2022 Springfield Community Health Improvement Implementation Plan

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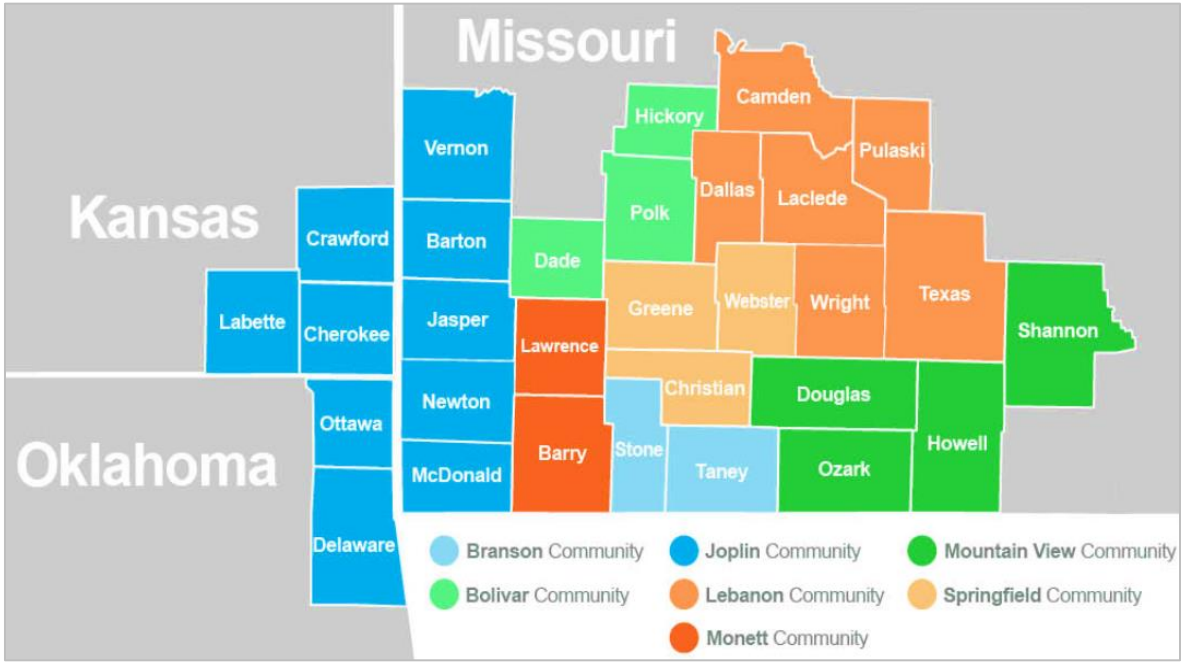
Introduction

In 2016, local hospital systems, public health entities, and other community organizations began collaborating under the umbrella of the Ozarks Health Commission (OHC) to publish triennial regional health assessments. While each community faces unique challenges and has implemented unique solutions to keep their residents healthy, there are a number of health related issues that impact the entire OHC Region.

The intent of this document is to inform the work of all organizations that influence the health or social determinants of health of citizens in the OHC Region. Gaining an understanding of the health outcomes, behaviors, and social determinants can help coalesce communities' efforts toward addressing root causes and developing upstream actions and interventions to yield positive change and collective impact for the betterment of health.



Ozarks Health Commission 2022 Regional Assessment Map
http://ozarkshealthcommission.org/communities/

The 2022 regional health assessment was completed using public health and historical data from various county-level sources, emergency department data from local hospital systems, including CoxHealth, Freeman Health System, and Mercy Hospitals, and input from community stakeholders and community members.

For the purpose of this assessment, the Springfield Community includes Greene, Christian, and Webster counties.

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Findings

Health Priorities Identified

The 2022 Community Health Needs Assessment (CHNA) builds upon the success of the 2016 and 2019 health assessments to promote further understanding of the health status, behaviors, and needs of the communities served. This assessment takes a comprehensive, data-driven approach to look at the health status of residents in the OHC Region by presenting more than 200 public health indicators including demographics, morbidity, mortality, risk factors, health status and behaviors, and social determinants of health, as well as hospital emergency department utilization data.

The core of the data used in the assessment included public community health indicators, as the data is readily available across various health categories. The steering committee determined that having current data via primary hospital data was a key component of the assessment. Not only does the data provide a unique and timely examination of a Community's health, it also provides the collaborative process for this type of collection and use of hospital data. To garner the perspective of partners and individuals within each of the Communities, it was decided that a consulting firm would conduct stakeholder interviews, focus groups, and community surveys to provide firsthand information and feedback on health issues and timely information on COVID-19 impacts.

Analysis focused on a series of assessed health issues (AHI) which were evaluated to determine the relative impact each has on the health of the Region's residents and overall community health. These conditions of focus are largely consistent with those evaluated in previous iterations of the assessment and include: cancer, COVID-19, diabetes, heart disease, lung disease, mental health, oral health, and substance use and recovery.

Attempts to address all identified AHI would dilute efforts and resources and minimize the ability to create meaningful impact, therefore, a diverse group of local stakeholders was convened to further consider and identify the top priorities for community focus efforts over

the following three years. These stakeholders utilized a combination of public health and hospital data, along with community survey data, to prioritize the AHI based on feasibility and community readiness to change the health issues. This prioritization process resulted in three top priorities for the Springfield Community: mental health, substance use and recovery, and diabetes. Additionally, every OHC Community also included COVD-19 as a special health issue in the 2022 assessment.

More details regarding the methodology and the results of priority ranking can be accessed in the OHC regional health assessment report for the Springfield Community available at http://ozarkshealthcommission.org/wp-content/uploads/2023/08/CHNA-Final-Springfield-2022.pdf. Printed copies are made available by CoxHealth upon request.

Common Threads Identified

Throughout the assessment, common threads often emerged in discussion around data and findings. These threads are indicators that could impact multiple AHI. Referred to here as social determinants of health (SDOH), these indicators could be included in community health improvement plans in order to move the needle on more than one AHI. Social determinants of health, per Healthy People 2030, are "… the conditions where people are born, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks."[1]

[1] US Department of Health and Human Services. (2021, 12 21). Social Determinants of Health. Retrieved from Healthy People 2030: https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Often, SDOH are referenced in the context of upstream factors that can ultimately impact an individual's health. For example, studies have long shown that tobacco use can have dire health consequences. By limiting behaviors that can lead to tobacco use, for example restricting use by minors or prohibiting tobacco use in public areas, the overall future health of an individual could be positively impacted. Broadly, these SDOH fall into six categories: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, social and community context, and health behaviors.

Strategy to Improve Health Priority Issues

In order to address mental health, substance use and recovery, and diabetes, OHC partners sought to develop a comprehensive approach. The logic model outlined in the assessment provides guidance to the process and approach to improve the health priority issues. The confluence of healthcare, public health, and community partners to create both upstream and downstream strategies occurs through activity within the model.

Upstream strategies implemented by the community have a wider reach and focus on the common threads. These strategies address the policy, community, and organizational levels of the Socioecological Model. They are coordinated by community coalitions and include both healthcare and public health. The downstream strategies, implemented by hospitals and health systems, focus on specific health issues in an effort to leverage and maximize existing hospital resources and programming.

These strategies address the organizational, interpersonal, and individual levels of the Socioecological Model. This structure provides a holistic approach to addressing the health priority issues and a more efficient means to generate improvement. It also recognizes that hospitals cannot address complex health issues independently of community support and resources. By collaborating with community agencies and coalitions to create systems and policy change focused on prevention, hospital-based population health strategies become more sustainable and health inequities are reduced. A strong, coordinated community response reduces inefficiencies and increases the likelihood of long-term success in improving health outcomes.

Strategy for Development of Implementation Plan

At CoxHealth, our mission is to improve the health of the communities we serve. This mission serves as our guiding force behind the initiatives selected for the 2022 Community Health Improvement Plan (CHIP). Members of the Ozarks Health Commission agreed upon common goals for the four priority health issues identified. Additionally, CoxHealth population health services curated a selection of proposed objectives and accompanying tactics for both system-wide initiatives and hospital-specific initiatives that maximize resources and ensure consistency and high reliability in the communities we serve. This menu of proposed objectives and tactics was presented to executive leaders in Springfield, Branson, Monett, and Barton County for approval. Executive leaders subsequently presented the information to the Board of Directors for final approval. Six objectives and ten associated tactics were approved for the CoxHealth.

CoxHealth Hospital System	2022 Community Health Improvement Plan Board Approval
Barton County	August 18, 2022
Monett	August 18, 2022
Springfield	August 18, 2022
Branson	September 29, 2022

CoxHealth 2022 Community Health Improvement Implementation Plan (CHIP)

COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

Assessed Health Issues

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Special Health Issue COVID-19 | Substance Use and Recovery | Lung Disease | Heart Disease | Diabetes | Mental Health

ASSESSED HEALTH ISSUE	OBJECTIVE	PROPOSED TACTIC	FY 2022 SPRINGFIELD	BRANSON	MONETT	BARTON COUNTY
Special Health Issue COVID-19	Decrease hospitalizations related to COVID-19	Support community initiatives, including increase percent of fully vaccinated individuals as recommended by CDC				
Substance Use and Recovery Lung Disease	Increase awareness of substance use prevention and treatment resources	Promote education and training related to substance use (examples: harm reduction, naloxone, mental health first aid)				
Heart Disease	Decrease tobacco and vape use rates	Increase access to clinical education and training related to tobacco and vape cessation				

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CoxHealth 2022 CHIP (continued)

ASSESSED HEALTH ISSUE	OBJECTIVE	PROPOSED TACTIC	FY 2022 SPRINGFIELD	BRANSON	MONETT	BARTON COUNTY
 Mental Health	Increase awareness of mental health services	Increase access through alternative care models				
		Implement Trauma Informed Care training and education				
		Improve process for securing mental health services (Barton County)				
 Diabetes	Improve chronic disease self-management	Increase referrals to self-management education				
 Lung Disease		Increase enrollment in care management programs				
 Heart Disease		Promote access to school-aged prevention education and care programs				

CoxHealth 2022 CHIP (continued)

ASSESSED HEALTH ISSUE	OBJECTIVE	PROPOSED TACTIC	FY 2022			
			SPRINGFIELD	BRANSON	MONETT	BARTON COUNTY
 Special Health Issue COVID-19  Mental Health  Substance Use and Recovery  Diabetes  Lung Disease  Heart	Engage in multi-sector care coordination to reduce health disparities and improve health outcomes	Implement Community Information Exchange (CIE)				

Objective	Decrease hospitalizations related to COVID-19
Tactic	Support community initiatives, including increase percent of fully vaccinated individuals as recommended by CDC
Summary	COVID-19 vaccines are safe and effective at protecting people from getting seriously ill, being hospitalized, and dying from the virus. Vaccination remains the safest strategy for avoiding hospitalizations, long-term health outcomes, and death. Additional information: *https://www.cdc.gov/coronavirus/2019-ncov/vaccines/vaccine-benefits.html*

Objective	Increase awareness of substance use prevention and treatment resources
Tactic	Promote education and training related to substance use (examples: harm reduction, naloxone, mental health first aid)
Summary	Evidence-based approaches are critical to engaging with people who use drugs. Shame and stigma often fuel addiction and prevent people from seeking treatment. Replacing judgement with knowledge, tools, and compassion equips us with information that creates positive change and potentially saves lives. Organizations who practice harm reduction incorporate a spectrum of strategies that serve as a pathway to additional health and social services, including additional prevention, treatment, and recovery services. Additional information: *https://www.samhsa.gov/resource-search/ebp#collapse-samhsa_uswds_base_resourcecenter* *https://www.addictiongroup.org/treatment/therapies/harm-reduction* *https://www.cdc.gov/opioids/naloxone/factsheets/index.html*

Objective	Decrease tobacco and vape use rates
Tactic	Increase access to clinical education and training related to tobacco and vape cessation
Summary	Tobacco use in the communities served by CoxHealth has been a prominent common thread identified in all previous CHNA cycles. Vape use continues to increase, particularly in youth. This is a complex and high-impact issue that necessitates a multipronged approach. CoxHealth will continue to build on previous CHIP objectives related to tobacco use by arming clinical staff with the tools necessary to acknowledge tobacco use, begin conversations about cessation, and refer patients to a tobacco/vape cessation program. Additional information: *https://www.cdc.gov/tobacco/patient-care/education-training/index.html*

Objective	Increase awareness of mental health services
Tactics	Increase access through alternative care models
	Implement Trauma Informed Care training and education
	Improve process for securing mental health services *(Cox Barton County)*
Summary	Mental health is a multifaceted health issue that affects many at-risk populations in the CoxHealth service area. These patients often have limited access to care due to geographical location and availability of resources. Through the utilization of advanced care technologies, CoxHealth continues to expand the rural telehealth program to provide patients with mental health needs a more convenient way to receive care. CoxHealth will also seek to increase awareness of Trauma Informed Care and implement related training and education. Additional information: *https://www.samhsa.gov/resource/ebp/telehealth-treatment-serious-mental-illness-substance-use-disorders* *https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/*

Objective	Improve chronic disease self-management
Tactics	Increase referrals to self-management education
	Increase enrollment in care management programs
	Promote access to school-aged prevention education and care programs
Summary	Chronic conditions, such as arthritis, cancer, diabetes, heart disease, and stroke, are among the most common health problems in the United States. Nearly half of all US adults live with one or more chronic health conditions. Self-management education refers to programs that help people who have ongoing health conditions learn how to take control and manage their own health. Self-management education has been proven to reduce symptoms of ongoing health problems and improve quality of life. Additional information: *https://www.cdc.gov/learnmorefeelbetter/sme/index.htm* *https://www.ahrq.gov/practiceimprovement/delivery-initiative/holtropstudysnapshot/index.html* *https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/family-based-physical-activity-interventions*

Objective	Engage in multi-sector care coordination to reduce health disparities and improve health outcomes
Tactic	Implement Community Information Exchange (CIE)
Summary	Community Information Exchanges (CIEs) are care coordination tools that bring together providers and data from the health and social services sectors. Communities across the country have joined a nationwide movement to use data to promote individual health and well-being as a foundation for a more comprehensive approach to health. As this movement has taken root, more communities have begun to initiate innovative cross-sector partnerships that share data to improve real-time care coordination. Additional information: *https://nhchc.org/wp-content/uploads/2020/04/NHCHC_Community-Information-Exchange2.pdf* *https://www.chea.upenn.edu/health-disparities-and-social-determinants-of-health/* *https://ciesandiego.org/national-movement/*