2025 Barton County Community Health Improvement Implementation Plan

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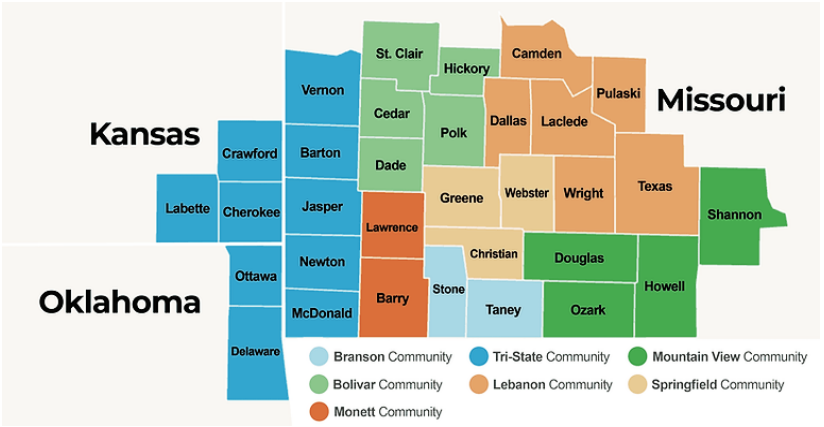
The Confluence of Healthcare, Public Health, and Community

Under the umbrella of the Ozarks Health Commission (OHC), local hospital systems, public health entities, and community health organizations work together to release a comprehensive Community Health Needs Assessment (CHNA) every three years. This group published community-level reports in 2016, 2019, and 2022. For the fourth iteration, the 2025 assessment has been compiled into community-level and regional snapshots, representing the combined service areas of CoxHealth, Mercy Hospitals, Citizens Memorial Hospital, and Freeman Health System. The collaborative effort spans three states, 33 counties, and four hospital systems.

Effective health improvement strategies hinge on the synergistic collaboration of healthcare providers, public health agencies, and community-based organizations. OHC partners recognized this crucial intersection, fostering a collaborative environment where expertise and resources are shared to maximize impact. This collaborative approach ensures that interventions are comprehensive, addressing both the clinical and social drivers of health.



The OHC Region encompasses a diverse range of communities. While each community faces unique challenges, 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 organizations that influence the health or social drivers/determinants of health (SDOH) of citizens in the OHC Region. Gaining an understanding of the health behaviors, outcomes, and social needs can help coalesce communities' efforts toward

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addressing root causes and developing upstream actions and interventions to yield positive change and collective impact for the betterment of health.

For this assessment, Barton County is included in the Tri-state Community, allowing for a comprehensive understanding of the health complexities and opportunities within this area.

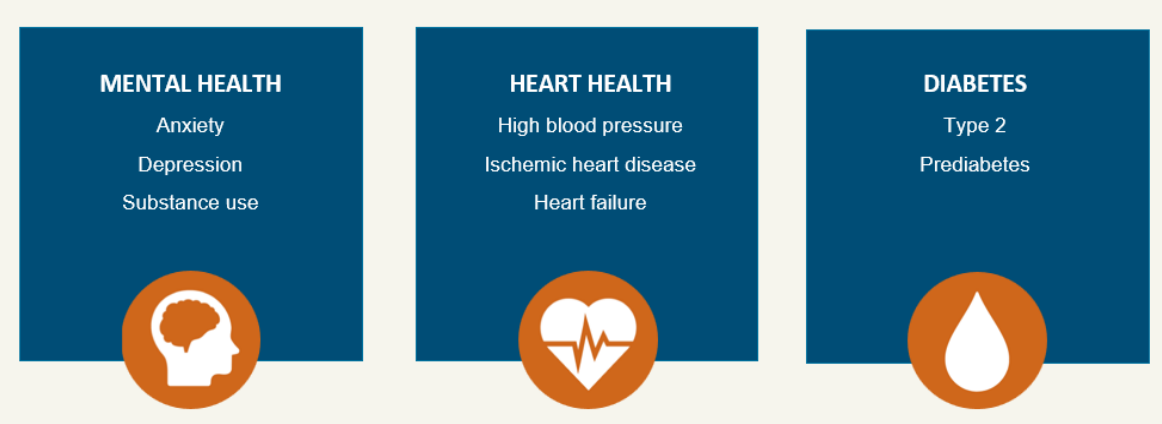
Health Priorities Identified

The triennial CHNA helps inform community health improvement efforts by identifying key health priorities. The 2025 assessment leveraged a comprehensive, data-driven approach, by incorporating:

- County-level public health data: Analysis of key health indicators and trends
- Missouri Hospital Association data: Insights into local healthcare utilization and outcomes
- Community stakeholder and member input**:** Gathering perspectives and experiences from residents across the region through interviews, focus groups, and community surveys

Attempts to address all identified heath issues 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 feedback and survey data, to prioritize the assessed health issues (AHI) based on feasibility of change and community readiness to impact the health issues.

Key findings highlighted **mental/behavioral health, heart health, and diabetes** as the top health priorities. Addressing these issues, along with social drivers of health, is crucial for improving overall community health.



Common Threads Identified

Throughout the assessment, common threads often emerged in discussions around data and findings. These threads, referred to as social drivers or determinants of health (SDOH) are non-medical factors that influence health behaviors and overall health status. SDOH can be integrated into Community Health Improvement Plans (CHIP) to simultaneously address multiple health concerns. Often, SDOH are referenced in the context of upstream factors that ultimately impact an individual's health. Broadly, these SDOH fall into five categories:

- Economic stability
- Education access and quality
- Healthcare access and quality

- Neighborhood and built environment
- Social and community context

Strategy to Improve Priority Health Issues

The Socioecological Model provides a framework for understanding the multiple levels of influence on health behaviors. The OHC partners applied this model to evaluate both upstream and downstream strategies. Addressing complex health priority issues such as mental health and chronic disease requires a multifaceted strategy. By integrating healthcare, public health, and community partners, and implementing strategies across the Socioecological Model, a holistic and impactful approach can be achieved.

CHIP objectives and tactics aim to reflect a strategic blend of upstream and downstream interventions, tailored to address the priority AHI. Specific interventions were identified. Progress is continually tracked and evaluated, and advancement toward goals is reflected on the CHIP scorecard.

The development of the Community Health Improvement Plan at CoxHealth involved a structured process:

1. Community Health Needs Assessment: Data was collected to identify the most pressing health needs in the community
2. Prioritization: Key stakeholders reviewed the CHNA data and selected priority health issues
3. Implementation Planning: Evidence-based objectives and tactics were identified to address each priority issue
4. Approval Process: The CHIP was presented to and approved by hospital leadership and the board of directors

2025 Community Health Needs Assessment Priority Health Issues Board Approval Dates	
Barton County	April 17, 2025
Branson	May 29, 2025
Monett	April 17, 2025
Springfield	April 17, 2025

2025 Community Health Improvement Plan Objectives Board Approval Dates	
Barton County	July 17, 2025
Branson	July 31, 2025
Monett	July 17, 2025
Springfield	July 17, 2025

Conclusion

Addressing priority health issues requires a strategic and collaborative approach. By integrating healthcare, public health, and community partners, and implementing strategies across the Socioecological Model, OHC partners have developed a comprehensive and impactful plan. The holistic approach, underscored by strong community collaboration, offers a promising pathway to improve health outcomes in behavioral health (mental health and substance use), heart disease, and diabetes. Continued investment in community-based initiatives and advocacy is vital to achieve sustained improvement in community health.

The full CHNA report, data, methodology, and priority ranking details are available in the Tri-state Community assessment at https://www.ozarkshealthcommission.org/communities/tri-state. Printed copies are made available by CoxHealth upon request.

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Objective	Reduce barriers to behavioral health care
Tactic	Promote stigma reduction related to mental health and substance use
Summary	According to the CDC, **1 in 7 Americans report experiencing substance use disorder (SUD)** and **1 in 5 Americans experience a mental health disorder** in a given year. Co-occurring mental health and substance use disorders are also common. There is a misconception that these disorders only happen to people with flawed character or moral failure. In reality, anyone can experience these issues. Stigma reduction, the elimination of prejudice and discrimination, is an essential part of this. Stigma refers to the negative stereotypes that people hold about mental health and substance use disorders. Stigma in the healthcare setting can undermine effective diagnosis, therapy, and optimal health outcomes. Behavioral health related stigma is damaging, often creating barriers to needed services, resources, and support. Reducing the stigma of mental health and substance use disorders creates a more supportive environment, leads to increased access to treatment and support services, and helps integrate patients into care systems where they can access appropriate care and support. Overall health outcomes improve when stigma is addressed. Research indicates that individuals in environments with reduced stigma are likely to experience lower rates of hospitalization, fewer relapses, and enhanced overall functioning. Promoting stigma reduction related to mental health and substance use requires a multifaceted approach that includes education, community engagement, and advocacy. By fostering a culture of understanding and support, we can help individuals feel safe in seeking the help they need, ultimately leading to better health outcomes for all. Examples of effective stigma reduction strategies include: • Education and awareness efforts focused on realities of mental health and SUD, emphasizing that they are treatable conditions • Training programs that incorporate motivational interviewing and direct contact with individuals who have lived experience • Using person-first language to emphasize the individual rather than defining them by their condition • Engaging the community in stigma reduction efforts to create a more inclusive environment
Resources and Tools	Communication Strategies to Counter Stigma and Improve Mental Health and Substance Use Disorder Policy https://pmc.ncbi.nlm.nih.gov/articles/PMC5794622/ Let's Talk about Stigma Reduction https://ncapda.org/stigma/ A Brief History of Stigma: Stigma Reduction Toolkit Stigma Reduction Strategies https://mentalhealthathome.org/wp-content/uploads/Stigma-Reduction-Strategies-1.pdf Interventions to Reduce Discrimination and Stigma: The State of the Art https://psychiatryonline.org/doi/full/10.1176/appi.focus.25023004 Anti-Stigma Toolkit: A Guide to Reducing Behavioral Health Disorder Stigma https://pttcnetwork.org/wp-content/uploads/2023/03/Anti-Stigma-Guide.FINAL_.2023.1.pdf Strategies to Reduce Mental Illness Stigma: Perspectives of People with Lived Experience and Caregivers https://pmc.ncbi.nlm.nih.gov/articles/PMC8835394/ The Overwhelming Case for Ending Stigma and Discrimination in Mental Health

Resources and Tools *(continued)*	https://www.who.int/europe/news/item/26-06-2024-the-overwhelming-case-for-ending-stigma-and-discrimination-in-mental-health The Effects of Stigma on Substance Use Disorders https://www.cdc.gov/stop-overdose/stigma-reduction/index.html Stigma and Substance Use Disorders: An International Phenomenon https://pmc.ncbi.nlm.nih.gov/articles/PMC5854406/ The Role of Stigma in U.S. Primary Care Physicians' Treatment of Opioid Use Disorder https://www.sciencedirect.com/science/article/abs/pii/S0376871621001228?fr=RR-2&ref=pdf_download&rr=986d0eaa2ee1d67c Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions https://pubmed.ncbi.nlm.nih.gov/28929889/ Reducing Discriminatory Practices in Clinical Settings https://www.samhsa.gov/sites/default/files/programs_campaigns/02._webcast_3_resources.pdf The Stigma of Substance Use Disorders https://www.cambridge.org/core/books/abs/stigma-of-substance-use-disorders/reducing-substance-use-stigma-in-health-care/E8711C5D4D0BA3EA15A2906584C1BD9C

Objective	Decrease tobacco and vape use rates
Tactic	Equip clinicians with tools, education, and/or training to acknowledge tobacco and vape use and offer appropriate support and resources
Summary	Tobacco use, including the rising trend of vaping, remains a critical health concern in our communities. Tobacco addiction is a chronic condition, often requiring multiple quit attempts. This issue has consistently appeared in previous iterations of the Community Health Needs Assessment, highlighting its persistent impact. **The ongoing use of tobacco products contributes to a wide range of health problems, including cardiovascular disease, respiratory illnesses, mental health and mood disorders, diabetes, and various forms of cancer**. Addressing tobacco use is essential to improving the overall health outcomes of our communities. This complex challenge requires a multipronged approach and cannot be solved by healthcare systems alone. It requires the combined efforts of schools, community organizations, families, and individuals to create a culture of health and wellness that discourages tobacco and vape use. By working together, we can create a healthier future for our community. Healthcare systems can contribute to these efforts by facilitating cessation conversations and connecting patients with evidence-based tobacco and vape cessation programs. Clinicians may also refer patients to resources such as counseling, support groups, and medication assistance to help individuals successfully quit. We remain committed to combating tobacco and vape use by equipping clinicians with the tools and support needed to deliver effective, evidence-based, brief clinical interventions.
Resources and Tools	Smoking and Tobacco Use: Clinical Education and Training https://www.cdc.gov/tobacco/hcp/patient-care/clinical-education-and-training.html Protocol for Identifying and Treating Patients Who Use Tobacco https://millionhearts.hhs.gov/files/Tobacco-Cessation-Protocol.pdf AMA The latest on smoking cessation: 8 things physicians should know https://www.ama-assn.org/public-health/behavioral-health/latest-smoking-cessation-8-things-physicians-should-know Smoking and Tobacco Use: Clinical Cessation Tools https://www.cdc.gov/tobacco/hcp/patient-care/clinical-cessation-tools.html Vaping and Mental Health https://pmc.ncbi.nlm.nih.gov/articles/PMC7837520/ A Scoping Review of Vaping, E-Cigarettes and Mental Health Impact https://pmc.ncbi.nlm.nih.gov/articles/PMC9195082/ American Diabetes Association: Smoking and Diabetes https://diabetesjournals.org/care/article/26/suppl_1/s89/21751/Smoking-and-Diabetes Diabetes and Smoking https://www.cdc.gov/diabetes/risk-factors/diabetes-and-smoking.html The Impacts of Vaping on the Cardiovascular System: A Systematic Review of Case Reports https://pmc.ncbi.nlm.nih.gov/articles/PMC11841693/ Health Effects of Cigarettes: Cardiovascular Disease https://www.cdc.gov/tobacco/about/cigarettes-and-cardiovascular-disease.html

Objective	Improve chronic disease management
Tactics	Refer patients for chronic disease self-management education
Summary	Nearly half of all adults in the United States live with one or more persistent health problems that require medical management and can significantly impact quality of life. **Diabetes, heart disease, stroke, and arthritis are a few examples of chronic disease.** Self-management education (SME) refers to programs that help individuals with chronic health conditions learn how to actively participate in managing their own health. These programs provide the knowledge, skills, and confidence needed to make informed decisions and adopt healthy behaviors. SME covers a variety of topics, including healthy eating, physical activity, stress management, problem-solving, and communication skills. SME programs are low-cost, evidence-based, and designed to help people with ongoing health conditions learn how to take control and manage their health. Participation in self-management education programs has been shown to: • Reduce symptoms: Less pain, fatigue, and other symptoms • Improve quality of life: Improved overall well-being and satisfaction with life • Increase self-efficacy: Develop problem-solving skills and strategies to overcome challenges • Lower healthcare costs: Understand treatment options, establish realistic goals, and make choices that align with personal values • Maintain a healthy lifestyle: Learn about nutrition, exercise, and other healthy habits that can improve well-being. • Improve mood: Reduced anxiety and depression • Communicate more effectively: Improve communication with healthcare providers, family, and friends
Resources and Tools	Effects of Chronic Disease Self-Management Programs for Participants with Higher Depression Scores https://pubmed.ncbi.nlm.nih.gov/25584089/ Health Promotion and Self-Management Among Patients with Chronic Heart Failure https://www.ncbi.nlm.nih.gov/books/NBK585653/ Evidence-Based Chronic Disease Self-Management Education Programs https://www.ncoa.org/article/evidence-based-chronic-disease-self-management-education-programs/ Impact of Chronic Disease Self-Management Programs on Type 2 Diabetes Management in Primary Care https://www.wjgnet.com/1948-9358/full/v5/i3/407.htm?appgw_azwaf_jsc=o8TMhHz74Pmx-PIb12VaV1w3r75cF7sGC_YuwYzsym0

Objective	Improve chronic disease management
Tactics	Enroll patients in care management programs
Summary	Nearly half of all adults in the United States live with one or more persistent health problems that require medical management and can significantly impact quality of life. **Diabetes, heart disease, stroke, and arthritis are a few examples of chronic disease.** Chronic Care Management (CCM) services improve health outcomes for patients and allow health care providers to be reimbursed for services many already provide. According to the Centers for Medicare and Medicaid Services (CMS), the analysis of two years' worth of data found that, with CCM, hospitalizations decreased by nearly 5% and emergency department visits declined by 2.3%. Providers also reported improved patient satisfaction and adherence to recommended therapies, along with improved clinician efficiency. A few examples of ways CCM benefits patients, clinicians, and health systems include: • Dedicated team member to oversee the patient's care and provide education • Regular interaction and familiarity with health history and status • Assistance staying on track with treatments, medication, referrals, and appointments through regular check-ins and reminders • Lower risk of emergency department visits, falls, or worsening health • Support needed between office visits • Enhanced communication, improved patient satisfaction
Resources and Tools	Chronic Care Management At-A-Glance https://www.cms.gov/files/document/chronic-care-management-glance.pdf Care Management: Implications for Medical Practice, Health Policy, and Health Services Research https://www.ahrq.gov/ncepcr/care/coordination/mgmt.html Methods and Outcomes of Care Management Programs https://www.ahrq.gov/practiceimprovement/delivery-initiative/holtropstudysnapshot/index.html Multiple Chronic Conditions: A Framework for Education and Training https://www.hhs.gov/sites/default/files/ash/initiatives/mcc/education-and-training/framework-curriculum/framework-curriculum.pdf Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report https://www.cms.gov/priorities/innovation/Files/reports/chronic-care-mngmt-finalevalrpt.pdf

Objective	Improve chronic disease management
Tactics	Engage patients in medication therapy management
Summary	Nearly half of all adults in the United States live with one or more persistent health problems that require medical management and can significantly impact quality of life. **Diabetes, heart disease, stroke, and arthritis are a few examples of chronic disease.** Medication Therapy Management (MTM) offers several benefits that contribute to improved health outcomes and reduced medication-related issues. The Benefits of MTM highlight the importance of these programs in supporting patients with complex medication needs and improving overall health management. Some of the key advantages of participating in an MTM program are: • Optimized therapeutic outcomes: MTM helps ensure patients get the most benefit from their medications • Improved medication adherence: Personalized counseling enhances med adherence through patient empowerment and education • Reduced risk of adverse drug events: Comprehensive med reviews identify and mitigate potential drug interactions and safe effects • Cost savings: MTM can identify ways to reduce med expenses, such as recommending generic alternatives or patient assistance programs • Better health outcomes: Coordinated care and ongoing follow-up contribute to improved overall health and well-being • Enhanced engagement: Active involvement in MTM encourages patients to be more knowledgeable and responsible for health and med use
Resources and Tools	Leadership for Medication Management: What is Medication Therapy Management https://www.accp.com/docs/govt/advocacy/Leadership%20for%20Medication%20Management%20-%20MTM%20101.pdf Medication Therapy Management (MTM) Resources https://www.amcp.org/medication-therapy-management-mtm-resources Centers for Medicaid and Medicare Services: Medication Therapy Management https://www.cms.gov/medicare/coverage/prescription-drug-coverage-contracting/medication-therapy-management What is MTM? https://www.nbmtm.org/what-is-mtm/ Pharmacist-Led Medication Therapy Management: Impact on Healthcare Utilization and Costs https://ajpps.org/pharmacist-led-medication-therapy-management-impact-on-healthcare-utilization-and-costs/