, preventative care, and life skills education, stress management and coping are needed to improve health and wellness decisions. While 76% of the survey respondents indicated they receive most of their health information from their doctor or health provider, a lack of time spent educating patients in the doctor's office was mentioned by discussion group participants as one barrier to helping patients understand their health condition and how to treat it. It was suggested in the input sessions that health education, preventative screenings, and social and emotional support services be delivered differently throughout communities rather than in the traditional class offerings or group settings. Expanding the opportunities for education of consumers through digital media, health kiosks, providing more mobile health care options, and using community health workers and case managers in a variety of settings, including churches, schools and colleges, to encourage and link individuals to health care or support services. In addition, 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 are some of the issues that undermine health and wellness.

Action Plan:

Improve Health Literacy

- Host, participate in and support community health fairs and events to share health information and resources with targeted populations in the community.
- Provide community CPR and first aid training.
- Implement RQI quarterly training for hospital staff.
- Continue to coordinate and provide community support groups for the following: Better Breathers, Stroke, Heart to Heart, AMI-Diabetes, Alzheimer's, Living in Recovery, Cancer (ETC, Men's), Social Skills, Wings of Hope and Parkinson's.
- Partner with Miller County Health Department to provide Diabetes Self-Management Program three times per year.
- Update smoking education packets and evaluate need for adding resources in Spanish.
- Provide health education opportunities to community members at least monthly.
- Offer "Keep Your Keys" program.
- Work with MODOT to be designated Buckle Up/Phone Down organization.
- Support program for child car seat replacement at Capital Region Emergency Department following an automobile accident to ensure proper fit and safety of care seat.
- Evaluate care management data tracking and patient communication tool.
- Evaluate potential program through our medical education department called "Tar Wars" to discourage use of tobacco products including cigarettes, e-cigarettes and vaping in elementary schools.
- Arthritis Self-Management Group offered monthly through Joint Replacement Program.

Prioritized Health Issue #5:

Address Social Determinants of Health

According to Healthy People 2020 the conditions in the social and physical environments in which people are born, live, work, and age can have a significant influence on health outcomes. Social determinants of health are impacting the health and wellbeing in our 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 need to be addressed. Discussion group participants shared concern for increasing poverty in some areas and multigenerational effects of poverty on families in their communities. It was also noted that there are many jobs available in mid-Missouri, however, it is difficult to fill those jobs because applicants cannot pass drug tests, lack appropriate job skills or coping skills, or are affected by family distress or crisis.

The lack of social and emotional support services for victims of abuse or neglect, particularly children, as well as social and emotional support services for the aging population in the rural communities are more restricted due to diminished resources and previous grant funding that is no longer available.

Local public health agencies (LPHA) and medical clinic providers reported seeing an increase in sexually transmitted diseases (refer to CHNA, LPH data on page 60). New cases of chlamydia, gonorrhea and syphilis are showing a five-year trend of rising sexually transmitted diseases in the five-county report area, according to the data provided by the LPHAs. It was reported that this increase may be due to a lack of awareness and changing sexual behavior. The local public health agencies discussed their fundamental activities in addressing communicable diseases, but noted they are challenged due to lack of funding and resources. A recent report published by the Missouri Association of Local Public Health Agencies, in a 2016 comparison of State general revenue spending on local public health showed that Missouri has the lowest general revenue per capita public health spending in the United States. The national average for per capita spending on public health is $31.62, while Missouri is at $5.88. Missouri is ranked 50th in state rankings for general revenue spending on public health. According to that report, Missouri has some of the highest rates of childhood obesity, heart disease, diabetes, high blood pressure, unintentional injuries, and sexually transmitted diseases in the nation.

Action Plan:

Address Social Determinants of Health

- Partnerships between our Medical Education Program with Community Health Center to provide medical services for low social-economic populations.
- Partnering with local schools to provide low and/or no cost sports physicals.
- Participating in local Unmet Needs Coalition sponsored by United Way.
- Partner with Department of Health on local Homeless Connect event annually.

Comparison to 2016-2018 Identified Priority Needs

1. Heart Disease/Obesity Prevention

Heart disease and obesity were the number one health priority in the 2015 CMCHAP report. The rate of obesity was attributed to many health problems, most notably heart disease, which is the most prevalent disease/condition and the leading cause of death in Missouri including three of the four counties in our region.

2. Mental Health

Mental health disorders was rated as the second health priority in the 2015 CMCHAP report for reasons that include: it was prominent discussions as an emerging health issue in all county input sessions among social service providers, law enforcement, clergy and school systems who agreed that there was a need for additional treatment services including for children, community education on types of mental health disorders, evaluation, treatment and the impact of social stigma for those who need services. The data also reflected that mental disorders were #3 for inpatient hospitalizations for Cole and Miller counties and #5 for Osage and state of Missouri data, ranked mental disorders as #3 for inpatient hospitalizations according to 2012 MICA.

3. Health Literacy

Health literacy was ranked as a number three priority in the 2015 CMCHAP report for reasons that included a significant need in helping people process and understand basic health information and services needed to make appropriate health and wellness decisions. Nearly nine out of 10 adults were shown to have difficulty using the everyday health information that is routinely available in health care facilities, retail outlets, media and community.

4. Substance Abuse

Substance abuse was ranked as a number four priority in the 2015 CMCHAP report as a result of frequent mentions as a serious issue by discussion group participants. The MICA data set ranked alcohol/substance abuse as the #2 disease or condition behind only diabetes. Overwhelmingly, the community leaders group had pointed to drug and alcohol use as a growing issue and expressed youth as a leading concern.

5. Dental Care

The need for dental care, particularly for adults, was ranked a fifth priority in the 2015 CMCHAP report for reasons that include: Missouri Medicaid coverage for dental treatment is restrictive; a shortage of dental providers who accept Medicaid existed, and that there is a strong connection to dental health and overall wellness and evidence linking dental health to poorly controlled diabetes and heart disease.

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:

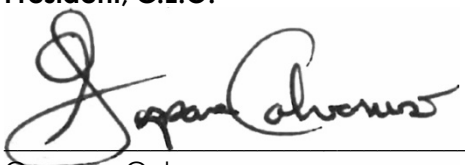
- Utilizing annual community outreach meetings to educate and receive feedback on CHNA Action Plan.
- Utilizing Capital Region Medical Centers' strategic plan dashboard metrics to monitor progress.
- Utilizing feedback obtained from community partners and Board of Directors to drive future to drive future strategies for addressing community needs.
- Developing a scorecard to evaluate effectiveness of our plan in meeting needs of our community and provide annual report to Board of Directors.
- 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 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

8-13-19
Date

Capital Region Medical Center
Board of Directors, Chair

Lorelei Schwartz

8-13-19
Date