BAPTIST®

REHABILITATION

GERMANTOWN

2012-2013

Community Health Needs Assessment Final Report

HOLLERAN

EXECUTIVE SUMMARY

CHNA Background

Baptist Memorial Health Care undertook a comprehensive Community Health Needs Assessment (CHNA) beginning in late 2011. Baptist Memorial Health Care has 14 affiliate hospitals serving 110 counties in Tennessee, Mississippi and Arkansas. The assessment was not only initiated to comply with current requirements set forth in the Affordable Care Act, but to further the health system's commitment to community health improvement. The findings from the assessment will be utilized by Baptist Memorial Health Care to guide various community initiatives and to engage appropriate partners to address the various needs that were identified. Baptist Memorial Health Care is committed to the people it serves and the communities they live in. Through this process, the hospital will be a stronger partner in the community and the health of those in the surrounding neighborhoods will be elevated.

The primary goals of the Community Health Needs Assessment were to:

- Provide baseline measure of key health indicators
- Establish benchmarks and monitor health trends
- Guide community benefit and community health improvement activities
- Provide a platform for collaboration among community groups
- Serve as a resource for individuals and agencies to identify community health needs
- Assist with community benefit requirements as outlined in Section 5007 of the ACA

CHNA Components

A variety of quantitative and qualitative research components were implemented as part of the CHNA. These components included the following:

- Statistical Household Survey
- Secondary Data Profiles
- Key Informant Interviews
- Focus Groups
- Prioritization
- Implementation Plan

Prioritized Community Needs

The findings from the CHNA were reviewed to identify the most vital community health needs. The following community health issues were identified as priority needs:

- Healthy Lifestyle Choices (Prevention & Education, Chronic Disease Prevention)
- Cancer
- Maternal and Women's Health (with a focus on Prenatal Care)
- Mental Health (with a focus on Caregivers and Alzheimer's Disease)

Documentation

A report of the CHNA was made public on the hospital's website in September 2013. An Implementation Strategy of how the hospital will address the identified priorities was developed and will be available on the website.

COMMUNITY HEALTH NEEDS ASSESSMENT OVERVIEW

Hospital Overview

Baptist Rehabilitation Germantown opened in 1964 as The Rehabilitation Hospital of the Mid South. The building originally housed an outpatient surgery facility operated by Baptist Memorial Hospital dealing primarily with ear, nose and throat and podiatry procedures. The hospital was licensed as an acute facility, but the main focus was rehabilitation. Initially, the building opened as several different companies working together.

In 1996, Baptist Memorial Health Care assumed a stronger presence and the hospital name was changed to Baptist Rehabilitation Germantown. On May 1, 1997, Baptist Memorial Health Care acquired rehab services, on July 27, Baptist Memorial Health Care acquired lab and pharmacy and on Sept 1 of the same year, Baptist Memorial Health Care acquired Ambulatory Medical Services thus pulling all services under 1 umbrella. At that time, Baptist Rehabilitation-Germantown had a total of 68 rehab beds, 17 acute care beds, and 6 operating rooms.

In 1998, Baptist Rehabilitation Germantown opened the first sports medicine program for Baptist and an outpatient diagnostic imaging center was also opened.

In November 2010, Baptist Rehabilitation Germantown converted 18 rehabilitation beds to skilled nursing and opened the skilled Rehabilitation Unit at Baptist Rehabilitation Germantown.

Definition of Service Area

Baptist Rehabilitation Germantown serves residents in Shelby County and the surrounding counties. For the purposes of the CHNA, the hospital focused on its primary service area of Shelby County, Tennessee. The following zip codes were included in the household study:

38002	38103	38111	38118	38128
38016	38104	38112	38119	38133
38017	38106	38114	38120	38134
38018	38107	38115	38122	38135
38028	38108	38116	38125	38138
38053	38109	38117	38127	38139
				38141

CHNA Background

Baptist Rehabilitation Germantown, part of the Baptist Memorial Health Care system, participated in a system-wide comprehensive Community Health Needs Assessment (CHNA) from October 2011 to September 2013. The assessment was conducted in a timeline to comply with requirements set forth in the Affordable Care Act, as well as to further the hospital's commitment to community health and population health management. The findings from the assessment will be utilized by Baptist Rehabilitation Germantown to guide its community benefit initiatives and to engage partners to address the identified health needs.

The purpose of the CHNA was to gather information about local health needs and health behaviors in an effort to ensure hospital community health improvement initiatives and community benefit activities are aligned with community need. The assessment examined a variety of community, household, and health statistics to portray a full picture of the health and social determinants of health in the Baptist Rehabilitation Germantown service area.

The findings from the CHNA were reviewed and health needs were prioritized to develop the hospital's Community Health Implementation Strategy. Baptist Rehabilitation Germantown is committed to the people it serves and the communities they live in. Through this process, the hospital will be a stronger partner in the community and the health of those in the surrounding neighborhoods will be elevated. Healthy communities lead to lower health care costs, robust community partnerships, and an overall enhanced quality of life.

Research Partner

Baptist Memorial Health Care contracted with Holleran, an independent research and consulting firm located in Lancaster, Pennsylvania, to conduct research in support of the CHNA. Holleran has 21 years of experience in conducting public health research and community health assessments. The firm provided the following assistance:

- Collected and interpreted Secondary Data
- Conducted, analyzed, and interpreted data from Household Telephone Survey
- Conducted, analyzed, and interpreted data from Key Informant Interviews
- Conducted Focus Groups with healthcare consumers
- Facilitated a Prioritization and Implementation Planning Session
- Prepared the Final Report and Implementation Strategy

Research Methodology

The health system undertook an in-depth, comprehensive approach to identifying the needs in the communities it serves. A variety of quantitative and qualitative research components were implemented as part of the CHNA. These components included the following:

A **statistical household survey** was completed with 528 adults from the Baptist Rehabilitation-Germantown service area. The survey that was utilized aligns with the Behavioral Risk Factor Surveillance System (BRFSS) questionnaire that is annually conducted nationwide by the Centers for Disease Control and Prevention (CDC) and state health departments. The survey assessed indicators such as general health status, prevention activities (screenings, exercise, etc.), and risky behaviors (alcohol use, etc.). The results were also examined by a variety of demographic indicators such as age, race, ethnicity, and gender.

A number of existing resources were reviewed to fully understand **secondary data** trends. The secondary data that was analyzed included statistics such as mortality rates, cancer statistics, communicable disease data, social determinants of health (poverty, crime, education, etc.), among others. This information was used to supplement the primary data that was collected and flesh out research gaps not addressed in the household survey. The primary sources of the secondary data included the U.S. Census Bureau, state public health agencies, and the County Health Rankings reports. Where available, the local-level data was compared to state and national benchmarks.

Key informant interviews were conducted with 75 professionals and key contacts in the areas surrounding the 14-hospital service areas. Working with leadership from each of the system hospitals, Baptist identified specific individuals to be interviewed and invited them to participate in the study. The survey included a range of individuals, including elected officials, private physicians, health and human services experts, long-term care providers, representatives from the faith community, and educators. A list of participants can be found in Appendix A. The content of the questionnaire focused on perceptions of community needs and strengths across three key domains: Perceived quality of care, key health issues prominent in the community, and quality of life issues.

In November 2012, healthcare consumers from the hospitals' service areas participated in **focus groups**. The focus groups addressed diabetes and pre-diabetes. Discussion topics included health knowledge, self-care behaviors, health care access, communication preferences, and desired support services. A discussion guide, developed in consultation with Baptist Memorial Health Care, was used to prompt discussion and guide the facilitation. Participants were recruited through telephone calls to households within the service area and through local health and human service organizations. Participants were pre-screened to ensure that they were either diabetic or pre-diabetic. Each session lasted approximately two hours and was facilitated by trained Holleran staff. In exchange for their participation, attendees were given a $50 cash incentive at the completion of the focus group; dinner was also provided. It is important to note that the focus group results reflect the perceptions of a small sample of community members and may not necessarily represent all community members in the hospital's service area.

Community Representation

Community engagement and feedback were an integral part of the CHNA process. A statistically valid sampling strategy ensured community representation in the household survey. Public health experts, health care professionals, and representatives of underserved populations shared knowledge and expertise about community health issues as part of the key informant interviews. Health care consumers, including medically underserved individuals and chronically-ill patients, were included in the focus groups.

Research Limitations

It should be noted that the availability and time lag of secondary data, as well as the ability to reach all segments of the population via the telephone survey, may present research limitations in the study. Baptist Memorial Health Care sought to mitigate limitations by including representatives of diverse and underserved populations throughout the research components.

Prioritization of Needs

Following the completion of the CHNA research, Baptist Memorial Health Care prioritized community health issues and developed an implementation plan to address prioritized community needs.

Documentation

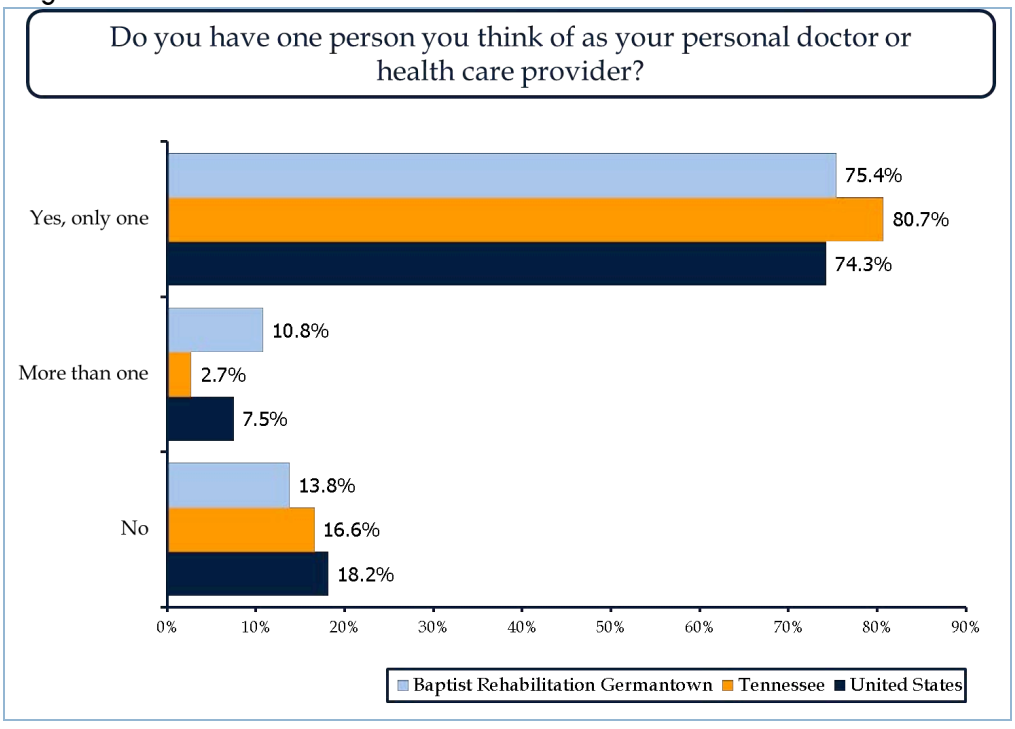
A report of the CHNA was made public on the hospital's website in September 2013. The Final Report serves as a compilation of the overall key findings of the CHNA. Detailed reports for each individual component were provided separately. An Implementation Strategy of how the hospital will address the identified priorities was developed and will be available on the website.

KEY ASSESSMENT FINDINGS

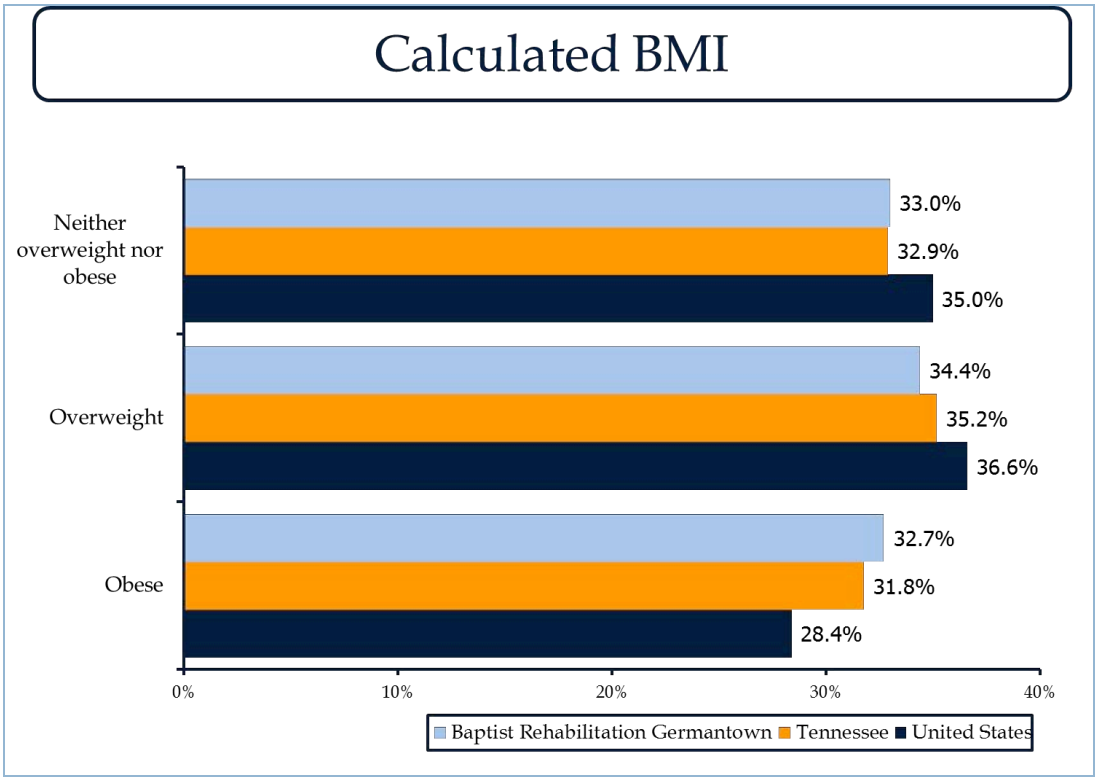
Household Survey Key Findings

A household survey of the Baptist Rehabilitation-Germantown service area included 692 randomly selected adults. The respondents were asked to rate their own health status, to provide information on behaviors and prevention activities, and to report the incidence of a variety of chronic illnesses such as diabetes and cardiovascular disease. Approximately 27% stated that their **general health** is "poor" or "fair," which is above the rates for Tennessee (19.5%) and the nation (16.3%). When looking at this indicator by race, African American respondents were more likely to say "poor" or "fair" compared to White respondents (30.5% vs. 20.5%). Ratings of poor physical health and poor mental health also compared less favorably. Male and females did not significantly differ in their ratings of general health status.

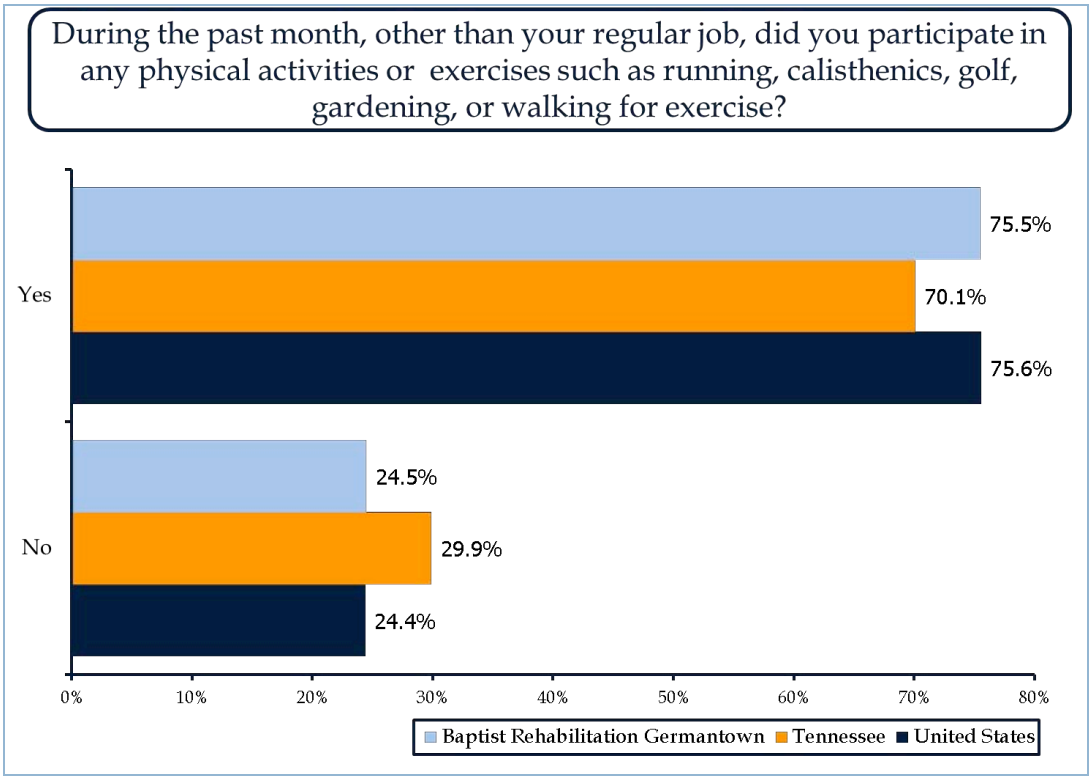
When asked about **access to care** issues, the survey revealed that area adults are just as likely as adults statewide and nationally to have some form of health insurance. Eighty-five percent (85%) of adults surveyed have health insurance. However, gender and racial differences exist. The percentage of insured among White residents is 93% compared to 80.7% among African American residents. Area adults are also more likely to have a usual provider of health care compared to nationally. However, having a usual provider for health care needs decreases among the African American population and males in the area. Almost 20% of males say they have no usual provider for care and 16.4% of African Americans report that they do not have one person they think of for their health care. Cost was a deterrent to seeking needed care for about 17% of area adults in the past year, which is similar to statewide and the U.S. as a whole. Males and females are similar in the likelihood of having cost as a barrier, but African American residents in the area are almost three times as likely as area Whites to have had cost keep them from seeking care. About 23% of African American survey respondents stated there was a time in the past year where they needed to see a doctor, but could not because of cost, which compares to 8% among area Whites.



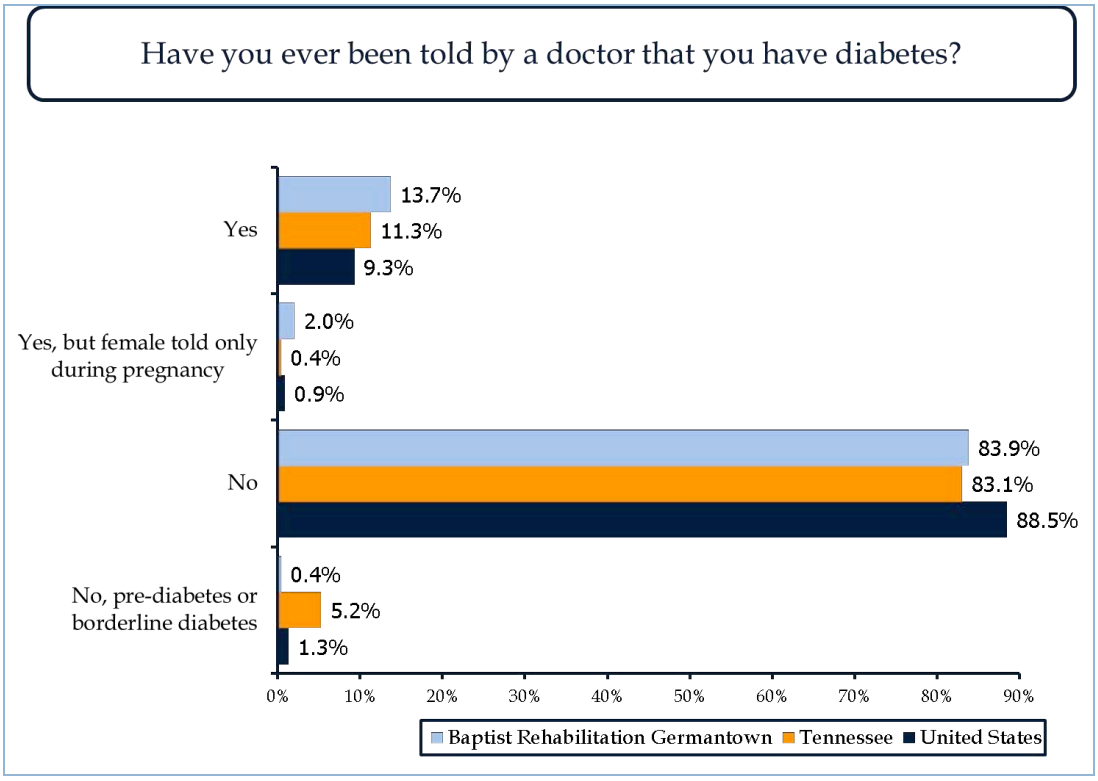
Body Mass Index (BMI) was calculated for each survey respondent based on the height and weight they provided. The hospital's service area compares similarly to Tennessee overall, but is significantly more obese and overweight compared to the Nation. Nearly 33% are technically obese and another 34.4% are overweight. When asked if a doctor or other healthcare provider had told them they were overweight or obese, only 23% responded "yes," which is well below the actual proportion of overweight and obese individuals.



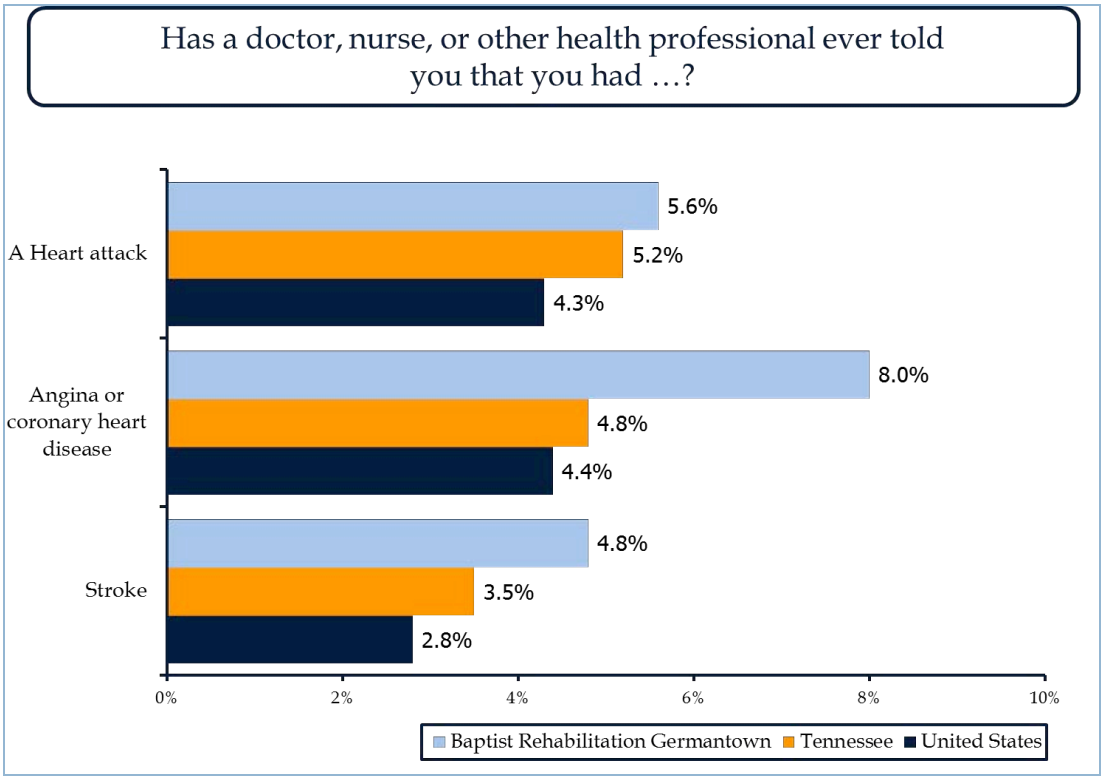
While the BMI statistics are similar to Tennessee, area adults are more likely to exercise in a typical month than statewide. Nearly 76% stated they engaged in some form of exercise in the previous month compared to 70.1% throughout the state. Eight out of 10 males reported exercising compared to seven out of 10 females and nearly 80% of Whites exercised, which is above the 73.2% of African Americans who reported exercising. Among those who didn't exercise, having an illness/disability and lack of motivation were the two most frequently cited reasons.



The reported incidence of **diabetes** and gestational diabetes is higher in the hospital's service area compared to nationally. Almost 14% of those surveyed reported that they have been told by a health professional that they have diabetes. This is similar to Tennessee overall (11.3%), but above the U.S. (9.3%). In addition to their own diabetes diagnosis, 45.3% stated that they have a family history of diabetes. The survey results also suggest a more severe form of diabetes among area residents as more reported the diagnosis at a younger age, more are insulin dependent, and there is a much greater degree of glucose and A1C monitoring compared to statewide and nationally. Nearly 18% of African American survey respondents stated they have diabetes compared to 10% of the White respondents. On a positive note, nearly 63% of those with diabetes have taken a course or class on how to manage their diabetes.



A number of items on the survey addressed **cardiovascular health**. When asked if they have ever had a heart attack, or myocardial infarction, 5.6% of area adults confirmed that they had. This is statistically similar to statewide (5.2%) and nationally (4.3%). The Germantown service area, however, is significantly higher than the Tennessee and U.S. percentages for angina or coronary heart disease. Eight percent (8%) of those surveyed confirmed that they have heart disease which is above the 4.8% statewide and 4.4% throughout the U.S. The incidence of stroke was not as high as the heart disease rate, but the local data still compared unfavorably to the nation. Locally, 4.8% report having had a stroke compared to 2.8% nationally. Area males were more likely to report incidence of heart disease, having had a heart attack, and a family history of heart disease than area females. White respondents were more likely to have had a heart attack than African American respondents (10% vs. 5%), but for stroke, African Americans reported a higher incidence rate than Whites (6.1% vs. 3.9%). Family history of heart disease was also higher among Whites.



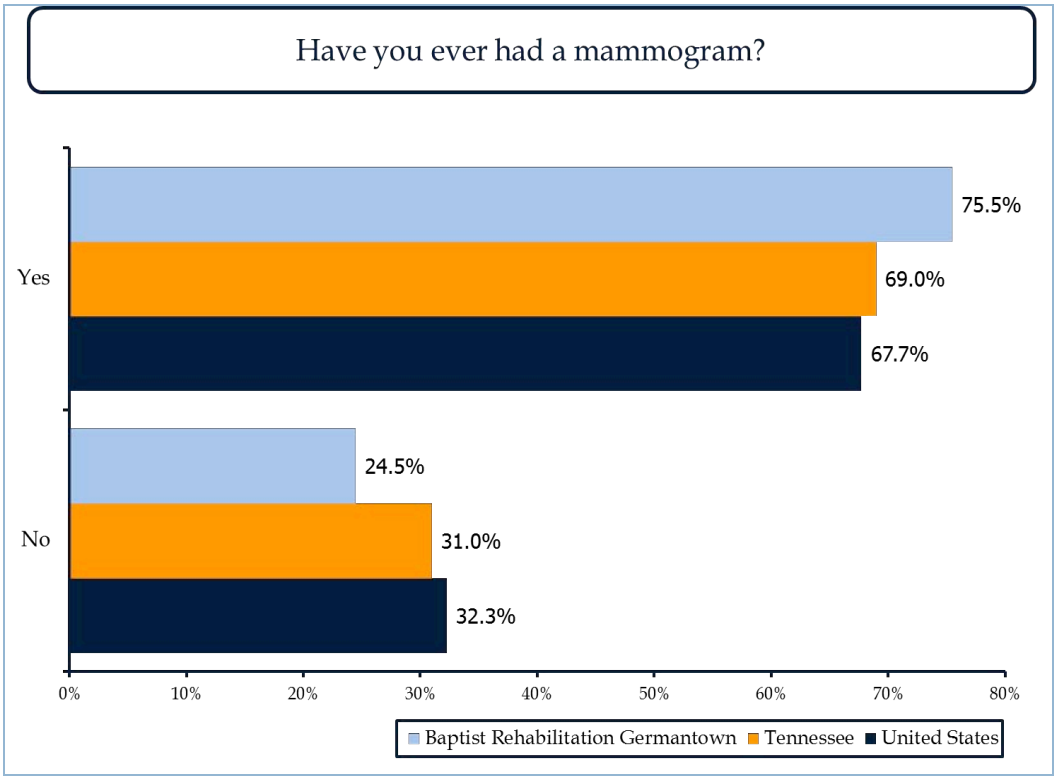
About 13% of the adults surveyed reported that they have had **asthma** at some point in their lifetime. Of this group, about half (55.6%) still have asthma. This lifetime incidence is slightly above Tennessee overall (9.3%), but similar to U.S. figures (13.5%). What does differ from both state and national figures is the percentage diagnosed at age 10 or younger. Nearly half (47.2%) reported that they were diagnosed at this young age, which is about 10% higher than statewide and nationally. Reported asthma was higher among African American survey respondents than Whites. About one in four stated that they have a child who was diagnosed with asthma as well.

Disability was assessed through questions regarding limitations and special equipment needs. One quarter of area adults (27.4%) reported that they are limited because of physical, mental

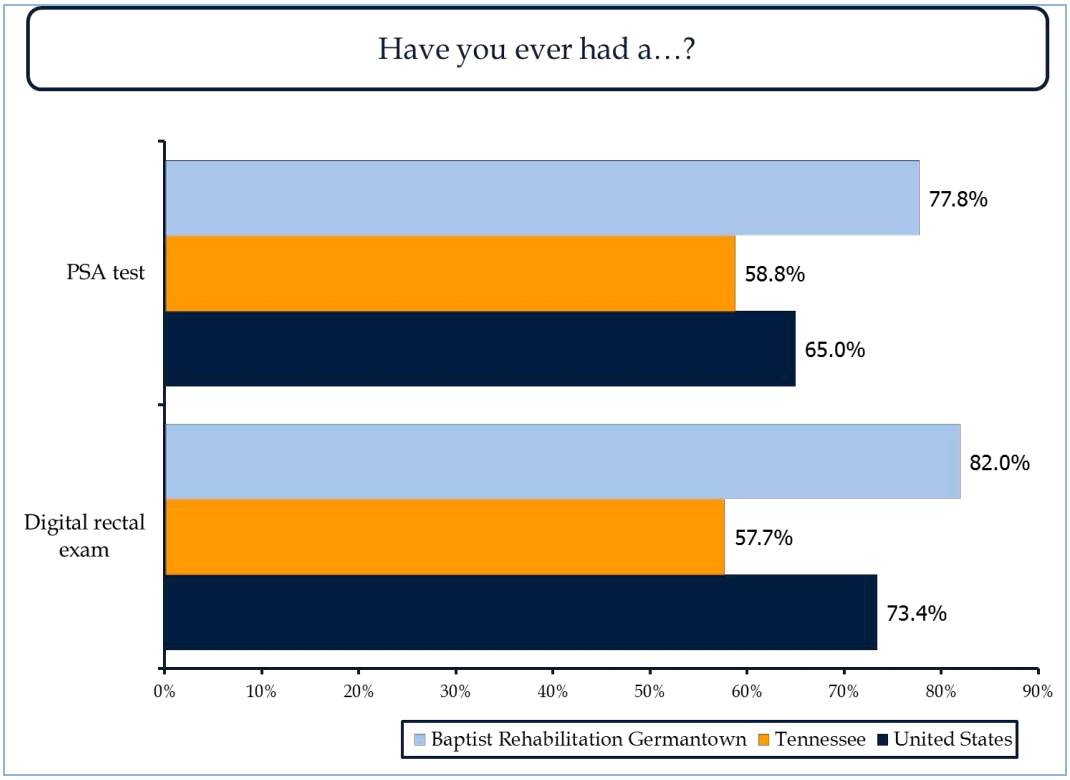
or emotional problems. While this is reflective of the state average (23.9%) for disability, it rates above nationally (20.8%).
The **oral health** survey item reveals that fewer adults in the area have had teeth pulled due to tooth decay or gum disease compared to statewide. Throughout Tennessee, nearly 14% of adults have had all of their teeth pulled because of decay or disease compared to 5.9% locally.

Roughly 43% of area adults have smoked at least 100 **cigarettes** in their lifetime, similar to state and national averages. Of those who smoked this amount in their lifetime, nearly 60% stated that they no longer smoke. Of those who do smoke, nearly 65% indicated that they had stopped smoking for one day or longer at some point in the previous year. Additionally, a small percentage (1.9%) use chewing tobacco, snus or snuff on a regular or semi-regular basis.

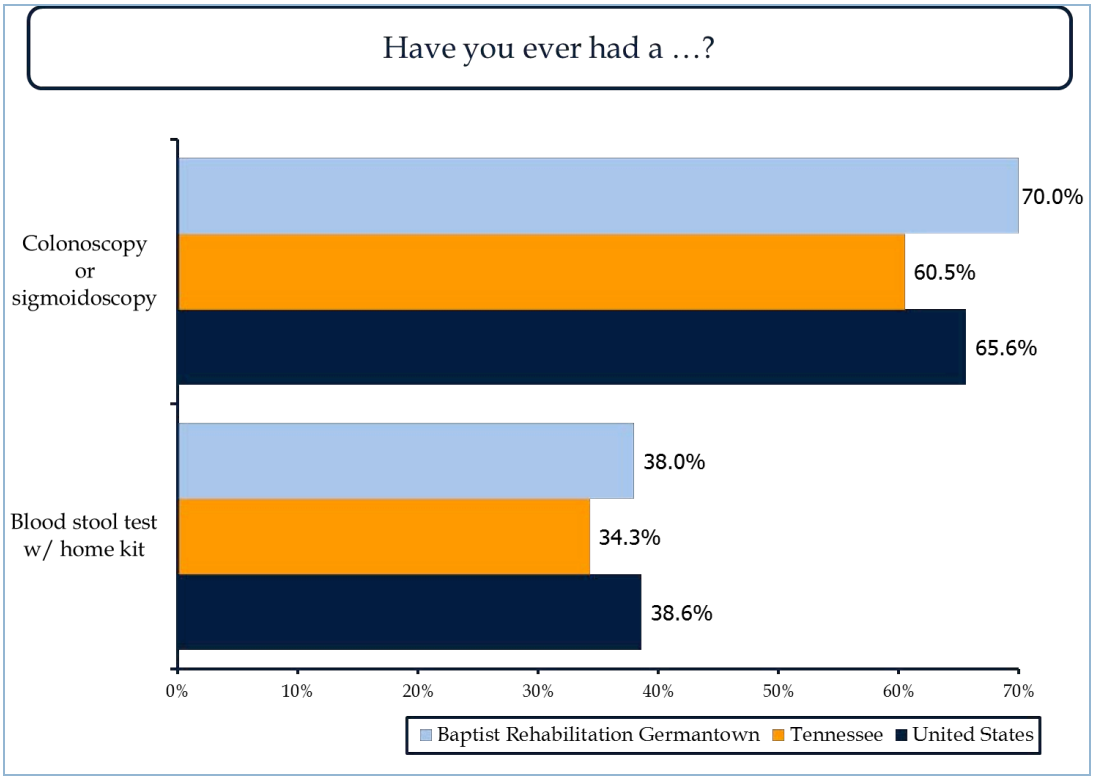
The survey also assessed **women's health** screenings such as mammograms, clinical breast exams and Pap tests. About 80% of area females have given birth. Of that 80%, 21.7% gave birth under the age of 19 and another 46.3% gave birth between the ages of 19 and 24 years. African American females in the area were more likely than White females to report a birth before the age of 19 (29% vs. 12.2%). Area females were more likely to have had a mammogram (75.5%) compared to females statewide (69%) and nationally (67.7%). With respect to clinical breast exams and Pap tests, area females were just as likely as their peers statewide and nationally to have had these tests. Roughly 88% have had a clinical breast exam and 94.2% have had a Pap test. While White females and African American females in the area do not differ in their likelihood of having had these tests in their lifetime, White females are more likely to have had these exams in the past year as opposed to several years ago.



Prostate cancer questions on the survey asked about the likelihood of having had a Prostate Specific Antigen (PSA) test and/or a digital a rectal exam. All of these questions were only asked of men 40 years of age and older. The majority of area men in this age group have had a PSA test (77.8%) and an even higher percentage (82%) have had a digital rectal exam. Both of these figures are higher than statewide and figures for PSA tests are also above nationally. When asked if they have ever been diagnosed with prostate cancer, 6.2% indicated that they had.



Area adults were also more likely to have had a **colorectal cancer** screening compared to statewide. Among adults 50 and older, 38% have had a blood stool test using a home kit, which is similar to Tennessee and the U.S. A higher percentage, 70%, have had a sigmoidoscopy or colonoscopy. While this is statistically similar to nationwide averages, it is above the Tennessee percentage (60.5%). No gender differences were uncovered for either test. No racial differences were noted with the likelihood of having had a colonoscopy or sigmoidoscopy, but Whites were more likely to have taken a blood stool test with a home kit than African Americans (43.5% vs. 30.9%).



Area adults were no different than the nation in their reporting of having had **cancer**. About 9% stated that they have had cancer, which is similar to nationally. Among those who have/had cancer, prostate cancer was the most commonly reported, followed by breast cancer and cervical cancer. Of those with cancer, about 22% are currently receiving treatment.

Related to cervical cancer is the **Adult Human Papilloma Virus (HPV)**. A much larger percentage of residents in the area have had this vaccination compared to nationally. Approximately 12% have had the HPV vaccination compared to 4.7% nationally. White area residents were less likely to have had the vaccination compared to African American residents (4.3% vs. 12.5%).

The survey respondents were also asked whether they provided regular care or assistance in the previous month to a friend or relative. Twenty-eight percent (28%) stated they had, which is well above the 16.8% nationally who served as a **caregiver**. The majority (61.6%) provided care for someone 65 years or older. Area residents who are African American were more likely to provide care for someone else compared to White residents (34.2% vs. 20.8%).

In summary, the household survey results reveal a number of areas of opportunity and needs in the community. However, several strengths exist as well. The likelihood of having teeth pulled because of decay or disease is less and the likelihood of having certain cancer screenings (mammograms, PSA tests, colonoscopies) is above state and national figures.

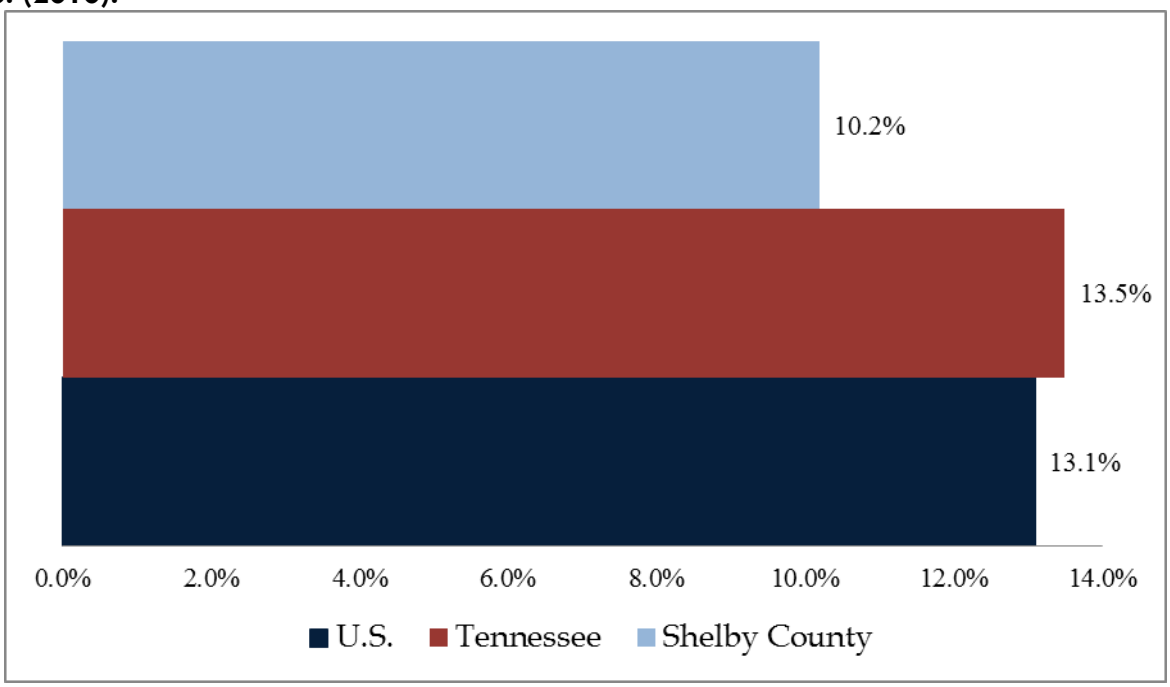
The household survey results were correlated with secondary data statistics and the qualitative research to determine key community health needs across all research components.

Secondary Data Key Findings

A number of data points were gathered to lend insight into the demographics, quality of life, and morbidity and mortality figures for Shelby County, Tennessee. A summary of the key findings is outlined below. All county data points were compared to state and national benchmarks and were evaluated as being more favorable or unfavorable to these comparisons.

The **demographics** of an area, as well as demographic shifts, can have a dramatic impact on the health care system. Shelby County, Tennessee is estimated to have a population of 927,644, which is an increase of 3.4% between 2000 and 2010. The population increase in the county is below the state (11.5%) and national growth (9.7%). Nearly 22% of the county's population is less than 15 years of age and as depicted in the graph below, the percentage of seniors (65+) who live in Shelby County is less than statewide and nationally.

Percent of population aged 65 years and over, Shelby County compared to Tennessee and U.S. (2010).



Shelby County has a significantly larger African American population (52.1%) compared to Tennessee (16.7%) and the U.S. (12.6%). 40.6% of the population is White and 5.6% is of Hispanic or Latino descent. The income statistics point to disparities within Shelby County. While the overall county's mean and median income levels are higher than in Tennessee, the poverty levels are higher as well. As depicted in the table below, nearly 20% of all people in Shelby County live in poverty. The rates are even higher when looking at single-mother households and families with children. It should be noted, however, that while the county income levels are above the state, the mean and median income is lower than the U.S. average. The unfavorable income levels may also be related to higher unemployment rates in Shelby County compared to statewide and nationally.

Poverty Status of Families and People in the Past 12 Months (2010)

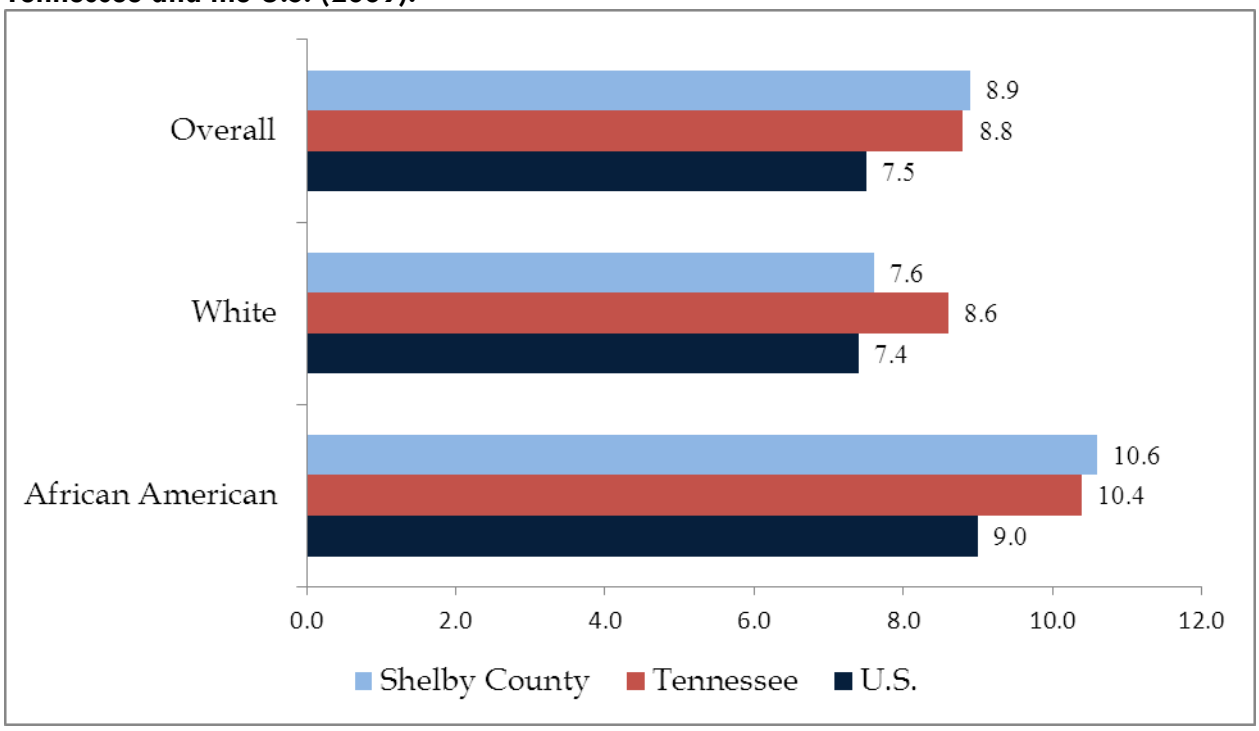
	U.S.	Tennessee	Shelby County
All families	10.5%	12.7%	15.4%
With related children under 18 years	16.5%	20.0%	23.0%
With related children under 5 years only	17.9%	23.8%	24.7%
Married couple families	5.1%	6.4%	5.0%
With related children under 18 years	7.5%	9.0%	7.1%
With related children under 5 years only	6.8%	10.0%	10.2%
Families with female householder, no husband	29.2%	34.1%	34.4%
With related children under 18 years	38.1%	43.5%	42.8%
With related children under 5 years only	46.1%	54.5%	48.0%
All people	14.4%	16.9%	19.9%
Under 18 years	20.1%	24.0%	30.3%
Related children under 18 years	19.7%	23.7%	29.8%
18 years and over	12.5%	14.7%	16.1%
65 years and over	9.4%	10.7%	11.3%
Unrelated individuals 15 years and over	25.4%	28.9%	27.6%

Source: U.S. Census Bureau, 2008-2010 ACS 3-year estimates

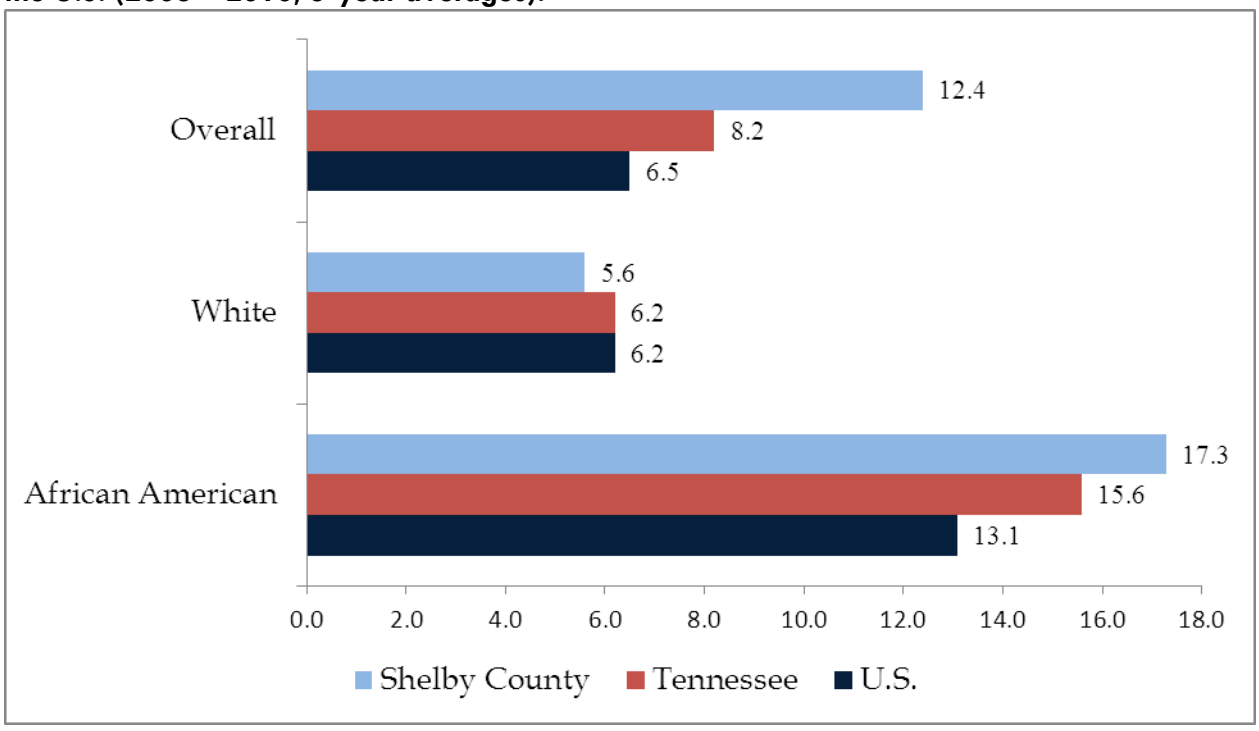
Mortality rates in the county reflect significant racial disparities. Overall, the age-adjusted mortality rate for Shelby County (8.9 per 1,000 population) exceeds national benchmarks (7.5). Shelby County, however, is in-line with the statewide mortality rate (8.8). When looking at White and African American resident mortality rates, the rate for African American individuals living in the county is three points above the rate for Whites. This disparity also exists throughout the country, but the gap is much greater in Shelby County than it is nationwide.

The **infant mortality rates** exceed the state and national rates. The infant mortality rate for Shelby County is 12.4 per 1,000 live births, which is greater than 8.2 for Tennessee and 6.5 for the U.S. as a whole. The infant mortality rate for African Americans in Shelby County is 17.3 compared to 5.6 for White infants. Again, these racial disparities are more pronounced than statewide and nationally. While a number of factors may influence infant mortality, the birth weight of the newborn can be one of the most correlated determinants. The percentage of low birth weight and very low birth weight newborns is well above Tennessee and the U.S. and is once again higher for African Americans than for Whites. The percentage of expecting mothers who receive prenatal care in the first trimester is only 50.5% among African Americans compared to 70.2% among White mothers. Recall that the poverty rates for Shelby County are also significantly higher for families with children. The graphs below visually display the mortality and birth weight figures.

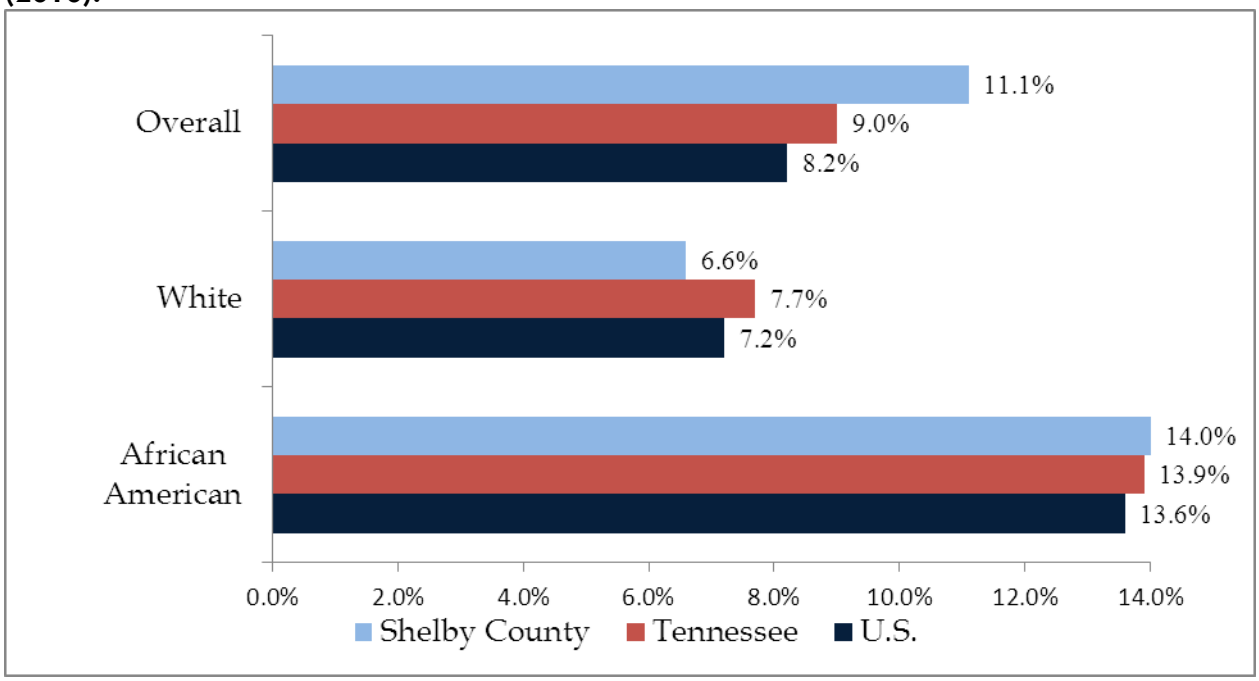
Age-adjusted mortality rates by race per 1,000 population, Shelby County compared to Tennessee and the U.S. (2009).



Infant mortality rate by race per 1,000 live births, Shelby County compared to Tennessee and the U.S. (2006 – 2010, 5-year averages).



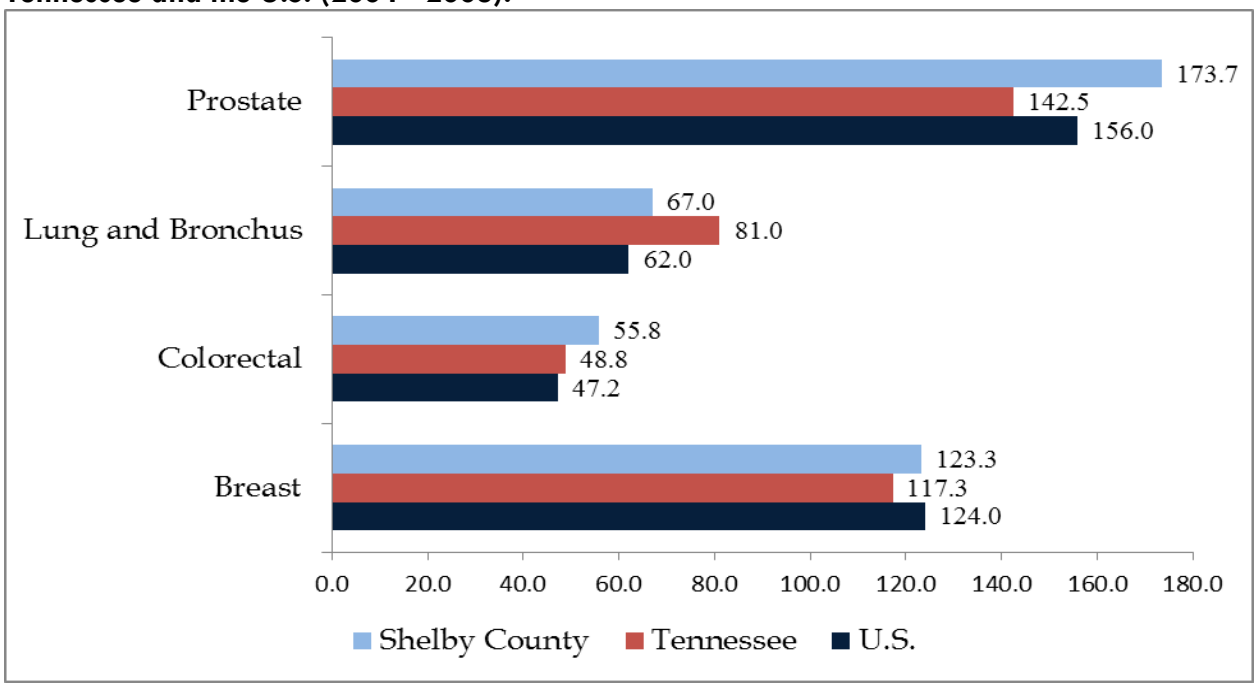
Percentage of low birth weight by race, Shelby County compared to Tennessee and the U.S. (2010).



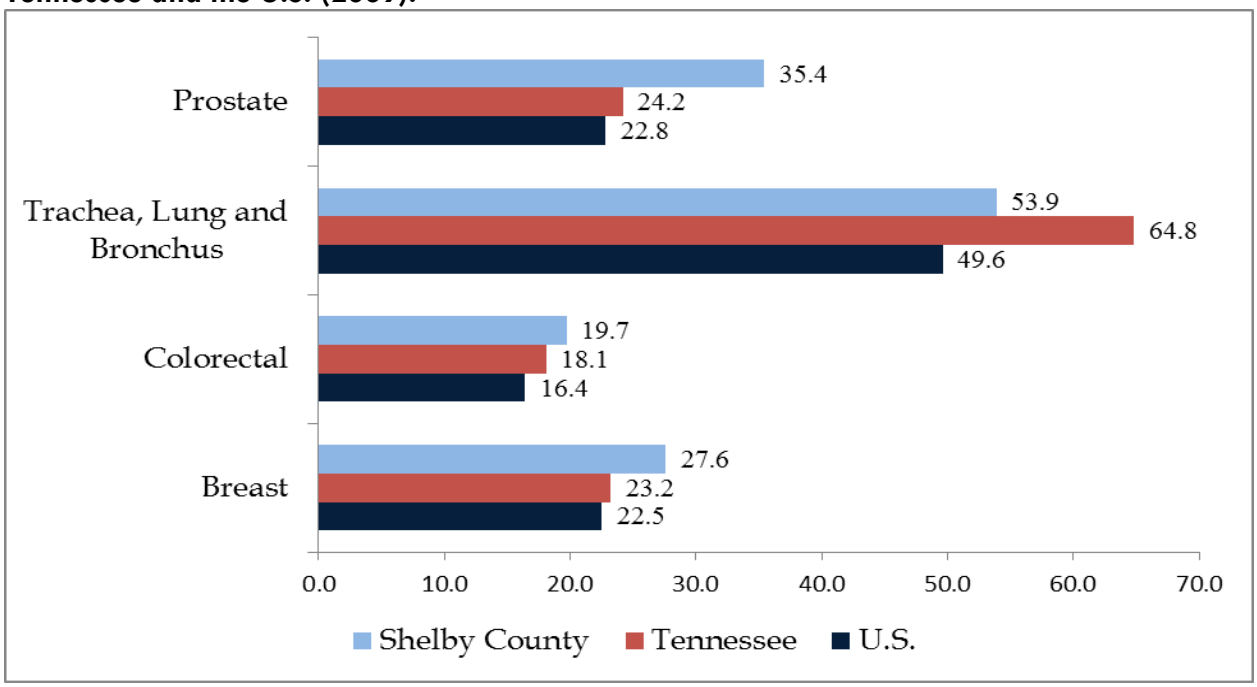
Communicable disease statistics for Shelby County include sexually transmitted illnesses such as HIV/AIDS and chlamydia as well as other communicable diseases like tuberculosis and hepatitis. The statistics in Shelby County for chlamydia, gonorrhea, and syphilis are well above the Tennessee and national rates. The HIV/AIDS mortality rate in Shelby County is also elevated (13.0) compared to statewide (3.8) and nationally (3.4). The mortality rate for HIV/AIDS among African Americans in Shelby County is 23.7 compared to 2.4 among Whites. The tuberculosis and MRSA (Methicillin Resistant Staphylococcus Aureus) cases are also above statewide.

The incidence of **cancers** overall (all sites) in Shelby County is equitable to statewide and national rates, however, several types of cancers are higher in Shelby County than throughout Tennessee or the rest of the nation. Prostate cancer rates are higher in Shelby County along with colorectal cancer incidence rates. On the other hand, the lung cancer incidence rate in Shelby County (67.0) is lower than the Tennessee rate (81.0). The incidence rates for colorectal cancer (both genders), prostate cancer and male all sites are higher in Shelby County than in Tennessee and the nation. The mortality rates for female breast cancer, colorectal cancer (both genders), prostate cancer, and all sites (both genders) are higher in Shelby County than in Tennessee and the nation. The childhood cancer mortality rate is also higher in Shelby County (32.8) than in Tennessee (25.1) and the nation (26.0).

Cancer age-adjusted incidence rates per 100,000 population, Shelby County compared to Tennessee and the U.S. (2004 - 2008).



Cancer age-adjusted mortality rates per 100,000 population, Shelby County compared to Tennessee and the U.S. (2009).



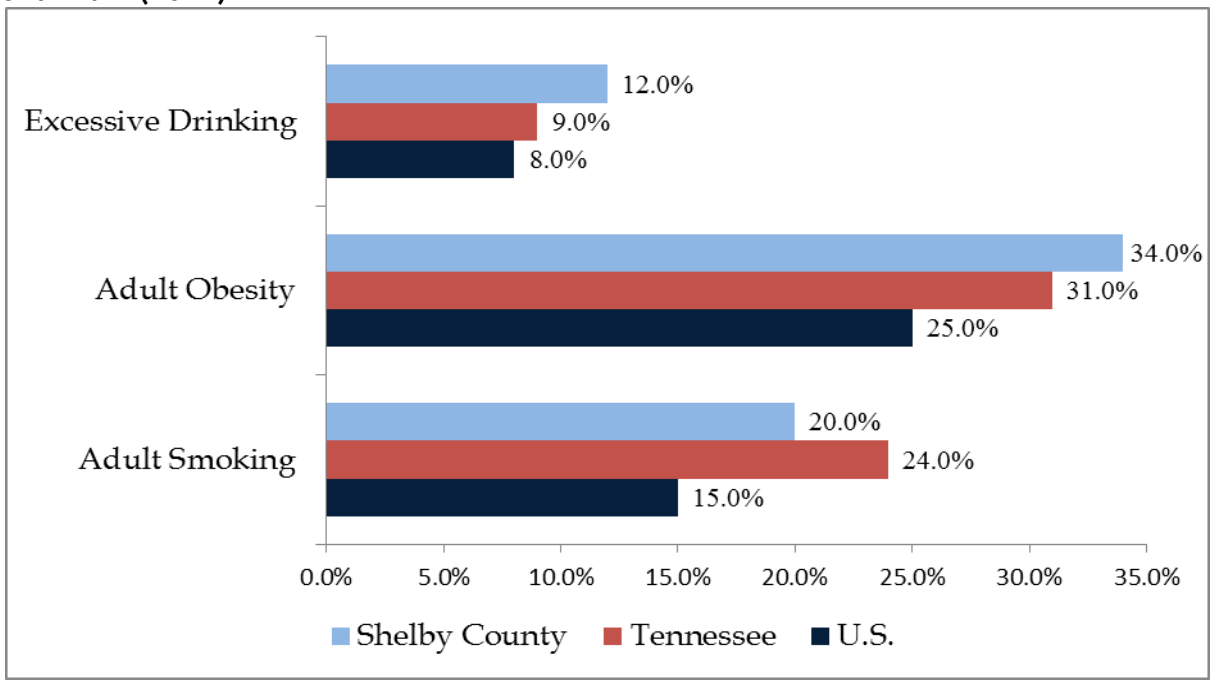
The **suicide** rates for Shelby County reveal an interesting pattern. While the overall rate for the county is 10.2 compared to 14.7 statewide and 11.9 nationally, there is an unfavorable comparison when looking at Whites only. The suicide rate for Whites in the county is 18.1 compared to 5.4 for African Americans. This rate among Whites is similar to Tennessee, but nearly

five points above the United States as a whole. A positive finding is that this pattern does not hold true for childhood suicide in the county (ages 10-19). The rate countywide is 1.4 compared to 4.4 for Tennessee and 4.4 nationally.

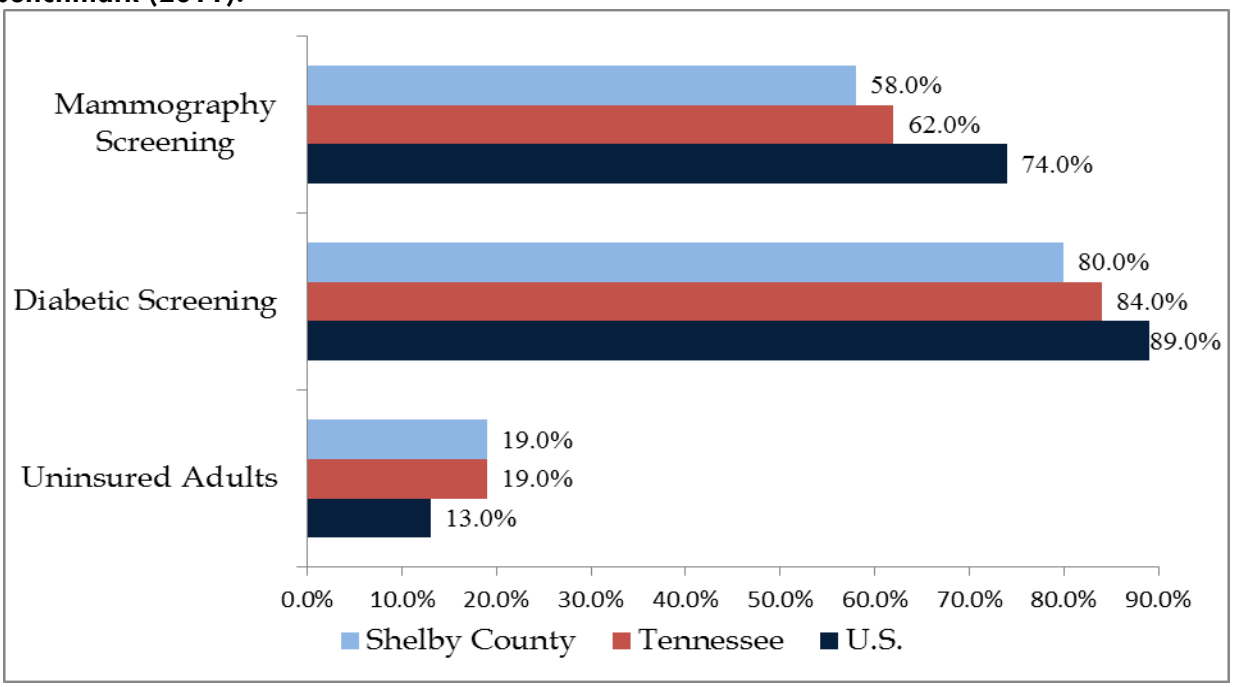
There are a higher number of inpatient **hospitalizations** among Shelby County residents. This is the case for both adults and children in the county. The number of emergency department visits for all age groups is also higher for Shelby County. Specifically, hospitalizations due to **asthma** among children present a problem area in Shelby County. There are significantly more emergency room visits and hospitalizations for children with asthma than what is typical throughout the state and nation. In a ranking of all Tennessee counties, Shelby County ranked the next to lowest for childhood asthma burden (94th out of 95 with 95 being the lowest ranking).

A number of **risky behaviors,** such as smoking and alcohol use, were evaluated as part of the report. While Shelby County adults are less likely to smoke on a regular basis compared to Tennessee overall, the percentage is above the U.S. data point. Higher rates were also found for excessive drinking and adult obesity rates in Shelby County. Related to obesity statistics are the availability of recreational facilities. Per the County Health Rankings report, Shelby County's rate is a 7.0 for recreational accessibility compared to 8.0 for Tennessee and 17.0 nationwide. The same report also states that 81% of county residents have access to healthy foods, which is better than Tennessee (57%), but worse than nationally (92%). Shelby County adults are also less likely to have had a mammogram and preventive screenings for diabetes. Nearly two out of 10 adults in Shelby County are uninsured, which is equal to the rate for Tennessee. Both of these figures are 6% higher than nationally. The graphs below show these comparisons.

Health behavior status percentages, Shelby County compared to Tennessee and the U.S. benchmark (2011).



Clinical care status percentages, Shelby County compared to Tennessee and the U.S. benchmark (2011).



In closing, the secondary data points to some key opportunities within Shelby County. While some areas of the county may be more or less served by the hospital than others, many of these health concerns are prominent in all regions. There are significant health disparities between White and African American residents in the county, most favoring White residents (exception is suicide). The infant mortality rates, prenatal care statistics, and teen pregnancy rates are significant concerns. These statistics are also aligned with poverty indicators, which correlate strongly with poorer health outcomes. Communicable disease rates are quite high in Shelby County as are the obesity rates and excessive drinking figures. Preventive screenings also appear to be lacking for a portion of the population. With nearly 20% uninsured in the county, healthcare barriers likely play a significant role in obtaining needed preventive care, primary care, and specialty care needed to address these health concerns.

The secondary data were correlated with household survey findings and the qualitative research to determine key community health needs across all research components.

Key Informant Interviews Key Findings

The key informant surveys gathered feedback on issues such as the overall quality of healthcare in the area, prominent health issues and barriers, and perceived quality of life. The initial section of the survey evaluated the quality of care, which included accessibility and availability of services such as primary care, dental care, and bilingual care. As detailed below, the area professionals were least likely to agree that there are a sufficient number of bilingual providers in the community.

On a scale of 1 (strongly disagree) through 5 (strongly agree), please rate each of the following statements:

Factor	Mean Response
The majority of residents in the community are able to access a primary care provider.	3.5
The majority of residents in the community are able to access a dentist when needed.	3.5
The majority of residents in the community are able to access a medical specialist.	3.2
There are a sufficient number of providers accepting Medicaid or other forms of medical assistance.	3.2
Transportation for medical appointments is available to the majority of residents.	3.0
There are a sufficient number of bilingual providers in the community.	2.2

Transportation for medical appointments garnered the second-lowest average rating (3.0) and the availability of medical specialists and the number of providers accepting Medicaid or other forms of medical assistance obtained ratings averaging 3.2 on the five-point scale. While overall, access to primary care and dental care were rated the highest, other comments throughout the survey suggest that significant barriers exist. The survey asked respondents what health care services were currently not provided in the community and medical specialists were noted by the majority. Specifically, mental and behavioral health specialists were listed along with endocrinologists, dieticians, dentists, cardiologists, and pediatricians.

When asked to select the three most significant health issues in the community, obesity, diabetes, and heart disease were selected the most often. Other common mentions included heart disease, cancer, and substance abuse.

"We have a lot of primary care physicians, but many of them do not accept TennCare. As for a safety net, we have some private Federally Qualified Health Centers, but those in between-such as the working poor-are caught in the middle and do not have enough places to go."

What do you perceive as the three most significant (most severe or most serious) health issues in the community?

Factor	Number of Mentions	Percent of Respondents (%)
Obesity	43	57.3
Diabetes	40	53.3
Heart Disease	32	42.7
Cancer	19	25.3
Substance Abuse	10	13.3

The questionnaire was not limited to the clinical aspects of community health, but also solicited feedback on several quality of life factors, including the availability of recreational activities, neighborhood safety, air and water quality, and job opportunities. A 1-5 scale (1=very poor; 5=excellent) was used to gather feedback on these aspects. The quality of the air and water was rated the highest in the communities, followed by road/traffic conditions, the availability of recreational activities, and the schools/education. The lowest ratings were given for job opportunities (3.1 average) and neighborhood safety (3.3 average).

Lack of insurance and inability to pay for healthcare services or prevention were seen as the most significant barriers that keep people in the community from accessing care when they need it. Cost was a factor not only in affording health insurance, but in covering co-pays and prescription medication. Low-income seniors were specifically mentioned as having greater barriers as well as members of racial minority groups such as the African American, Hispanic/Latino, and Asian communities. Transportation was also seen as a significant barrier. The need for mobile health vans or buses was mentioned a number of times as a potential remedy to transportation barriers. Another common theme was that the average consumer does not understand how to effectively navigate the healthcare system. There is a lack of awareness of what is available and a perception of limited health literacy across a number of area residents.

"Hospitals need to focus on preventive care instead of sick care."

While the survey was aimed at identifying gaps in services and community needs, it was also important to identify existing assets and strengths in the community. Area hospitals were noted as assets in the community as well as area clinics which provide services for the uninsured and under-insured. Public health agencies and not-for-profit community organizations were also praised for their outreach efforts.

Prevention and education were seen as the two greatest opportunities for achieving optimal health and well-being. Most key informants suggested continued or increased community outreach regarding healthy lifestyle choices, nutrition, exercise, and chronic disease management. Opportunities to partner with community and faith-based organizations were acknowledged.

Several respondents also noted the opportunity for policy change. Specifically, suggestions were made to consider land use and local regulations and make healthy foods more available. A number of mentions were made to focus on the children and youth in the community. Outreach through schools and churches were seen as worthwhile so that behavior change can potentially continue into adulthood.

In conclusion, more than half of the respondents listed the health care system as the greatest community asset. Many specifically listed Baptist Memorial Hospitals and acknowledged their high quality of care and community commitment. The quality of life in the communities was also seen a strength. Respondents indicated a strong sense of community and respect of community leadership. These strengths should be utilized to address the community needs identified. Specific needs that were apparent throughout the feedback include barriers to healthcare for low-income and minority groups, increased need for health literacy, and a focus on prevention and healthy living.

The Key Informant Survey results were correlated with the household study, secondary data statistics, and focus groups findings to determine key community health needs across all research components.

Focus Groups Key Findings

The focus groups addressed diabetes and pre-diabetes, including questions about health literacy, self-care, health care access, and awareness of services. The summary is broken out by feedback about self-care and disease management, followed by access to care issues, and health education and communication.

> *"I've seen family members suffer from it. My grandmother lost her sight and her legs. I'm pre-diabetic now, and I feel resigned that I will get diabetes."*

Knowledge of diabetes and self-care management

The focus groups began with a discussion about the participants' knowledge of diabetes. The group was asked what having diabetes meant to them. While the feedback varied somewhat, much of the discussion was about how diabetes has limited their life. According to one participant, having diabetes is a "huge hassle." Another said that it means "watching everything." Other participants commented that having diabetes affects your quality of life. "I can't do everything I want anymore," said one participant. Several participants talked about having to make significant changes to their lifestyle because of diabetes. One participant commented, "You need to change your whole lifestyle. If you don't maintain a regime, it just isn't going to work." Another stated that "Diabetes is like an addiction and you have to take it one day at a time." Participants discussed having to change their eating habits. One said, "You can't enjoy foods you grew up with."

The participants also spoke of physical complications such as foot problems and deteriorating vision. One participant commented, "I have neuropathy in my feet. When you feel that tingling and burning in your feet, that's your nerve endings dying. Once you've lost it, it's gone." A few participants had to have toes, feet, and even legs amputated due to complications from their diabetes. Several participants discussed vision problems and fear of diabetes causing damage to their eyes. One participant shared, "I worry more about my eyes than anything else." Others explained that having diabetes "means you could go blind." Another participant commented, "I have diabetic retinopathy. I am legally blind." Others explained that having diabetes puts them at risk for other health complications such as heart problems/heart failure and kidney problems/kidney failure.

In addition to physical complications, participants explained that diabetes also has psychological effects. One participant commented that "Having diabetes takes a toll on you – mentally and physically." Several participants complained of being tired or sluggish and having difficulty sleeping. Some felt that diabetes and depression seemed to go hand in hand and that dealing with fear, stress, and mood changes complicated their disease management. One participant shared, "The first few weeks after I was diagnosed, I didn't want to do anything. I just sat in my chair and watched TV." Another stated, "I just want to have a normal life again. Sometimes it makes you depressed."

When asked how they believe they got diabetes or became pre-diabetic, many spoke of a genetic link where parents and/or grandparents had diabetes. One participant said, "My mother had diabetes and her mother had diabetes. I figured I would get it someday, too." Another commented, "I have aunts and uncles who lost all their limbs to diabetes." While factors such as

nutrition and obesity were mentioned as risks by some, there was a sentiment of helplessness due to the hereditary link. Several did point to poor eating habits and lack of exercise as factors that increased the risk of getting diabetes. One participant said, "Anybody who lives in this world, if you don't eat right, you can get it." Others commented that being overweight is what led to their diabetes. In addition, participants mentioned a number of other potential causes to their diabetes including stress, fatigue/sleep deprivation, thyroid problems, steroids, other diseases, caffeine, drinking, smoking, vaccines, and exposure to chemicals/environmental pollutants.

When asked what they do on a daily basis to care for their diabetes, participants emphasized the importance of checking their blood sugar/glucose. One participant stated, "The first thing I do when I get up is do a glucose test." Another explained, "You have to get up, take your medications, check your sugar, then I take my shot, then I eat, then wait two hours and check it again. It has to be a routine. If it's not a routine, you'll forget and you won't do it. It's a regiment." Most checked their blood one to three times a day. "I'm supposed to test twice a day, but I only do it once," admitted one participant. Another said they check their glucose every four hours. One participant complained that constantly having to poke her fingers made them sore and sensitive.

Participants also discussed having to take medications. Some were taking pills to control their diabetes while others took insulin shots. Some participants expressed fear and apprehension about the prospect of having to switch from pills to injections to control their diabetes. "I don't want the needle. Thinking of that makes me sick," said one participant. Participants talked about planning and monitoring their diet in order to control their diabetes. One participant stated, "I have to think about it all the time. Do I have time to eat small meals? Will I have access to healthy choices or do I need to bring food with me?" While another said, "I spend a lot of time thinking about what I am going to eat."

Routine exercise is also an important part of diabetes management. Many participants were trying to get regular exercise in a variety of ways including walking/running, biking, swimming, yoga, dancing, and group exercise classes. One participant shared, "Exercise, along with watching my diet helps. I walk at least 10 minutes at a pretty good clip, best I can. I do that two to three times a week. I don't do it every day." One older woman stated that she walks almost every day to manage her diabetes. Another stated, "I started doing yoga three years ago. I go three days a week. I lost weight and feel more connected with my body." Some members of the group admitted that they did not get enough exercise, if any. Some had difficulty finding the time or motivation while others had physical complications that made it difficult for them to exercise.

When asked what barriers people face when trying to take care of their diabetes, participants suggested a number of challenges. Specifically, they mentioned the following common challenges to eating healthy and exercising regularly:

- Cost
- Motivation/Effort
- Time/Convenience

- Education/Knowledge

Several participants indicated that cost is a barrier. They explained that healthy foods like fresh fruits and vegetables can be expensive, and unhealthy food is often cheaper. Participants mentioned that there are some local Farmer's Markets that increase access to fresh produce, but not everyone can afford to buy it. One woman stated, "A lot of people don't know how to cook healthy foods that are affordable." A participant shared that his family relies on food stamps and food pantries for food and that their options are often limited. Another participant commented, "It's cheaper and easier to go to the dollar menu at McDonald's than to buy food and cook it."

Participants also discussed time as a major barrier to proper diabetes management. One participant commented, "I'm supposed to eat six small meals a day, but I can't do that. I work full-time. Who has the time?" Several participants explained that travel can be difficult because it changes their regular routine and can sometimes limit the control they have over their food choices. One participant says when she travels she has to remember to take measuring cups, a food scale, food, and medications. There were also discussions about having difficulty breaking old unhealthy habits. One participant said, "You gotta wanna quit, before you can quit. I drank a fifth of whiskey Friday, Saturday, and Sunday night. I stopped all that after I was diagnosed, but changing my diet was the hardest."

Attendees discussed how attitudes and behaviors related to food are often established at a young age. They grew up eating certain foods, and now they need to change their eating habits. Several participants explained that they were raised to eat everything on their plate and not waste food. Learning proper portion control has been challenging for some participants. Many participants mentioned that family and friends can be barriers to maintaining healthy habits. They explained that it is hard when you are the only one in the family that has diabetes. Most have family that does not understand or support their diet.

When asked what kinds of things were helpful to participants when they tried to be physically fit and eat healthier, the participants mentioned the following supports:

- Making health a priority
- Creating a plan and establishing goals
- Cooking simply
- Cutting out soda and junk food
- Trying to be a role model for children/family
- Making a commitment to having family dinner
- Having a buddy/mentor to help with motivation
- Group/team-based physical activity like walking clubs
- Finding a type of exercise you enjoy doing – make it fun

Access to Healthcare

When asked how often they need to see a doctor for their pre-diabetes/diabetes care, most stated that they see the doctor every three months or as needed depending on their recent A1C tests. Some go every month. One participant explained, "My last test was high, and they read me the riot act. I have to go back every month now and I'm working on keeping my levels down." A few only go twice a year. Usually they need to see the doctor to check their A1C and get a new prescription for their medication. Some indicated that their appointments only last 10 minutes

while others last 30-40 minutes. Some participants felt that every three months was often enough, while a few said they would go more frequently if it was more affordable.
Some indicated that doctors did foot checks as a routine part of the check-up, but many others did not get foot checks from their doctor. The majority of participants said diet and exercise were rarely mentioned at the ongoing appointments. In most cases, participants received literature at diagnosis and there was little follow up regarding behavior. Some were referred to classes and support programs, but many others weren't. There was clearly a lot of variation in their experiences with their doctors. When asked where they usually seek health care, the majority of participants indicated a primary care/family doctor or practice for their diabetes care. In addition, many see an endocrinologist and an eye doctor for diabetes care.

Participants were asked about barriers to accessing health care services in the community. Several participants indicated that they or someone they know have had difficulty obtaining health care services. The groups discussed how the economic downturn has further complicated access to health care. A few participants were newly unemployed and struggling to manage their disease after losing health care coverage. Participants indicated that lack of insurance coverage and inability to pay were major barriers to accessing health care services in the community.

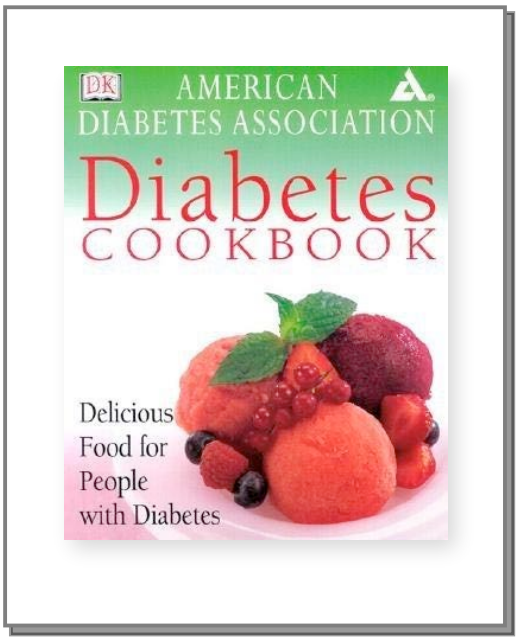
When asked where uninsured and underinsured individuals go for health care, participants indicated that uninsured residents often utilize the Emergency Department for primary health care because the Emergency Department will not turn them away if they do not have insurance. Others forgo care. Co-pays, deductibles, and prescription costs also present challenges in accessing health care. One participant commented, "I don't have any money to pay the co-pay." Some participants shared information about prescription discount cards and prescription assistance programs through pharmaceutical companies, but most were unaware of these resources. Several participants mentioned that testing strips are expensive and that supplies are not always covered by insurance. Several participants expressed frustration that their insurance does not adequately cover specialty services related to their diabetes such as podiatrists, endocrinologists, optometrists, nutritionists, dieticians, and exercise physiologists. Even some participants with comprehensive insurance had difficulty accessing specialists because there were usually four to six month waiting lists for endocrinologists.

When asked whether there are services or resources needed to support diabetes management, participants had a number of suggestions.

- Financial Assistance
- Food Assistance
- Transportation Assistance
- Patient Navigation Services
- Information & Referral Resources
- Prescription Assistance Programs
- Discounted Medical Supplies
- Oral Health Services
- Nutrition Counseling & Nutrition Programs
- Health Coaches
- Optometrists
- Endocrinologists
- Podiatry Services/Foot Care
- Physician Education/Training on Diabetes
- Exercise Physiologists
- Exercise Programs including walking programs and aquatic programs
- Chronic Disease Management Programs/Workshops
- Support Groups

Health Education and Communication

The groups discussed where they received health information, what education options were currently available, and what they would like to see to assist them in managing their diabetes. When asked where participants generally get health information, most said they had received written literature (brochures/pamphlets) from their health provider when they were first diagnosed. While most considered their physician as a source of information, some physicians were viewed as more knowledgeable than others. Several participants commented that they received a lot of valuable information from their insurance provider. In addition, participants indicated that they get information from newspapers, magazines, hospital newsletters, insurance mailers, flyers, brochures, church bulletins, and church leaders. The school systems, libraries, the health department, and community agencies were also mentioned as resources for information. In some cases, they learn about programs and services through word of mouth from friends, family, and neighbors. Several participants indicated that they also get health information online and through television programs like Dr. Oz. Participants also suggested that they are becoming increasingly reliant on the internet for information and suggested that easily accessible websites and social media were great tools to share information.



Participants indicated that they would appreciate a short informational video/DVD explaining diabetes and diabetes management in addition to written information. Several participants suggested that a monthly newsletter with healthy recipes and health tips about diabetes management would be a great way to connect to diabetes patients and encourage them to maintain healthy habits. Some would prefer this in an e-newsletter format while others still like to receive hard copies in the mail. In addition, participants also felt it would be helpful to speak to a nurse practitioner, physician's assistant, health educator, or nutritionist after being diagnosed. Some participants did receive diabetes nutritional education at the onset of diabetes, but then never had another opportunity to ask additional questions.

Participants who had attended diabetes management workshops felt they received the most valuable information through those programs. The majority of participants felt that group workshops were effective ways to disseminate information and many wished they had been referred to available programs. Several participants were interested in support groups. They felt there was a lot to learn from each other and were encouraged to see that they were not alone in their struggles.

Overall, focus group participants had common experiences and concerns across the geographic areas. Individuals living closer to larger population centers were more likely to have access to supportive services, programs, and resources to assist them in their diabetes management. Participants emphasized the need to improve communication and awareness about existing services.

Based on the feedback from the focus group participants, several themes appeared as areas of opportunity.

- Lack of awareness/knowledge about Diabetes, Diabetes prevention and Diabetes management
- Lack of access to affordable health care for people with diabetes including specialty services (podiatry, optometry, endocrinology, dental health)
- Need for assistance with prescription, medical supplies, and healthy food
- Lack of community awareness of available programs and resources
- Need for collaborative provider network with efficient referral system
- Need for health education programs including nutrition, exercise, diabetes management
- Need for supportive services such as support groups and health coaches

The Focus Group results were correlated with the household study, secondary data statistics, and key informant interview findings to determine key community health needs across all research components.

CONCLUSIONS

The four research components reveal a number of overlapping health issues for residents living in the Baptist Rehabilitation Germantown service area. The following list outlines the key needs that were identified.

- **Infant mortality:** As pointed out by the secondary data, the infant mortality rates are significantly higher in Shelby County than statewide and nationally. They are most elevated among African American infants. Infant mortality rates are also accompanied by elevated rates of low and very-low birth weight babies, high teen pregnancy rates, and half of mothers receiving adequate prenatal care. Many of these factors are likely exacerbated by high levels of poverty among households with children and single-mother households.

- **Sexually transmitted illnesses:** The rate of many sexually transmitted illnesses is higher in Shelby County as is the mortality rate for HIV/AIDS. This death rate is especially elevated for African American adults. The household survey showed that individuals in the area are more likely than nationwide to have had the HPV vaccination. Based on other statistics, this may be due to the fact that many more are at an increased risk for contracting the virus.

- **Childhood asthma:** Shelby County rates the second to worst in the state for asthma burden. Compared to Tennessee, there are more inpatient hospitalizations and more emergency department visits for asthma among children less than 18 years old.

- **Suicide rates:** The suicide rate among White adults in the area is elevated above Tennessee and national comparisons. The rate for White adults is more than three times greater than that for African American adults. Childhood suicide does not show the same pattern and in fact compares better than state and national statistics.

- **Cancers (prostate, breast, colorectal)**. The incidence and mortality rates from the Tennessee Department of Health show specifically that prostate, female breast, and colorectal cancers are above state and national comparisons. The positive finding is that more area residents are having mammograms, digital rectal exams, PSA tests and colonoscopies as reported in the survey. An interpretation of that, however, may be that they are having more tests because of increased risk factors.

- **Obesity and overweight:** The obesity statistics for the area are alarming. One-third of the adults are obese and another third are overweight. Relatedly, diabetes rates are elevated. While some have been told by a doctor or health care professional that they are overweight, this percentage is lower than the actual number of overweight or obese individuals. This is a significant area of opportunity. Survey respondents also revealed that they are less likely to exercise than their peers nationally. Focus group participants spoke of lifelong eating habits and cultural influences in how food is cooked and prepared. The area also rates low on the availability of healthy foods and recreational programs.

- **Diabetes:** As stated previously, diabetes and obesity are highly linked. Many residents state that they have a family history of diabetes. They are resigned to the fact that they will likely be diagnosed with diabetes. There is a lack of awareness and understanding of how to prevent and effectively manage diabetes and pre-diabetes.

- **Access to care for the uninsured/low income:** Poverty rates in the county are alarming and present significant challenges to obtaining needed healthcare. This is true even for those with insurance. Increasingly, co-pays are burdensome and the ability to pay for prescription medications or supplies for diabetes is limited. Unemployment rates in the area are above state and national averages. There is ongoing need for more primary care and specialty care for the uninsured and underinsured groups. The survey did not reveal significant differences overall for health insurance coverage in the hospital's service area. Regional differences exist within Shelby County with varying degrees of poverty and the uninsured.

- **Alcohol use:** The secondary data sources report that excessive drinking rates in the area are above state and national figures. The key informants also reported substance abuse as a significant concern in the area.

- **Cardiovascular health:** The proportion of adults who have heart disease and the number who have had a stroke are all above national comparisons. White residents appear to be the most affected by heart disease and African American residents reported a higher incidence of stroke. Area professionals that were surveyed also listed heart disease as one of the top health concerns in the community.

- **Significant health disparities:** The health outcomes, risky behaviors, mortality rates, and social determinants of health are least positive for African Americans in the area. While there are some exceptions (cancer), generally speaking African American residents in the hospital's service area are more likely to be obese, to have diabetes, and to have a variety of high risk factors than other racial groups. They are also less likely to have health insurance and face more barriers to receiving needed health care.

- **Caregiving:** Twenty-eight percent (28%) of area adults provide care for a family member or friend in a typical month. This is nearly 10% higher than nationally. Area residents who are African American are more likely to provide caregiver services to another individual compared to White residents. The care is most often given to older adults, age 65 and over, and roughly 20% have some form of dementia or Alzheimer's.

PRIORITIZATION OF COMMUNITY HEALTH NEEDS

On February 25, 2013, 14 individuals from Baptist Memorial Health Care gathered to review the results of the CHNA. The goal of the meeting was to discuss and prioritize key findings from the CHNA. Baptist Memorial Health Care aimed to create system-wide priorities and set the stage for the development of each system hospital's Implementation Strategy.

The objectives of the half-day strategic planning session were to:

- Provide an overview of recently compiled community health data and highlight key research findings
- Initiate discussions around key health issues and prioritize needs based on select criteria
- Brainstorm goals and objectives to guide Baptist Memorial Health Care Hospitals' Implementation Plans
- Examine Baptist Memorial Health Care's role in addressing community health priorities

Prioritization Process

The meeting began with a research overview presented by Holleran Consulting. The presentation covered the purpose of the study, the research methodologies, and the key findings. Following the research overview, Holleran staff facilitated large group discussion to identify a "Master List of Needs" based the CHNA research and participant's knowledge of community issues. The following list was developed:

- Obesity & Related Chronic Conditions
- Access to Care
- Cardiovascular Health
- Diabetes
- Maternal and Women's Health
- Cancer
- Smoking
- Respiratory Disease
- Suicide
- Caregiver Needs
- Palliative Care
- Senior Health
- Services for Disabled Individuals
- Mental Health
- Substance/Alcohol Abuse
- Alzheimer's Disease
- Stress
- Health Literacy
- Nutrition
- Physical Activity
- Domestic Violence/Child Abuse
- Prenatal Care

The group discussed the inter-relationship of needs and special populations within the community. Social determinants of health, including education, poverty, access to care, and social norms were considered to better understand the issues. Participants worked to consolidate the master list by identifying overlapping issues, root causes of health, and the types of strategies which would be employed to address the needs. The Master List was consolidated to reflect the following cross-cutting issues as follows:

- Obesity & Related Chronic Conditions
- Access to Care & Preventive Health Education (Health Literacy, Nutrition, Physical Activity, Smoking)
- Diabetes
- Cardiovascular Disease
- Cancer (Lung Cancer)

- Maternal and Women's Health (Prenatal Care)
- Caregiver Needs (Palliative Care, Seniors, Disabled)
- Mental Health (Substance/Alcohol Abuse, Alzheimer's Disease, Stress)

Determination of Priority Areas

To determine community health priorities, participants were provided with information regarding the prioritization process, criteria to consider when evaluating key areas of focus, and other aspects of health improvement planning, such as goal setting and developing strategies and measures.

Holleran staff facilitated an open group discussion among attendees. The following criteria were used to identify the most pressing needs in the community:

- Scope of Issue (How many people are impacted?)
- Severity of Issue (What will happen if the issue is not addressed?)
- Ability to Impact the Issue (Are health and human services providers able to impact the need?)

Using these criteria and an understanding of the relationships between the needs and cross-cutting strategies, the participants agreed upon the following "Prioritized List of Needs:"

Prioritized List of Community Needs:

- Healthy Lifestyle Choices (Prevention & Education, Chronic Disease Prevention)
- Cancer
- Maternal and Women's Health (with a focus on Prenatal Care)
- Mental Health (with a focus on Caregivers, Alzheimer's Disease)

The group saw Access to Care as an overarching issue in delivering health care, managing chronic conditions, and providing preventative care and education. As such, it was agreed that strategies to address each of the prioritized needs would include elements to break down barriers to accessing care for residents.

IMPLEMENTATION STRATEGY

In support of the 2012-13 Community Health Needs Assessment, and ongoing community benefit initiatives, Baptist Rehabilitation Germantown developed an Implementation Strategy to guide community health improvement efforts and measure impact. The goals and objectives for each priority area are listed below. The full implementation strategy was developed and will be available on the website.

Healthy Lifestyle Choices

Recognizing the connection between Diabetes, Cardiovascular Disease, and other chronic conditions to healthy lifestyle choices, Baptist Rehabilitation Germantown will seek to reduce these chronic conditions by focusing education and awareness on promoting healthy eating and physical activity. A reduction in chronic disease rates will likely not be seen in the initial three-year cycle, however, Baptist Rehabilitation Germantown expects that success in increasing awareness of the relationship between healthy lifestyle choices and disease will impact the number of residents at risk for or diagnosed with Diabetes, Cardiovascular Disease, and other chronic conditions in the future.

GOAL: Reduce risk factors for chronic disease and improve management of chronic disease through healthy lifestyle choices.

OBJECTIVES:

- Provide education about healthy lifestyle choices.
- Increase residents' awareness of relationship between healthy lifestyle and chronic disease.
- Reduce prevalence of overweight and obesity for those at risk or diagnosed with chronic conditions.
- Decrease readmissions for chronic disease management.

Cancer

With the support of the Baptist Cancer Center, Baptist Rehabilitation Germantown will seek to educate residents about the risk factors for Cancer and early detection, with the goal of improving Cancer mortality rates and quality of life for patients with Cancer.

GOAL: Provide early detection and treatment to reduce Cancer mortality rates and improve quality of life for patients living with Cancer.

OBJECTIVES:

- Invest in newest technologies for detection and care of Cancer.
- Increase community awareness of signs of Cancer and early detection.
- Improve availability of Cancer screenings and services.
- Provide free or reduced cost screenings and services.

Maternal & Women's Health

Improving outcomes for babies starts by ensuring pregnant mothers have access to early prenatal care and begin to make healthy lifestyle choices during pregnancy and continue healthy behaviors after giving birth.

GOAL: Promote prenatal wellness to improve outcomes for mother and child.

OBJECTIVES:

- Reduce low birth weight/premature birth
- Reduce infant mortality rates
- Improve healthy lifestyle choices for pregnant mothers

Mental Health

Recognizing the relationship between mental health and optimal physical health for patients and their caregivers, Baptist Rehabilitation Germantown will aim to help residents identify the signs of dementia and/or Alzheimer's disease and provide support for caregivers.

GOAL: Increase early detection of dementia and provide support services for residents with dementia and/or Alzheimer's and their caregivers.

OBJECTIVES:

- Help residents identify early signs of dementia/Alzheimer's Disease.
- Promote support services for residents with dementia and/or Alzheimer's and their caregivers.

DOCUMENTATION

The CHNA Summary Report was posted on the hospital's website in September 2013 to ensure it was widely available to the community. The hospital's Board of Directors will review and adopt an Implementation Strategy and the plan will be available on the website.