BAPTIST®

MEMORIAL HOSPITAL

GOLDEN TRIANGLE

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

With 315 beds, Baptist Memorial Hospital-Golden Triangle is the largest of the entity hospitals in the Memphis, Tennessee-based Baptist Memorial Health Care. The hospital opened in 1969 as Lowndes General, a public, not-for-profit, county owned facility. It merged with the privately owned Columbus Hospital in 1989, giving the facility a total of 38,000 square feet on a 69-acre campus. It was leased by Baptist Memorial Health Care in March 1993.

Baptist began a $44 million construction and renovation project in 1995 and completed in 1998, doubling the size of the hospital. A new 39-bed emergency room, 18-bed critical care unit, plus six surgical suites were added to better serve patients. Also added was a four-story ambulatory center, providing outpatient diagnostic imaging services, a new cardiac and pulmonary rehab facility, pre-admission testing, outpatient surgery and physician offices.

In May 2005, the hospital opened a $34 million, five-story, 167,000-square-foot bed tower adding151 patient rooms including ten labor/delivery/recovery suites and special C-section suites and an advanced infant security system. The 26,100-square-foot Baptist Behavioral Health Care facility was opened adjacent to the main hospital building in December 2011.

Definition of Service Area

Baptist Memorial Hospital-Golden Triangle serves residents in Lowndes County and the surrounding areas. For the purposes of the CHNA, the hospital focused on its primary service area of Lowndes County, Mississippi. The following zip codes were included in the household study:

39701	39702	39705	39740	39743	39766

CHNA Background

Baptist Memorial Hospital-Golden Triangle, 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 Memorial Hospital-Golden Triangle 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 Memorial Hospital-Golden Triangle service area.

The findings from the CHNA were reviewed and health needs were prioritized to develop the hospital's Community Health Implementation Strategy. Baptist Memorial Hospital-Golden Triangle 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 541 adults from the Baptist Memorial Hospital-Golden Triangle 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.

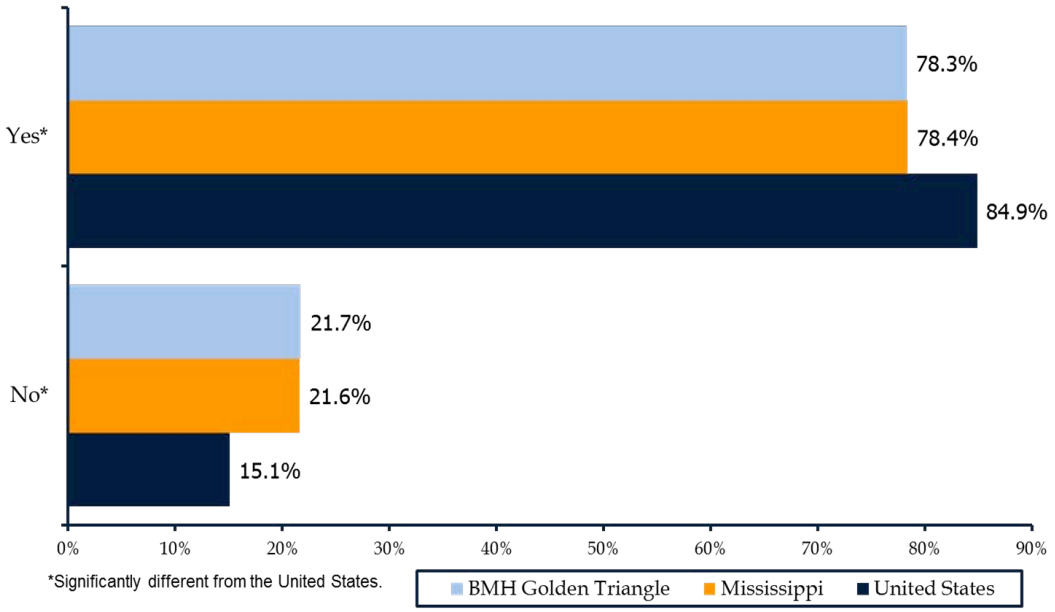
KEY ASSESSMENT FINDINGS

Household Survey Key Findings

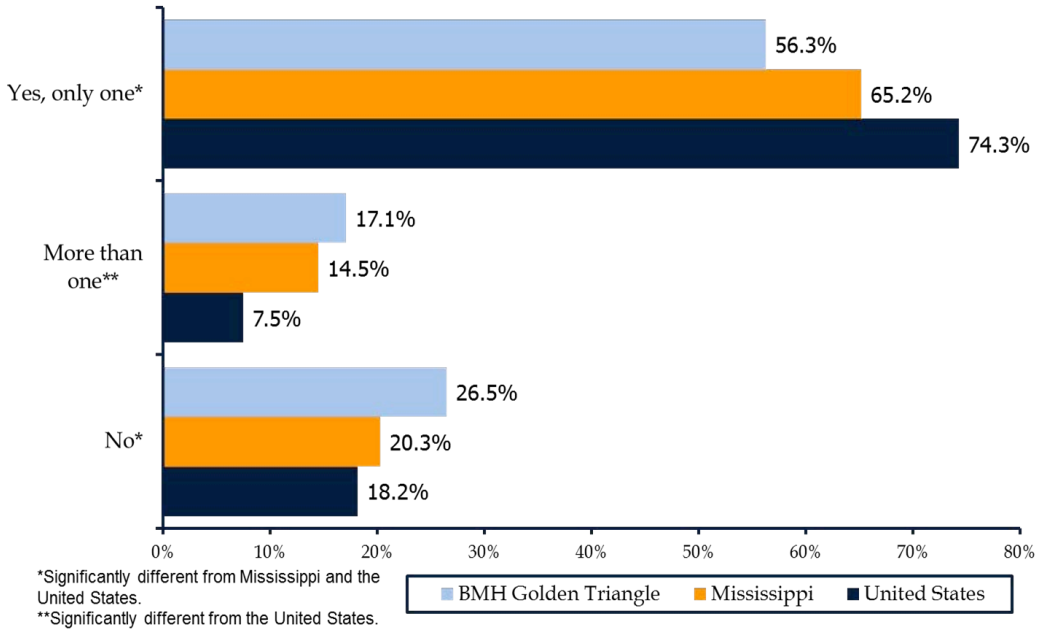
A household survey of the Baptist Memorial Hospital-Golden Triangle service area included 541 randomly selected adults. The respondents were asked to rate their own health status, to provide information on behaviors and prevention activities, and to report the incidence of a variety of chronic illnesses such as diabetes and cardiovascular disease. When asked to rate their **general health**, 75.7% responded "good," "very good" or "excellent." This is similar to what is seen throughout Mississippi (76.3%), but is below the ratings that are typically seen throughout the U.S. (83.6%). Area residents were also more likely to report days of poor physical health in an average month. Ratings of poor mental health, on the other hand, were equitable to the state and national benchmarks. In general, area females were more likely than the males to report days of poor physical or mental health.

Access to care issues were assessed by asking several survey questions about health insurance coverage, cost as a barrier to seeking care and whether or not there is a regular source of health care. Approximately 78% of those surveyed reported that they have some form of health insurance. While this is similar to the proportion statewide (78.4%), the national figure for uninsured adults is at 84.9%. The survey identified racial disparities with regard to insurance coverage. Roughly 82% of the White survey respondents had health insurance coverage compared to 74% of the African American respondents. The survey also gathered feedback on whether or not the residents in the area have a regular provider for their healthcare. Around three out of four residents (73.5%) indicated that they have someone they think of as their regular provider. This compares against 79.7% throughout Mississippi and 81.8% for the U.S. average. Nearly 23% of area adults had a time in the past year where they needed to see a doctor, but could not because of cost and 80.3% had a regular checkup in the past year. African Americans who live locally were more likely than White area residents to report cost as a barrier to receiving care (27.6% vs. 19.3%).

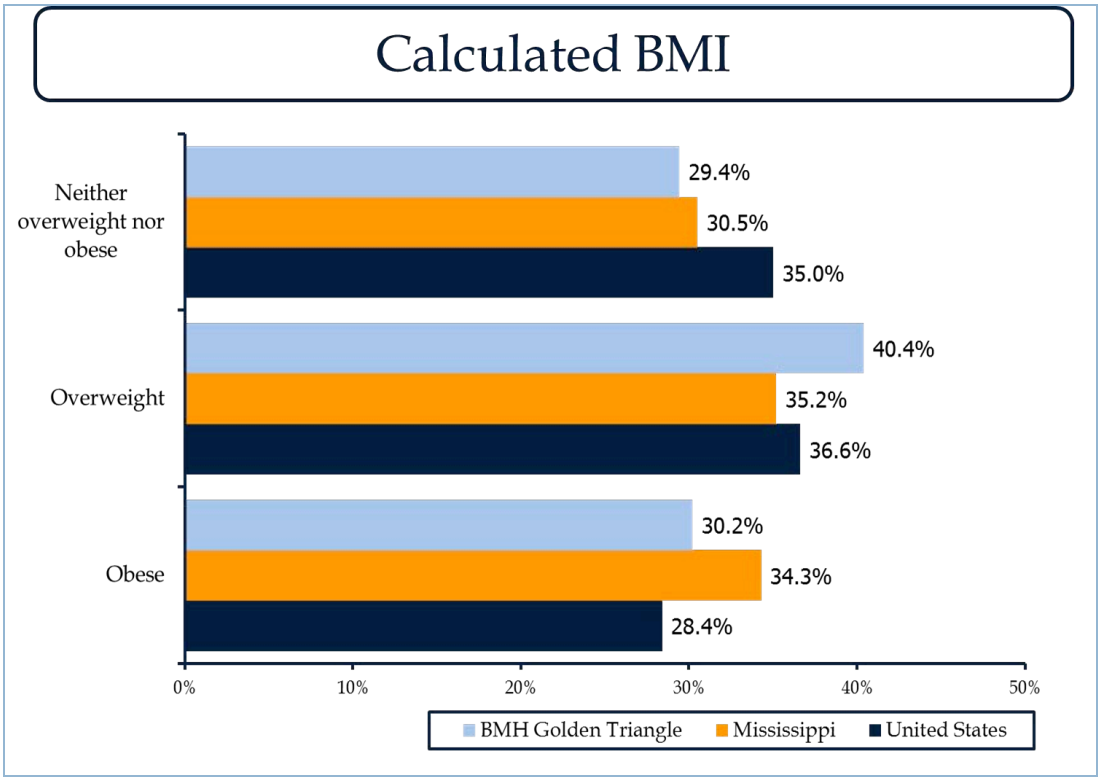
Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?



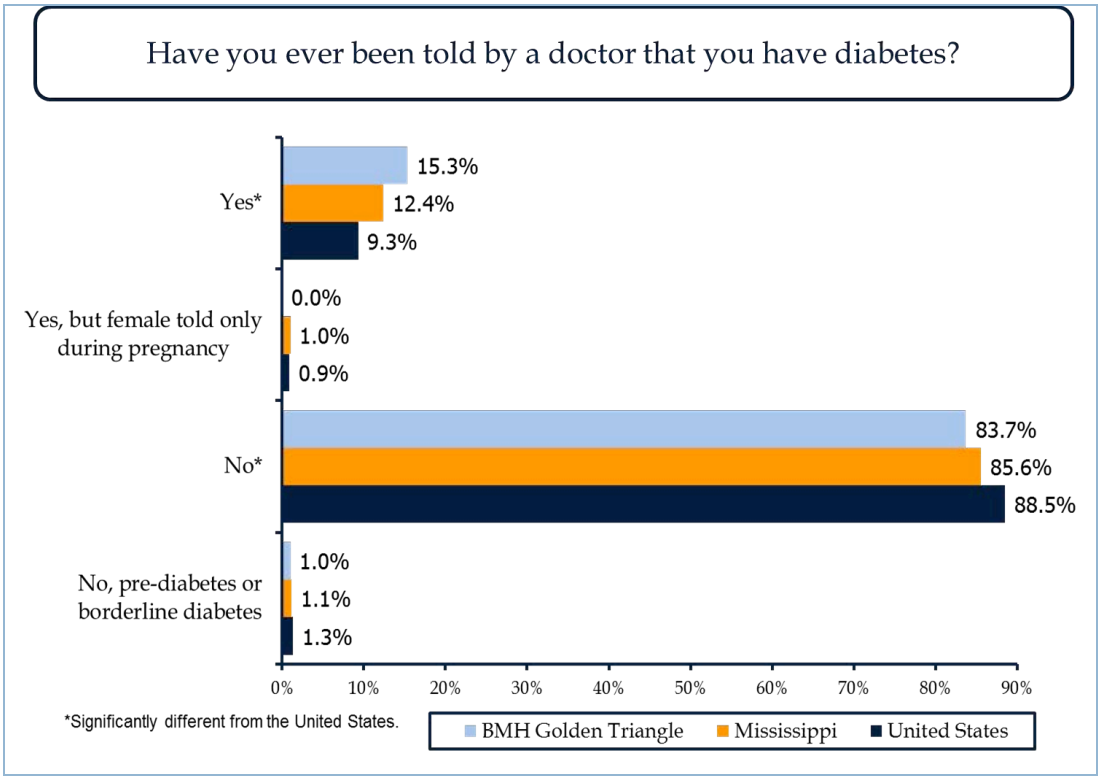
Do you have one person you think of as your personal doctor or health care provider?



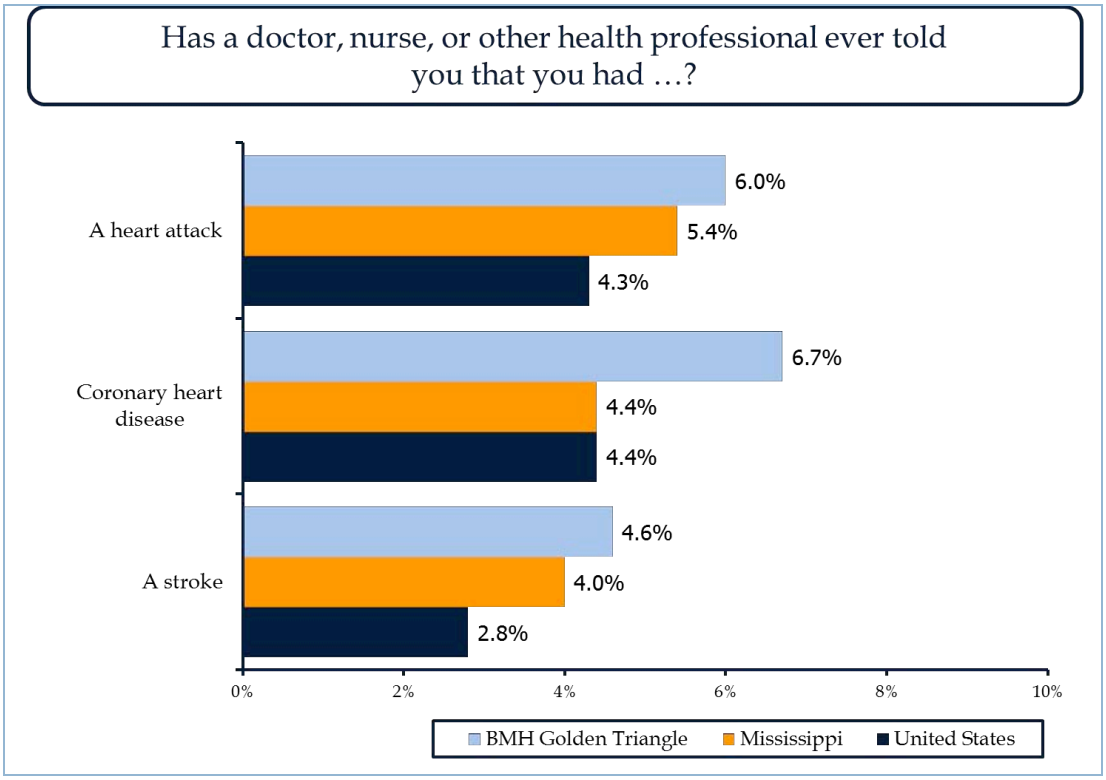
Weight and nutrition was assessed as well. **BMI (Body Mass Index)** was calculated for each survey respondent based on their reported height and weight. As shown in the graph below, approximately 30% of area adults are technically obese. An additional 40.4% are overweight. Area residents are similar to Mississippi in their likelihood of being overweight or obese, but compare less favorably to national statistics. When asked if they exercised in the previous month, 74.2% indicated they had. This is above the 67% for Mississippi, but fairly similar to the U.S. (75.6%). Males were more likely than females to report that they exercised (81.7% vs. 66.3%). Despite having seven out of 10 overweight or obese adults in the area, only 19% of those surveyed indicated that they had been told by a healthcare provider in the previous two years that they were overweight or obese. About 67% reported that they eat the recommended servings of fruits and vegetables in a typical day. While African American residents are less likely to exercise than White residents (68.7% vs. 78.7%), they are more likely to eat the recommended daily servings of fruits and vegetables (74.3% vs. 61.4%).



Closely linked to being overweight or obese is the incidence of **diabetes**. Roughly 15% of the survey respondents reported being told by a doctor that they have diabetes. This is similar to the rate for Mississippi (12.4%), but above the rest of the country (9.3%). When asked about a family history, nearly half (47.4%) indicated that they have a family member with diabetes. Fewer individuals with diabetes locally reported that they have taken a course or class in how to manage their diabetes compared to the number nationally. Nearly 50% of local diabetics have taken a class, above Mississippi (44.2%), but lower than throughout the U.S. (54.8%). The household survey did not reveal any significant differences between Whites and African Americans with regard to the incidence of diabetes.

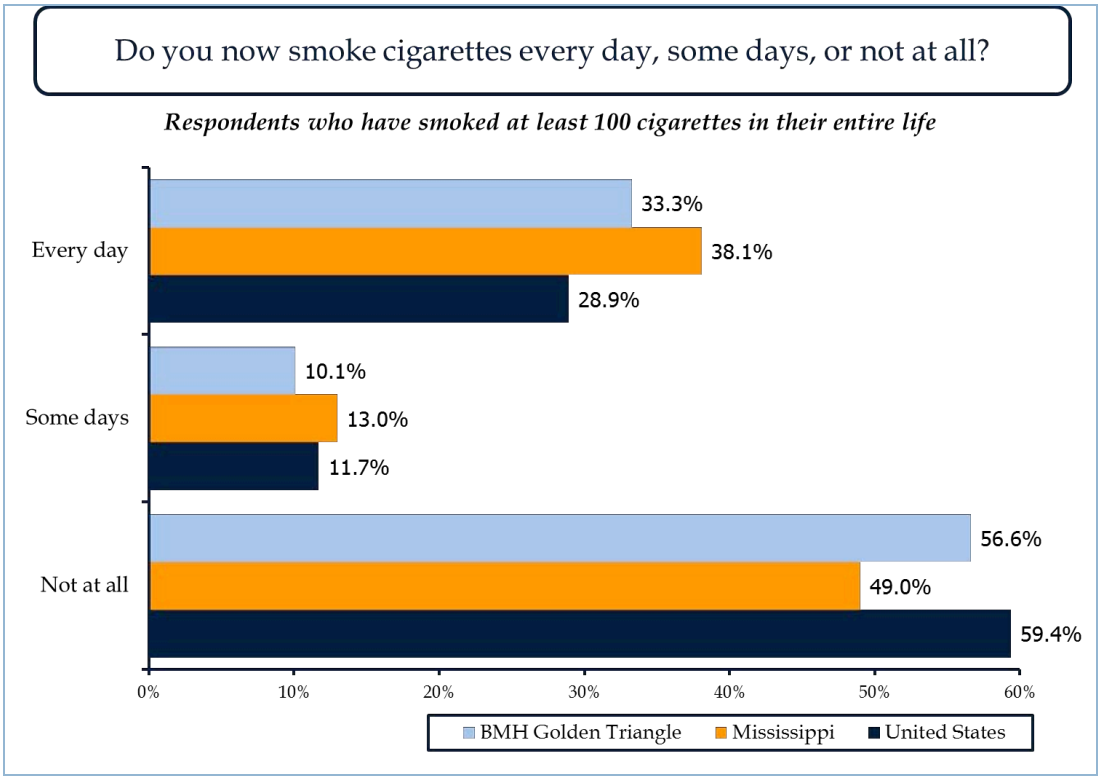


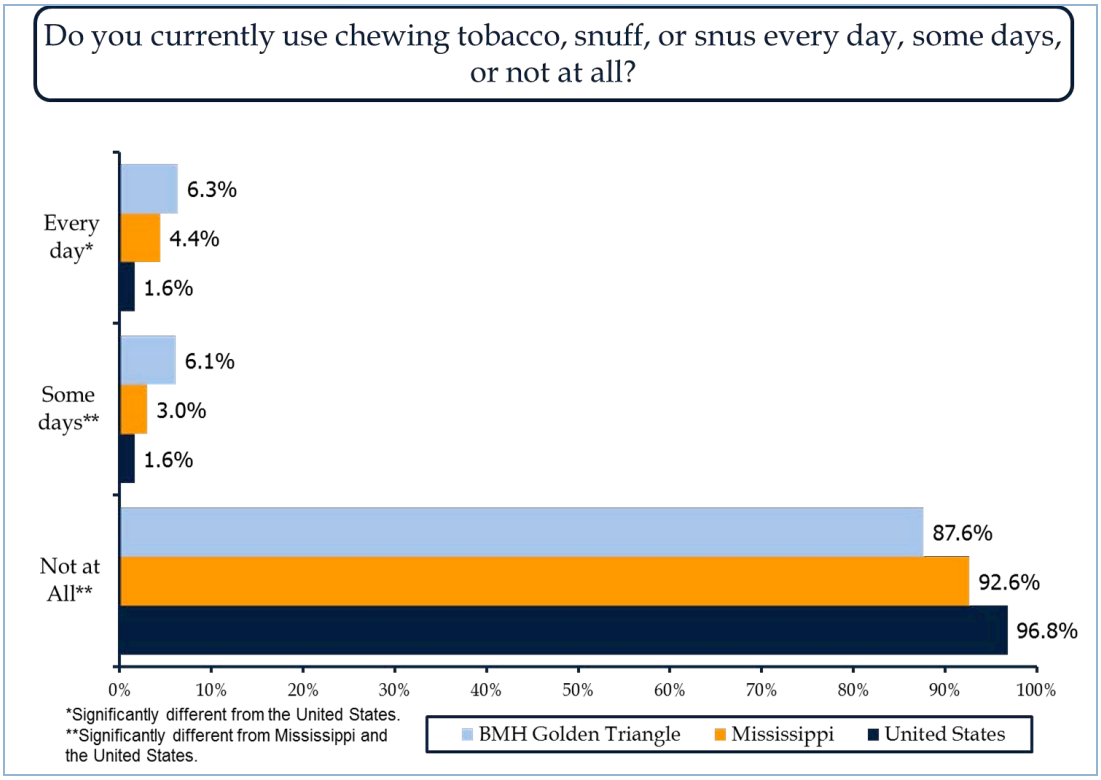
Cardiovascular disease was assessed through questions about heart attacks, heart disease and stroke. Residents living in the hospital's service area look fairly similar to adults throughout Mississippi and the U.S. with regard to the percentage who have had a heart attack or stroke. The exception is in the percentage who have angina or coronary heart disease. As detailed in the graph below, 6.7% of area adults have heart disease. This is above Mississippi (4.4%) and above the U.S. (4.4%). Around four out of 10 adults locally indicated that they also have a family history of heart disease. Area African Americans were slightly above Whites locally to have had a heart attack, to have heart disease and to have had a stroke.



Roughly 27% of the survey respondents reported being limited in some way because of physical, mental, or emotional problems. This is equitable to the statewide percentage of 25.3%, but above the U.S. figure of 20.8%. Additionally, 13.5% reported that they have a health problem that requires the use of some form of special equipment (e.g. cane, wheelchair, etc.). While the household survey data was statistically weighted to account for any demographic imbalances, such as age, a higher proportion of older adults in the survey sample may have an impact on the results of these particular questions.

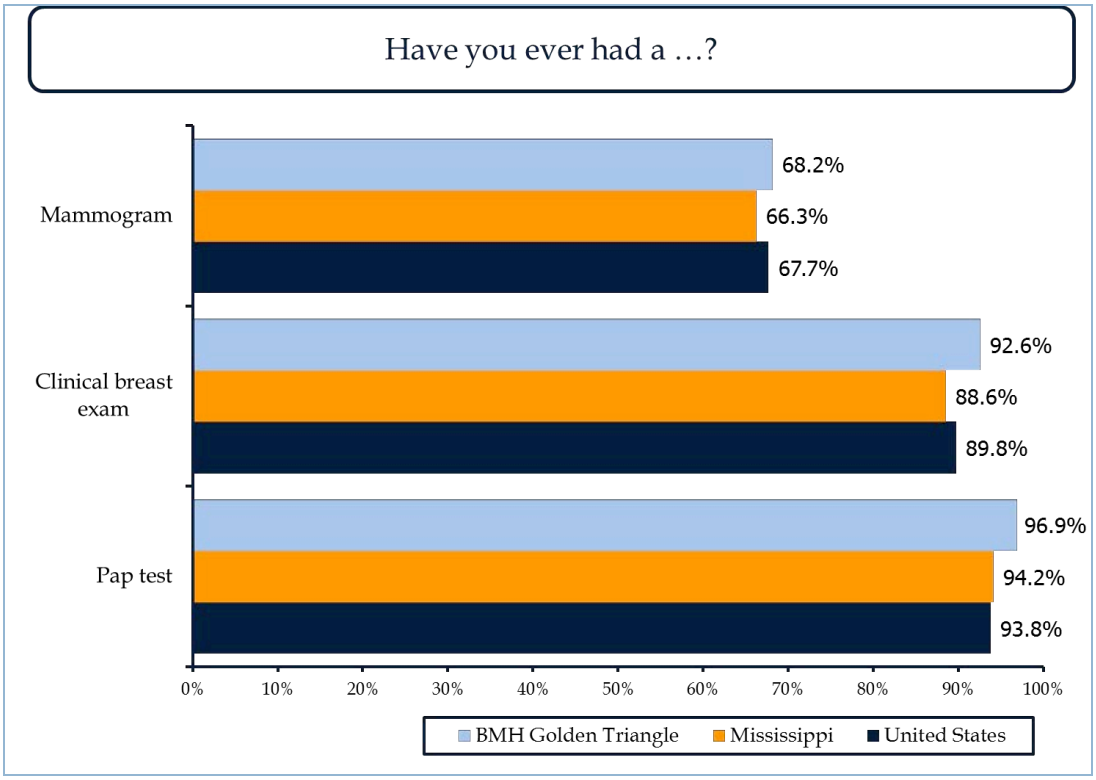
Tobacco use was assessed through questions regarding cigarette smoking and chewing tobacco. Forty-two percent (42%) of those surveyed stated that they have smoked at least 100 cigarettes in their lifetime. This is slightly below Mississippi overall (45%), but equal to the U.S. figure (42%). Among those who have smoked 100 cigarettes, less than half (43.4%) now smoke some days or every day. In general, adults locally are less likely to currently smoke than adults throughout Mississippi. Area Whites were more likely to have smoked at least 100 cigarettes than area African Americans (50.5% vs. 31.9%). One area of concerns is the percentage of current smokers who indicated that they have quit smoking for at least one day in the past year. Locally, 47.7% stated that they had quit for at least one day, which is below Mississippi (63.9%) and the U.S. (59%). An additional negative finding for the hospital's service area is a higher proportion of adults, largely males, who use chewing tobacco or snuff. Around 12% of area adults use chewing tobacco compared to 7.4% statewide and 3.2% nationally.



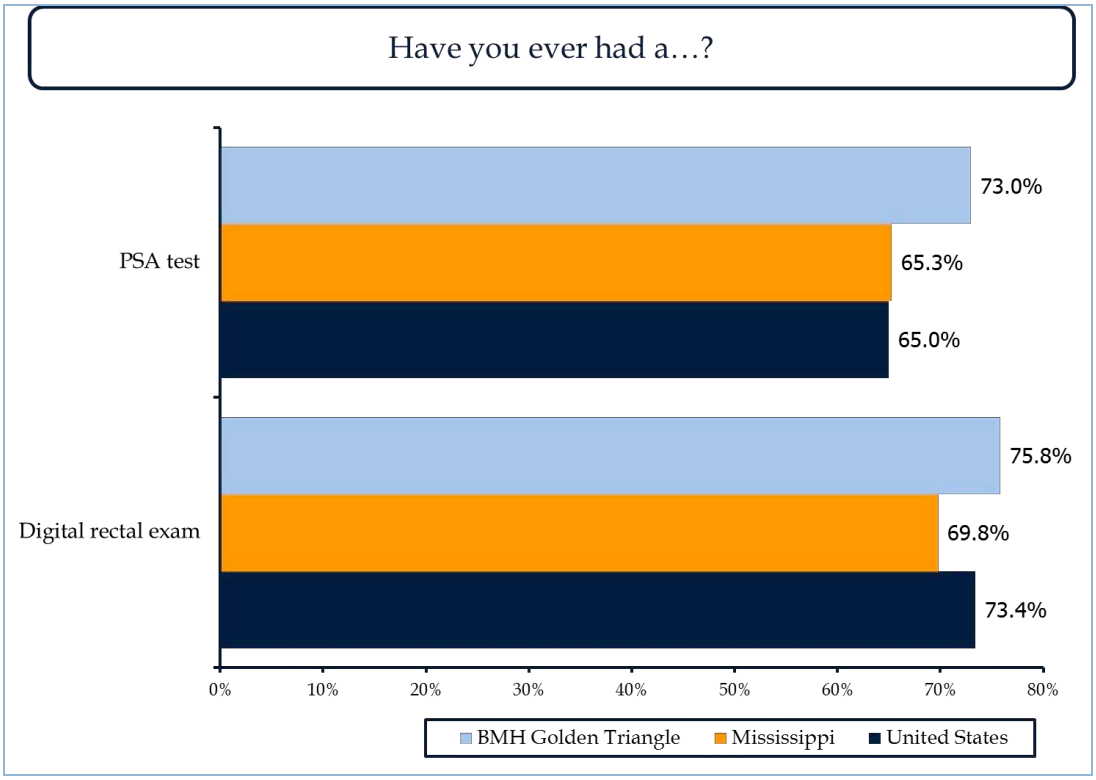


Adults locally are less likely than adults nationwide to always wear a seatbelt. Nearly 82% always wear a seatbelt, which is similar to Mississippi (80.6%), but lower than throughout the U.S. (86.6%). Area females are more likely than area males to always wear a seatbelt (88.6% vs. 75.4%).

Female respondents were asked a variety of **women's health** questions. The majority of females that were surveyed locally have had a mammogram at some point in their lifetime (68.2%). This is similar to the percentage throughout Mississippi (66.3%) and the U.S. (67.7%). African American females were less likely to have had a mammogram than White females (64.1% vs. 72.4%). Rates for clinical breast exams are similar to what is seen statewide and nationally as are the rates for Pap tests. There were no significant racial differences locally in the likelihood of having had a clinical breast exam and the percentage who have had a Pap test.



Tests for **prostate cancer** include Prostate Specific Antigen (PSA) tests and digital rectal exams. These questions were asked of area males 40 and older. Approximately 73% of the males in this age range have had a PSA test, which is above Mississippi (65.3%) and the U.S. (65%). A larger percentage of males have had a digital rectal exam. Locally, 75.8% of males 40 and older have had this exam compared to 69.8% statewide and 73.4% nationally. When asked if they have ever had prostate cancer, 5.7% of males in this age group indicated that they have. This is comparable to the state and national percentages for prostate cancer. White males were more likely to have had a PSA test than African American males (78.6% vs. 67.3%) and also more likely to have had a digital rectal exam (80.2% vs. 68%).

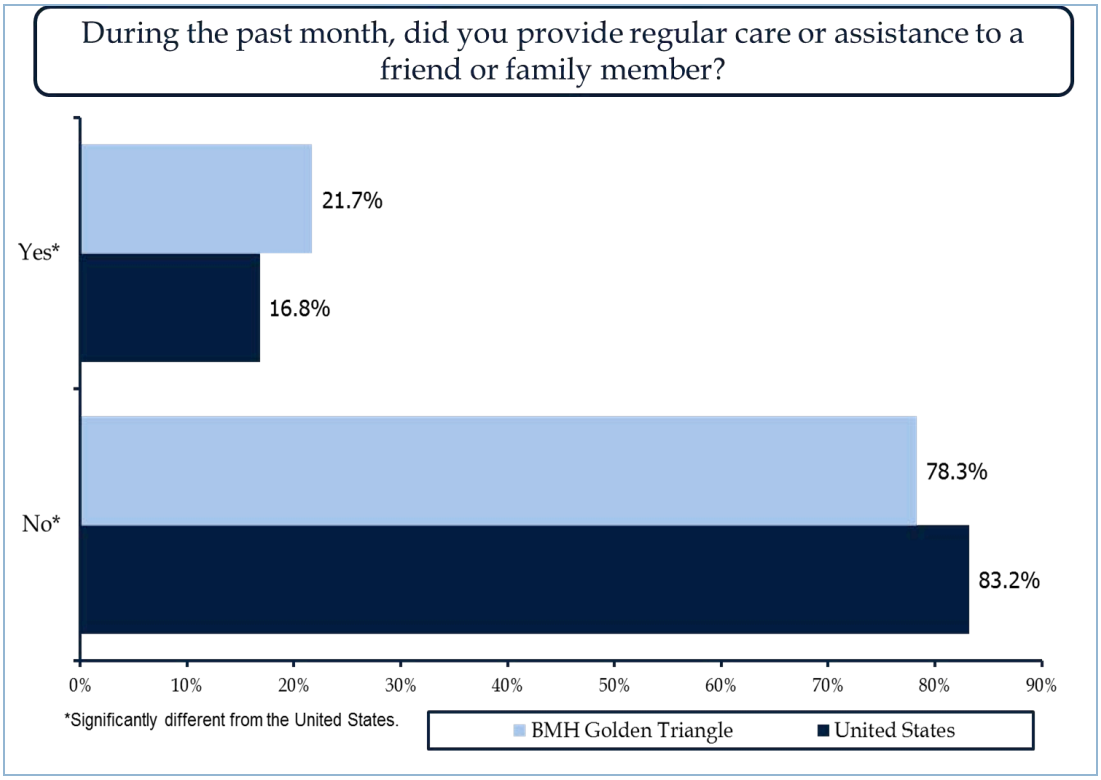


Colorectal cancer screening questions were included in the survey as well. Around 41% of adults 50 and older have had a blood stool test using a home kit, which is above the percentage statewide (34.3%), and above nationally (38.6%). A higher percentage reported having had a colonoscopy or sigmoidoscopy. Around 66% of adults 50 and older have had a sigmoidoscopy or colonoscopy, above the 59.5% throughout Mississippi and similar to the 65.6% throughout the U.S. African Americans living locally were less likely to have had a colonoscopy or sigmoidoscopy than Whites locally (57% vs. 72.2%).

Eight percent (8%) of adults surveyed reported that they have had **cancer** at some point in their lifetime. This is compared to 9.4% nationally. The most commonly reported types of cancers were prostate, breast, and colon cancer. More White residents in the area reported having had cancer at some point in their lifetime than African American survey respondents (10.1% vs. 4.3%).

Arthritis was reported by 36.4% of area adults. This is above the Mississippi (31%) and U.S. (30.3%) figures. Locally, Whites were more likely to report being diagnosed with some form of arthritis, gout, lupus or fibromyalgia compared to African Americans (42.2% vs. 30.4%).

Caregiving is increasingly an issue throughout the country as the number of older adults continues to grow. Nearly 22% of those surveyed reported that they provide regular care or assistance to a friend or family member. This compares to 16.8% nationwide. The largest proportion (72.2%) takes care of someone who is 65 years or older. Locally, females are more likely to provide caregiving to a friend or family member as well as White residents.



In summary, the household survey results reveal a number of areas of opportunity throughout the hospital's service area. Area adults reported a lower general health status compared to state and national figures. Local statistics are less healthy for obesity, diabetes and heart disease. The rate of uninsured in the hospital's service area is similar to Mississippi, but higher than what is seen nationally. In addition, fewer area adults have a regular source of health care and more have had cost limit their ability to see a doctor. While cigarette smoking rates are similar to the nation and better than Mississippi, the use of chewing tobacco is much higher among local residents.

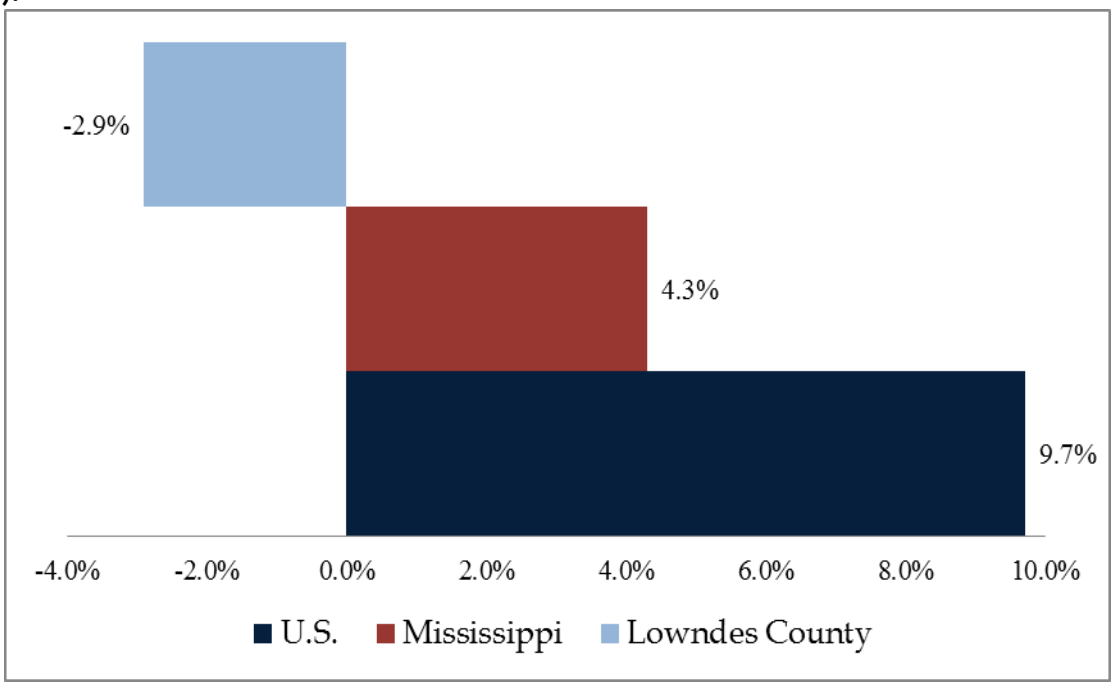
The household survey results were correlated with secondary data statistics and the qualitative research to determine key community health needs across all research components.

Secondary Data Key Findings

A number of data points were gathered to lend insight into the demographics, quality of life, morbidity and mortality figures for Lowndes County, Mississippi. 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. Between 2000 and 2010, Lowndes County saw a 2.9% decrease in its population while the rest of the country had population growth. The racial composition of Lowndes County is 54% White, 43.5% African American and 1.5% are of Hispanic or Latino descent. The vast majority of households (96.9%) speak only English.

Population percentage change, Lowndes County compared to Mississippi and U.S. (2000 – 2010).



Household statistics reveal a higher proportion of individuals who rent as opposed to own their homes. Around 37% of households are renter occupied, which compares to 30.4% statewide and 34.9% nationally. The percentage of single-mother households is slightly higher than nationally as is the number of females 65 and older who live alone. Median home values are above Mississippi, but lower than the U.S. median value.

Households by Occupancy, Type, and Value (2010)

	U.S.		Mississippi		Lowndes County	
Occupancy[a]	n	%	n	%	n	%
Occupied housing units	116,716,292	88.6	1,115,768	87.5	23,487	88.4
Owner-occupied	75,986,074	65.1	777,073	69.6	14,853	63.2
Renter-occupied	40,730,218	34.9	338,695	30.4	8,634	36.8
Household Type[a]	n	%	n	%	n	%
Family households	77,538,296	66.4	770,266	69.0	16,041	68.3
Female householder, no husband present	15,250,349	13.1	205,972	18.5	4,515	19.2
Nonfamily households	39,177,996	33.6	345,502	31.0	7,446	31.7
Female, 65 yrs & over	7,823,965	6.7	75,845	6.8	1,683	7.2
Value for Owner-Occupied Units[b]	n	%	n	%	n	%
Median value (dollars)	187,500		99,800		117,800	

Income levels in Lowndes County look similar to Mississippi overall. The median household income in the area is roughly $36,000. This compares to $37,000 statewide and $51,000 for the U.S. overall. The median family income in the county ($45,997) is again below the national figure ($62,112), but remains similar to Mississippi's family income ($46,746). Countywide, poverty rates are higher than state and national figures. This holds true for nearly all demographic groups.

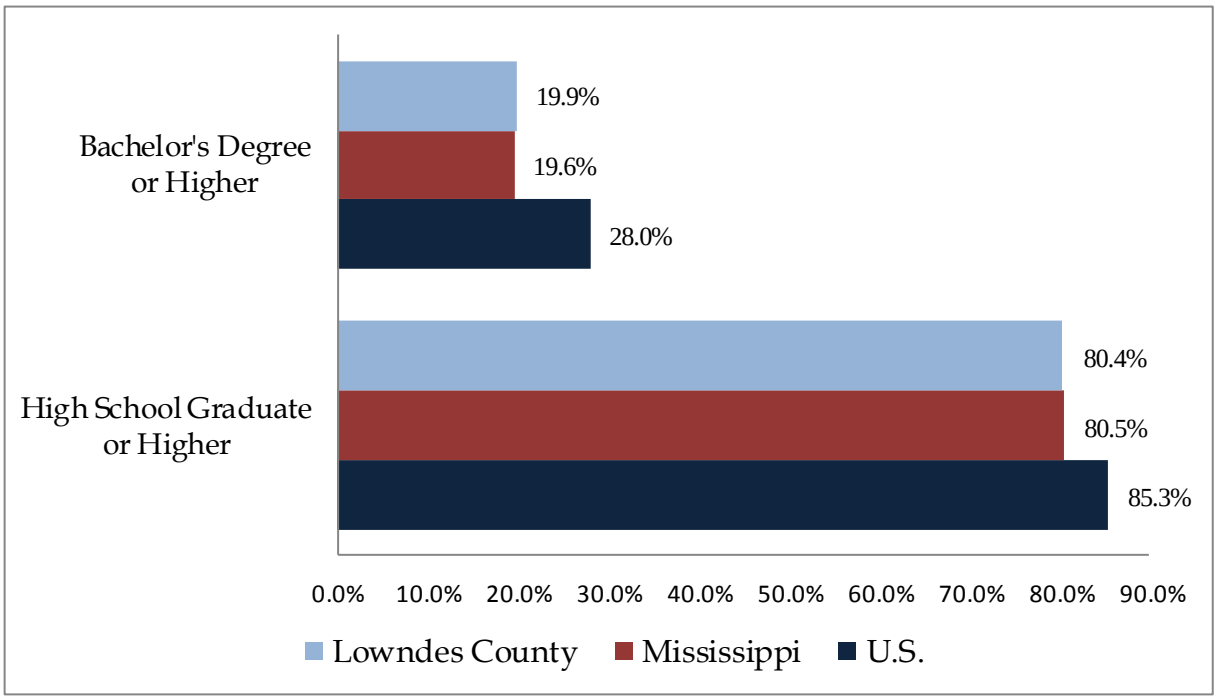
Poverty Status of Families and People in the Past 12 Months (2010)

	U.S.	Mississippi	Lowndes County
All families	10.5%	17.2%	21.2%
With related children under 18 years	16.5%	25.9%	33.6%
With related children under 5 years only	17.9%	27.0%	40.4%
Married couple families	5.1%	7.1%	7.1%
With related children under 18 years	7.5%	9.8%	12.6%
With related children under 5 years only	6.8%	9.6%	23.1%
Families with female householder, no husband present	29.2%	41.7%	60.1%
With related children under 5 years only	46.1%	56.4%	81.4%
All people	14.4%	21.8%	25.4%
Under 18 years	20.1%	31.6%	38.7%
Related children under 18 years	19.7%	31.3%	38.5%
18 years and over	12.5%	18.4%	20.9%
65 years and over	9.4%	14.7%	17.6%

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

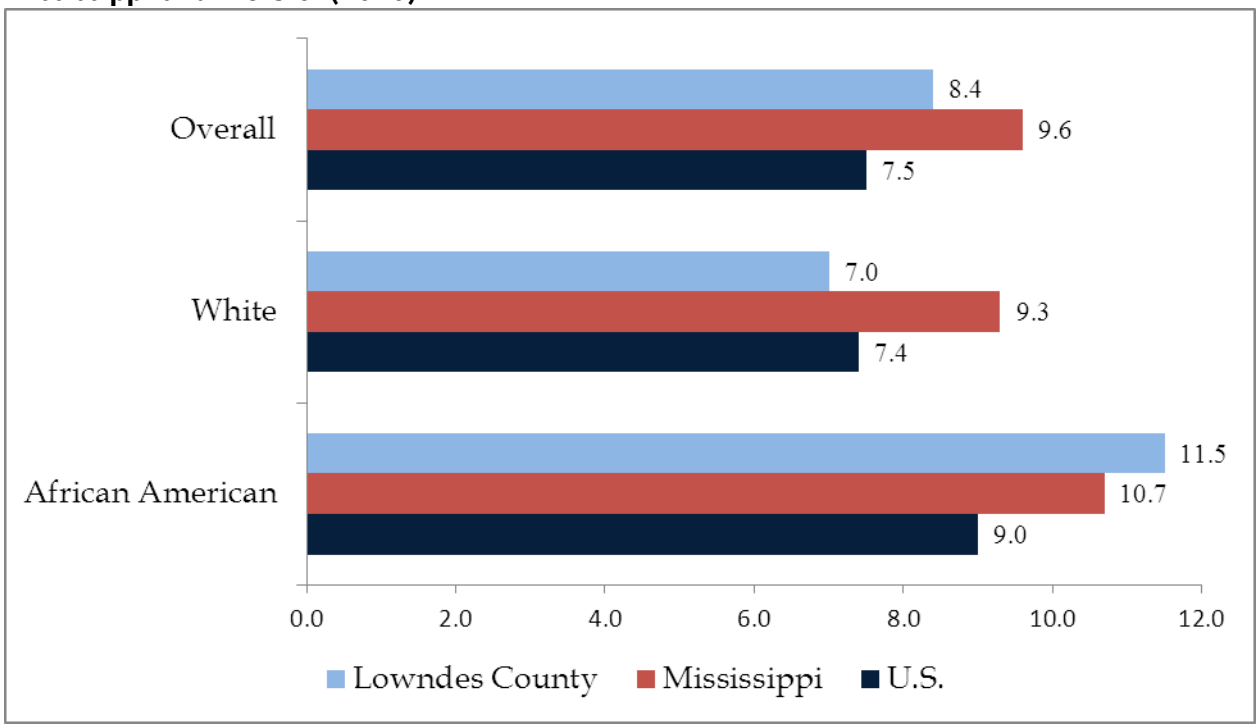
About six out of 10 county residents who are 16 years of age and older are in the labor force, similar to the 59.6% for Mississippi, but lower than the 65.1% nationwide. Unemployment rates in the area are higher than elsewhere. Proportionally, Lowndes County has a higher number of individuals employed in manufacturing and retail trade than statewide and nationally. It is estimated that around 20% are uninsured locally compared to 17.7% for Mississippi and 15% nationwide. The educational attainment in the county is similar to what is seen throughout the state, but fewer adults in the county have a bachelor's degree or higher when compared against national statistics. As depicted below, the proportion that have at least a high school diploma or equivalent is also lower than nationally.

Educational attainment percentages for population 25 years and over, Lowndes County compared to Mississippi and the U.S. (2010).



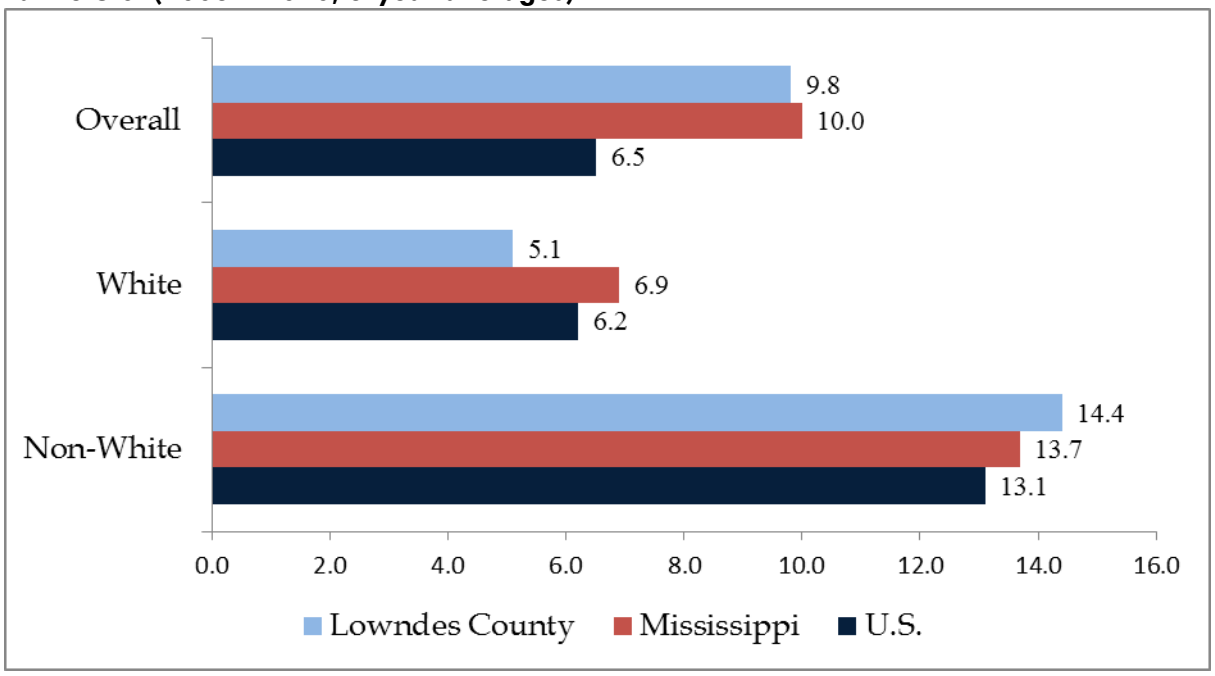
The overall age-adjusted **mortality rate** for Lowndes County is 8.4 per 1,000 population. While this is lower than Mississippi (9.6), it is higher than the U.S. rate (7.5). An examination of the mortality rates by race reveal a disparity in the rate of death. Locally, African Americans have a higher death rate than Whites (11.5 vs. 7.0) and a rate that is higher than what is seen among African Americans statewide (10.7) and nationally (9.0). Mortality rates for heart disease are higher than what is typically seen elsewhere.

Age-adjusted mortality rates by race per 1,000 population, Lowndes County compared to Mississippi and the U.S. (2010).

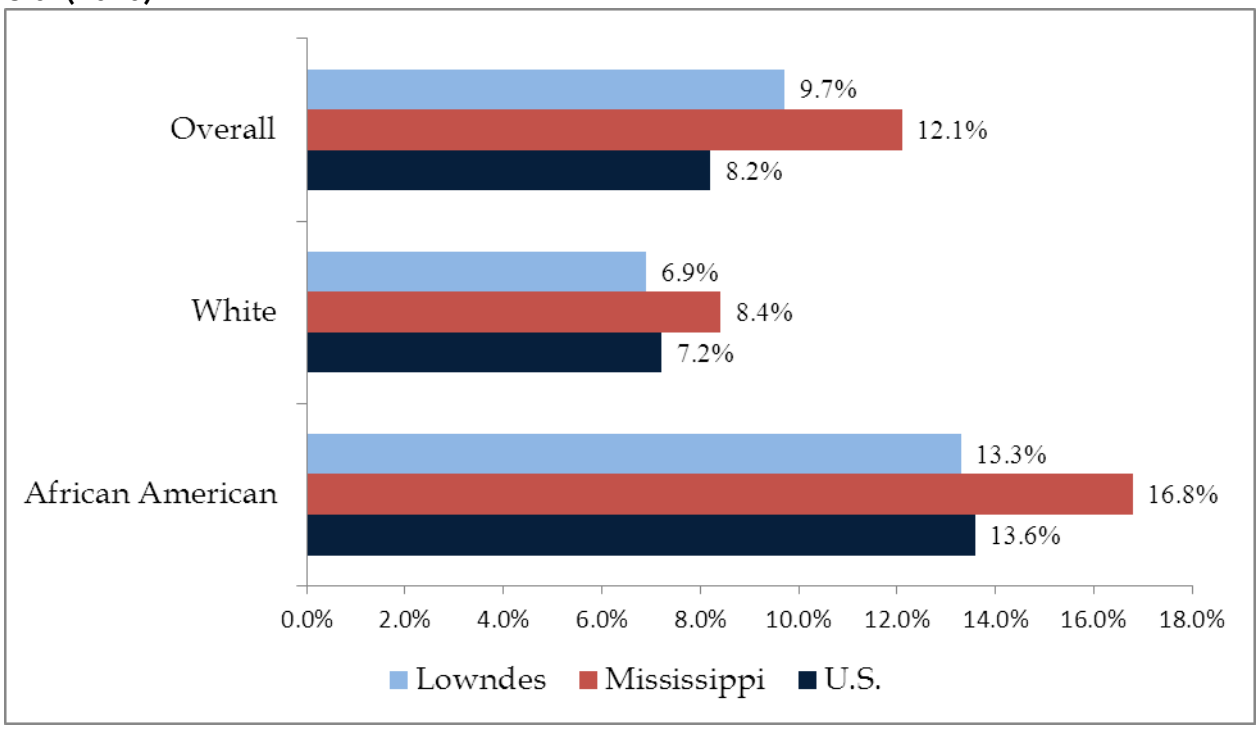


The county's **infant mortality rate** is similar to the statewide rate, but exceeds the rate nationally. Specifically, the infant mortality rate among African American newborns exceeds state and national figures. This is the opposite of what is seen for White newborns, where the local rate is lower than the statewide and national rate. Birth weight is also tracked and shows that throughout the county, the percentages of low birth-weight and very low birth-weight babies are both lower than Mississippi and equal to or lower than the U.S. As is seen throughout the country, low birth-weight statistics are elevated among African Americans and Lowndes County follows this trend. The rate of teen pregnancies in the county (64.6 per 1,000 females) is above statewide (55) and nationally (34.3). On a positive note, most expecting mothers locally receive prenatal care in the first trimester.

Infant mortality rates by race per 1,000 population, Lowndes County compared to Mississippi and the U.S. (2006 – 2010, 5-year averages).

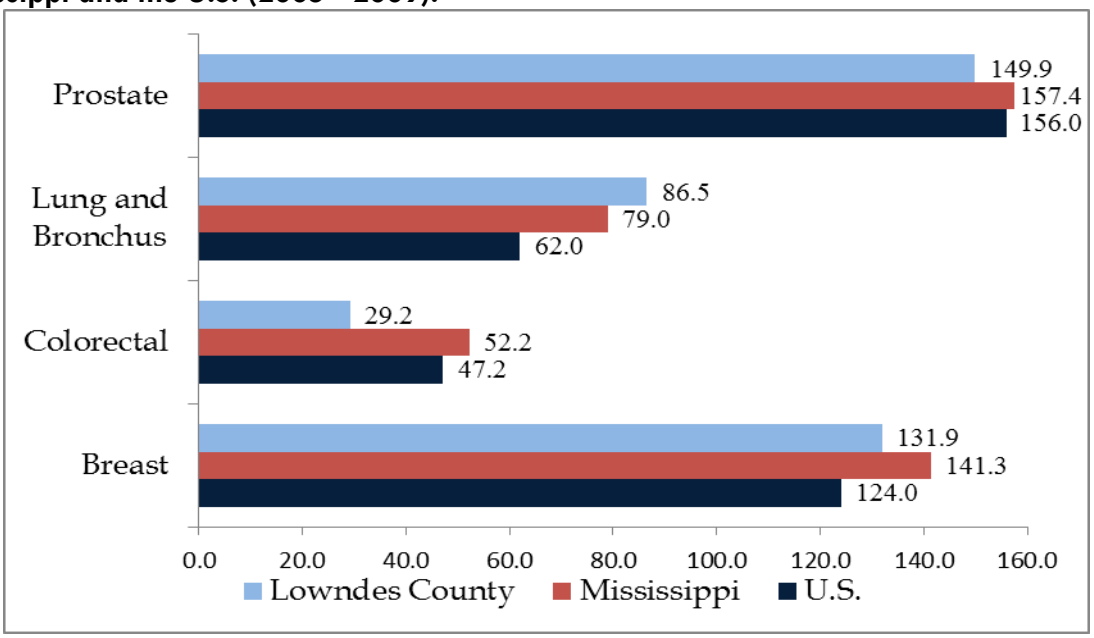


Percentage of low birth weight by race, Lowndes County compared to Mississippi and the U.S. (2010).

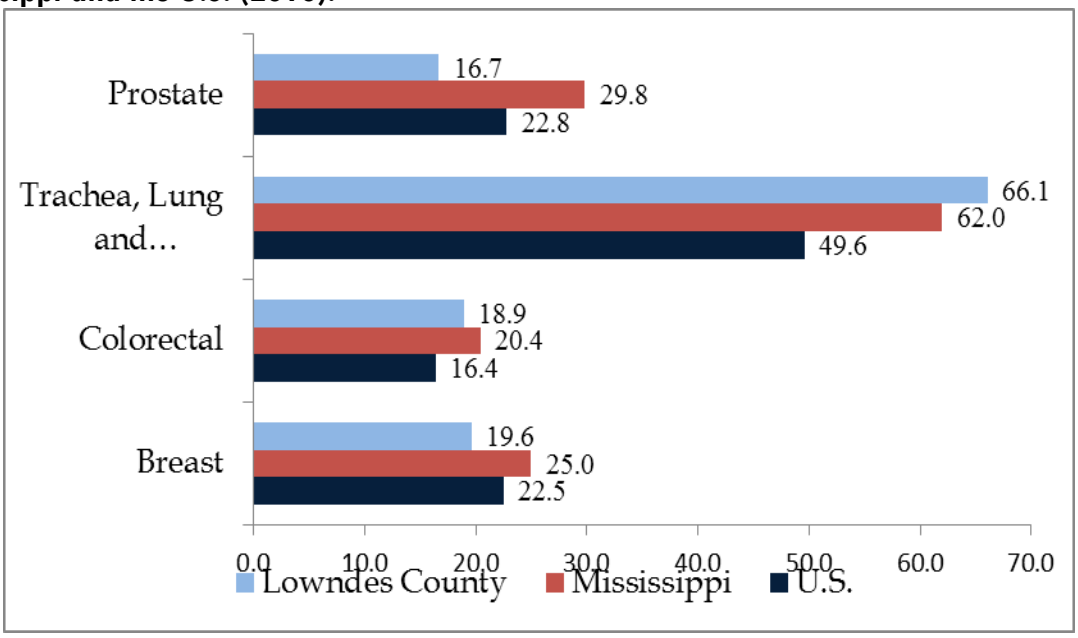


Overall **cancer** incidence rates within Lowndes County are lower than what is seen statewide and nationally. The overall cancer incidence rate is 423.3 per 100,000 individuals, which is below Mississippi (503.9) and the U.S. (464.4). The one exception to this is the incidence of lung cancer. The local incidence rate is 86.5, which is above the 79.0 for the state and 62.0 for the country. The overall mortality rate due to cancer is 169.5 throughout the county compared to 201.1 statewide and 175.8 nationally.

Cancer age-adjusted incidence rates per 100,000 population, Lowndes County compared to Mississippi and the U.S. (2005 - 2009).

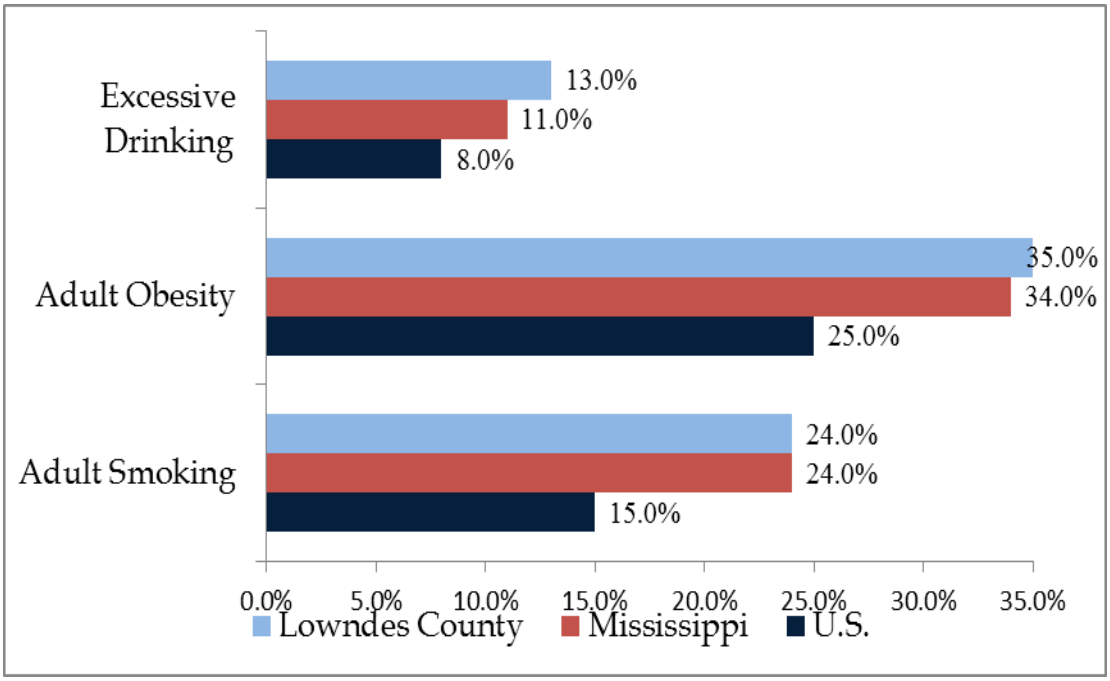


Cancer age-adjusted Mortality rates per 100,000 population, Lowndes County compared to Mississippi and the U.S. (2010).



Health risk factors such as smoking, excessive drinking and an unhealthy weight are all related to poorer health outcomes. Unfortunately in Lowndes County, all of these indicators are more prevalent than throughout the U.S. For the most part, Lowndes County residents are very similar to their peers throughout the state in their likelihood of being obese and their propensity to drink alcohol and smoke cigarettes. Thirteen percent (13%) of area adults drink excessively, 35% are technically obese and 24% smoke cigarettes on a regular basis. Again, these are all above what is seen throughout the U.S.

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



In closing, the secondary data points to some key opportunities throughout Lowndes County. The socioeconomic indicators for the area point to lower income levels, higher unemployment rates, fewer homeowners and a decreasing population. A number of racial disparities are evident. African Americans living in the county have a higher mortality rate, both adults and infants, than statewide and national benchmarks. Additional statistics point to concerns with the rate of alcohol use and cigarette smoking. On a positive note, with the exception of lung cancer, the incidence and mortality rates for cancer are lower throughout Lowndes County.

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 Medicaid. 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.

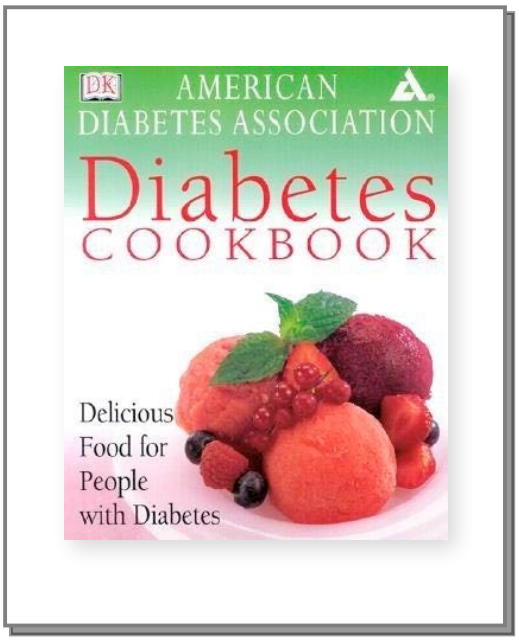
When asked where uninsured and underinsured individuals go for health care, participants indicated that uninsured residents often utilize the Emergency Department for primary health care because the Emergency Department will not turn them away if they do not have insurance. Others forgo care. Co-pays, 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 Memorial Hospital-Golden Triangle service area. The following list outlines the key needs that were identified.

- **Access to care:** Access to primary care, as well as access to preventive care, is increasingly an issue throughout the country. These issues appear more pronounced locally. The rate of uninsured is higher and more adults report that they have not been able to see a doctor because of cost. Additionally, fewer adults in the area report that they have on person they think of as their regular doctor or health care provider. Key informants shared concerns as well about the ability for residents to obtain the healthcare services that they need as did focus group participants.

- **Alcohol consumption:** Key informants pointed to concerns about substance abuse among residents. The household survey did not dig deeper into addiction issues, but the secondary data profile revealed that significantly more adults in Lowndes engage in excessive drinking.

- **Lung cancer:** In general, cancer rates in Lowndes County are below what is seen throughout the country. The exception is in the rates for lung cancer. In Lowndes County, more individuals have lung cancer and are more likely to die from the lung cancer than statewide and nationally.

- **Diabetes:** Related to obesity, as well as a number of other chronic illnesses, is the incidence rate of diabetes. There are more individuals in the hospital's service area who have been diagnosed with diabetes when compared against the U.S. overall. Focus group participants elaborated on their experiences with diabetes and difficulties with self-management of diet and general physical health. They anecdotally shared of the comorbidity between diabetes and other chronic illnesses. While the focus group participants spoke of the need for greater awareness of available services and increased need for education, the household survey identified that fewer individuals with diabetes locally have attended a class or course on how to manage their diabetes.

- **Obesity:** All four research components pointed to local issues with obesity. The household survey identified that the majority of local adults are overweight or obese as did the secondary data profile. The household survey also revealed that the majority of overweight or obese adults in the area have not been told by their doctor or health care provider that they are obese or overweight. The connection between obesity and chronic illness (e.g. diabetes) was noted multiple times during the focus groups and in the key informant interviews as well. Many suggestions were made to improve accessibility to healthy foods as well as recreational opportunities such as walking paths, community parks, etc.

- **Racial disparities:** There are significant disparities between White and African American residents in the county. With some exceptions (e.g. cancer), health status and outcomes are worse among African American residents. The mortality rate among African Americans locally is significant higher than that of Whites. The pattern is the same with regard to the infant mortality rate.

- **Smoking:** Lung cancer incidence rates and mortality rates are much higher in the hospital's service area than statewide and nationally. The secondary data also revealed that more adults in the county smoke cigarettes than nationally. Chewing tobacco rates for the hospital's service area exceed state and national rates.

- **Social determinants of health:** The data reveals an area were many residents live in poverty and rent their homes as opposed to owning them and where fewer adults have advanced degrees. These statistics present a number of barriers to obtaining needed health care, to purchasing fresh fruits and vegetables and living a life focused on prevention. The connection between poverty and health outcomes has been noted in many studies and is an area of concern locally.

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 community health issues:

- 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 (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 Memorial Hospital-Golden Triangle 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 Memorial Hospital-Golden Triangle 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 Memorial Hospital-Golden Triangle 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 Memorial Hospital-Golden Triangle 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 Memorial Hospital-Golden Triangle 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.