IMPLEMENTATION PLAN

The top needs identified in the assessments [Access to healthcare and Chronic disease care] are addressed in this separate Implementation Plan – attached to Form 990. An evidence-based, community-wide intervention strategy was selected by the hospital. The Implementation Team will be led by hospital staff (Heather Wood, BSW, Social Services - Lead) with volunteer Implementation Team members from the community (Moore Fan Company, A Sayre; Brookfield City Council, S Wessing; North Central Missouri Health Center, C Heaney; Children's Division, S Stallo; and Linn County Health Department, K Neblock) to help execute the plan. A small budget will be assigned to the initiative by the hospital, the project will be formally adopted by the Board of Trustees, and annual reporting of how needs were addressed and progress evaluated will be documented.

The implementation plan is linked to the hospital's strategic plan and meets our mission: Serving others through quality, compassionate care. Two priority health issues are addressed (Access to healthcare and Chronic disease care) that specifically affect our most vulnerable populations: low-socio-economic, seniors, medically underserved, and those with chronic illnesses. Secondary health needs, although not directly addressed in the initiative, will be indirectly addressed. Most are primarily contributing risk factors for the top two issues. Developed and adopted by a hospital-community partnership, the prioritization team analyzed primary and secondary data using multiple methods. The hospital will collaborate with those and additional community partners through meetings, partnership events/activities, care coordination/provider referrals, and marketing/promotion of the initiative.

Community Health Needs Assessment Implementation Plan
Health Issue #1 Chronic Disease Care – High rates of hospitalizations. Rates for hospitalizations for the chronic conditions of heart disease, all cancers, diabetes, COPD, smoking-related, and arthritis are significantly higher than the state rate (MO Department of Health and Senior Services/Missouri Resident Chronic Disease Comparisons Profile, 2019).
Contributing Factors To Health Issue #1: Behavioral risk factors: Smoking (24%) and physical inactivity (32%) are higher than the state rate (County Health Rankings and Roadmaps/Linn (LN), 2021). Obesity (33.3%) prevalence is also high (US News Healthiest Communities/ Overview of Linn County, MO, 2020). Economic stability/Socio-economic factors: Overall, socioeconomic factors rank for the county is 88/115 (ExploreMOhealth/MO Health Atlas/Linn County, 2021). Poverty - Linn County, with a poverty rate of about 19% (higher than the state rate) (US Census, 2019), ranks in the lower half of Missouri counties related to health outcomes and premature death/life expectancy (County Health Rankings and Roadmaps/Linn (LN), 2021; ExploreMOhealth/MO Health Atlas/Linn County, 2021). Healthcare Access/Quality: About 14% of county adults under 65 are without health insurance (higher than state rate) (US Census, 2019). Rural Linn County is a HRSA-designated Health Professional Shortage Area and a Medically-Underserved Area (dataHRSA.gov/HUA/HPSA Find, n.d.). Vulnerable populations: One-third of county seniors (33.1%) possess a disability (MO Census Data Center/MCDC ACS Profiles, 2021). Low-income seniors possess heart disease rates higher than state rates (US News Healthiest Communities/ Overview of Linn County, MO, 2020).

Three Year Goal For Improvement: By 2025, decrease the hospitalization rates for the chronic conditions of heart disease (Linn 140/MO 109) and COPD (Linn 33/MO 20) in Linn County adults to at least the state rate.				
Budget For Health Issue #1 $3,000				
Strategies to Achieve Goal	Specific Actions to Achieve Strategies	Specific Partners and Roles for Each Strategy	Specific Three Year Process Measure(s) for Each Strategy	Specific Three Year Outcomes Measures for strategies (should align with SMART Goal for health issue)
Awareness/Screening	1. Promote chronic disease self-management awareness at hospital and community events.	• <u>Hospital awareness and information dissemination & event promotion</u>: Marketing/Benefits, Population Health Office staff - promotions • <u>Community awareness and information dissemination & event promotion</u>: Senior center, Ministerial Alliance, Health department, Nutrition sites-promotions	By 2025, the hospital/community will hold at least two chronic disease self-management awareness and information dissemination events each year at the hospital and in the community as evaluated by number/counts of events per year. [Baseline: 0/year, Target total = 4/year]	By 2025, at least 25% of selected hospital and community event participants will be aware of at least 1 risk factor for chronic disease as evaluated by post-event awareness Likert-scale survey. [Baseline = 0%; Target = 25%] By 2025, decrease the hospitalization rates for the chronic conditions of heart disease (Linn 140/MO 109) and COPD (Linn 33/MO 20) in Linn County adults to at least the state rate. [Heart disease Baseline rate= 140; Target rate =109. COPD Baseline rate = 33; Target rate = 20]

	2. Sponsor/conduct chronic disease screenings at hospital and community events.	• <u>Screens at hospital– Provide screens/services</u>: PMHS, Rural health clinic – conduct screens • <u>Screens at community events- Provide screens</u>: Community Partners – conduct screens • <u>Promote and advertise screening events:</u> Local government – City Hall/Parks and Recreation, Local worksites – Walsworth/Stansbury, Local businesses – Moore Fan Co, Local and social media/Channel 6 – run ads/promotions	By 2025, the hospital/clinic will provide at least one chronic disease screening quarterly at their sites as evaluated by number/counts of screenings offered. [Baseline = 1/year/site; Target = 4/year/site] By 2025, the hospital will assist community partners such as Health Department etc. to provide at least one chronic disease screening quarterly as evaluated by number/counts of screenings offered. [Baseline = 0/year/site; Target = 4/year/site]	By 2025, at least 25% of selected hospital and community screening participants will be aware of at least 1 risk factor for chronic disease as evaluated by post-screening awareness Likert-scale survey. [Baseline = 0%; Target = 25%] By 2025, decrease the hospitalization rates for the chronic conditions of heart disease (Linn 140/MO 109) and COPD (Linn 33/MO 20) in Linn County adults to at least the state rate. [Heart disease Baseline rate= 140; Target rate =109. COPD Baseline rate = 33; Target rate = 20]

ACTIVITY DOCUMENT

Health Issue #1 Chronic Disease Care – High rates of hospitalizations

SMART GOAL: By 2025, decrease the hospitalization rates for the chronic conditions of heart disease (Linn 140/MO 109) and COPD (Linn 33/MO 20) in Linn County adults to at least the state rate.

STRATEGY: Promote/sponsor chronic disease education and screening events; Implement Chronic Disease Self-Management Program (CDSMP) interventions.

ACTIVITIES	TACTICS	RESPONSIBLE	MET/NOT MET	BARRIERS
1-3 MONTHS				
3-6 MONTHS				
6-9 MONTHS				
9-12 MONTHS				
YEAR 2				
YEAR 3				

PARTNERS: Marketing/Benefits, Population Health Office staff; Senior Center, Ministerial Alliance, Health department, Nutrition sites, PMHS, Linn County Food pantry, Rural health clinic, Local government – City Hall/Parks and Recreation, Local worksites – Walsworth/Stansbury, Local businesses – Moore Fan Co, Local and social media – Channel 6 .

Community Health Needs Assessment Implementation Plan

Health Issue #2 Access to Healthcare – Preventive services/Adult vaccinations.

Contributing Factors To Health Issue #2

Economic stability/Socio-economic status: Overall, socioeconomic factors rank for the county is 88/115 (ExploreMOhealth/MO Health Atlas/Linn County, 2021). About 14% of county adults under 65 are without health insurance (higher than state rate) (US Census, 2019). Those without coverage have less access to care, leading to lack of preventive services for major health conditions (Kaiser Family Foundation/Key Facts about the Uninsured Population, 2020).

Clinical care - Barriers/gaps: Resident poor physical and mental health days (4.6%; 4.9%) are higher than state rates, and clinical care indicators such as insured, screenings, and vaccinations are worse than state rates (County Health Rankings and Roadmaps/Linn (LN), 2021). Many residents also reported lack of recent flu immunization (66.35%) and, for those over 65, lack of pneumonia vaccination (37.74%); both higher than the state rate (MO Department of Health and Senior Services/Missouri Resident County-Level Study Profile, 2016). Rural Linn County is a HRSA-designated Health Professional Shortage Area and a Medically-Underserved Area (dataHRSA.gov/HUA/HPSA Find, n.d.). Top hospital ED DRGs past two years: respiratory/pneumonia.

Vulnerable populations: Only 40% of Medicare recipients obtained their annual flu vaccination, and only 37% of female Medicare recipients received an annual mammogram (ExploreMOhealth/MO Health Atlas/Linn County, 2021). In addition, only 11% of Medicare beneficiaries had a recent primary care visit, lower than the state rate (US News Healthiest Communities/ Overview of Linn County, MO, 2020).

Three Year Goal: By 2025, increase by 10% the proportion of county adults/seniors reporting recent flu and pneumonia vaccination (Baseline: 66%; 38%).

Budget For Health Issue #2 $3,000 yearly

Strategies to Achieve Goal	Specific Actions to Achieve Strategies	Specific Partners and Roles for Each Strategy	Specific Three Year Process Measure(s) for Each Strategy	Specific Three Year Outcomes Measures for strategies (should align with SMART Goal for health issue)
Environmental/Policy	1. Create/implement hospital health equity committee to bridge preventive service/vaccination gaps for low-income, medically-underserved, seniors, and those	• Create sub-committee within the existing community groups such as Community Connections and C-2000: Health Department, PHS-lead strategy, Social	By 2025, the hospital will create and staff one sub-committee as evaluated by bylaws adopted. [Baseline = 0 committees; Target 1 committee]	By 2025, increase by 10% the proportion of county adults/seniors reporting recent flu and pneumonia vaccination (Baseline: 66%; 38%).

	with chronic conditions	Services Offices, Church		
	2. Partner with existing community-based health preventive groups to improve services/vaccination within existing coalitions such as C-2000, etc.	• Health department, Rural health clinic - <u>lead strategy</u>	By 2025, the hospital will assist the health department/Leads to create and staff one community committee as evaluated by community organization. [Baseline = 0 committees; Target 1 committee]	By 2025, increase by 10% the proportion of county adults/seniors reporting recent flu and pneumonia vaccination (Baseline: 66%; 38%).
Awareness/Education	1. Create and launch a local mass-media/multi-media communications and special events campaign for preventive health services/annual vaccinations	• <u>Create/plan promotional campaign and special events</u> : Community-based health preventive services/vaccination coalition – draft materials/schedules, • <u>Implement campaign</u>: Local mass media/community information channel - run promotions	By 2025, the hospital will assist the coalition with at least 2 campaigns/events each year as evaluated by number of campaigns/events launched. [Baseline = 0/year; Target = 4 each year]	By 2025, at least 25% of sampled target population would have viewed/heard campaign//participated in event as evaluated by survey [Baseline – 0%; Target 25%] By 2025, increase by 10% the proportion of county adults/seniors reporting recent flu and pneumonia vaccination (Baseline: 66%; 38%).

	2. Author/distribute community resource manual/webpage identifying county agencies and preventive health/healthcare services/vaccinations	• <u>Research/collect resources and create manual/site:</u> Community-based health preventive services/vaccination coalition – coordinate resources. Community Connections- Strategy lead	By 2025, the hospital will assist the coalition in authoring one community resource manual/webpage as evaluated by number of manuals/sites published. [Baseline = 0 publications; Target = 1 publication]	By 2025, increase by 10% the proportion of county adults/seniors reporting recent flu and pneumonia vaccination (Baseline: 66%; 38%).

ACTIVITY DOCUMENT

Health Issue #2 Access to Healthcare – Preventive services/Adult vaccinations

SMART GOAL: By 2025, increase by 10% the proportion of county adults/seniors reporting recent flu and pneumonia vaccination (Baseline: 66%; 38%).

STRATEGY: Create equity committee/coalition, health communications/promotional events campaign, preventive resource manual/website

<u>ACTIVITIES TACTICS RESPONSIBLE MET/NOT MET BARRIERS</u>

1-3 MONTHS

3-6 MONTHS

6-9 MONTHS

9-12 MONTHS

YEAR 2

YEAR 3

PARTNERS: Population Health Office, Social Services Office, Strategic Planning Office, Health department, rural health clinic, new coalition members, local and social media.

Community Health Needs Assessment Implementation Plan
Health Issue #3 Childhood/Adult Obsity
Contributing Factors To Health Issue #3 Behavioral Risk Factors and Poverty: Overall, socioeconomic factors rank for the county is 88/115 (ExploreMOhealth/MO Health Atlas/Linn County, 2021). Smoking (24%) and physical inactivity (32%) are higher than the state rate (County Health Rankings and Roadmaps/Linn (LN), 2021). Obesity (33.3%) prevalence is also high (US News Healthiest Communities/ Overview of Linn County, MO, 2020). Obesity increases the risk factors of various types of chronic disease. Economic stability/Socio-economic factors: Overall, socioeconomic factors rank for the county is 88/115 (ExploreMOhealth/MO Health Atlas/Linn County, 2021). Poverty - Linn County, with a poverty rate of about 19% (higher than the state rate) (US Census, 2019), ranks in the lower half of Missouri counties related to health outcomes and premature death/life expectancy (County Health Rankings and Roadmaps/Linn (LN), 2021; ExploreMOhealth/MO Health Atlas/Linn County, 2021). Vulnerable populations: Children and adults are at an increased risk of obesity if living in poverty. Food gaps related to poverty increase the chances that a family does not have access to healthy balanced diet filled with nutritious foods; making the population more vulnerable to engaging in poor eating habits that will contribute to obesity. Socioeconomic factors also increase the risk for obesity by impacting the populations ability to access organizations such as the YMCA, school events, and community events due to a limited income to put toward other resources outside of the basic necessity of food, clothing, shelter and utilities.
Three Year Goal: By 2025, increase by 50% public understanding of factors impacting obesity and how to prevent or decrease obesity.
Budget For Health Issue #3 $3,000 yearly

Strategies to Achieve Goal	Specific Actions to Achieve Strategies	Specific Partners and Roles for Each Strategy	Specific Three Year Process Measure(s) for Each Strategy	Specific Three Year Outcomes Measures for strategies (should align with SMART Goal for health issue)
Early Intervention	Expand an early intervention obesity prevention program	<u>Expand a child-family food service program:</u> Healthy take-home snacks/meals project. Linn County Food Pantry-Lead, Pershing Hospital - expand/fund larger program School systems, Health Department, YMCA, food pantry, mental health	By 2025, expand to at least half of eligible county school-aged children-families participating in the project. [Baseline = 25%; Target = 50%] By 2025 increase public awareness on healthy lifestyle and nutrition. Coordinated and sponsor community events that encourage and promote healthy nutrition and lifestyle in Adults, teens, toddlers, children and seniors.	By 2025, decrease county obesity rate by 5%. [Baseline= 33.3%; Target= 28%]

Total budget of $10,000 to be divided between three goals equally