NEA BAPTIST MEMORIAL HOSPITAL

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

NEA Baptist Memorial Hospital is an affiliate of Baptist Memorial Health Care, an award-winning network dedicated to providing compassionate, high-quality care for patients. The 100-bed facility has partnered with NEA Baptist Clinic to provide integrated health care in the Northeast Arkansas area. The hospital offers a number of services, including cancer, emergency, neurology, radiology, and surgery. The hospital's Women's Center offers labor and delivery services, as well as childbirth and breastfeeding classes. Its Heart Center offers interventional cardiology, cardiac rehabilitation, and chest pain emergency care, among other services.

NEA Baptist Health System is in the process of building a new medical campus which will include a new hospital and specialty clinic as well as a free standing cancer care center on the northeast side of Jonesboro.

Definition of Service Area

NEA Baptist Memorial Hospital serves residents in the northeast Arkansas region. For the purposes of the CHNA, the hospital focused on its primary service area of Poinsett and Craighead Counties, Arkansas. The following zip codes were included in the household study:

72354	72411	72419	72437
72365	72414	72421	72447
72386	72416	72429	72472
72401	72417	72432	72479
72404			

CHNA Background

NEA Baptist Memorial Hospital, 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 NEA Baptist Memorial Hospital 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 NEA Baptist Memorial Hospital service area.

The findings from the CHNA were reviewed and health needs were prioritized to develop the hospital's Community Health Implementation Strategy. NEA Baptist Memorial Hospital's 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 health care 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 548 adults from the NEA Baptist Memorial Hospital 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 to 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. 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, health care consumers from the hospitals' service areas participated in **focus groups**. The focus groups addressed diabetes and pre-diabetes based on findings from the surveys. 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 staff from Holleran. 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

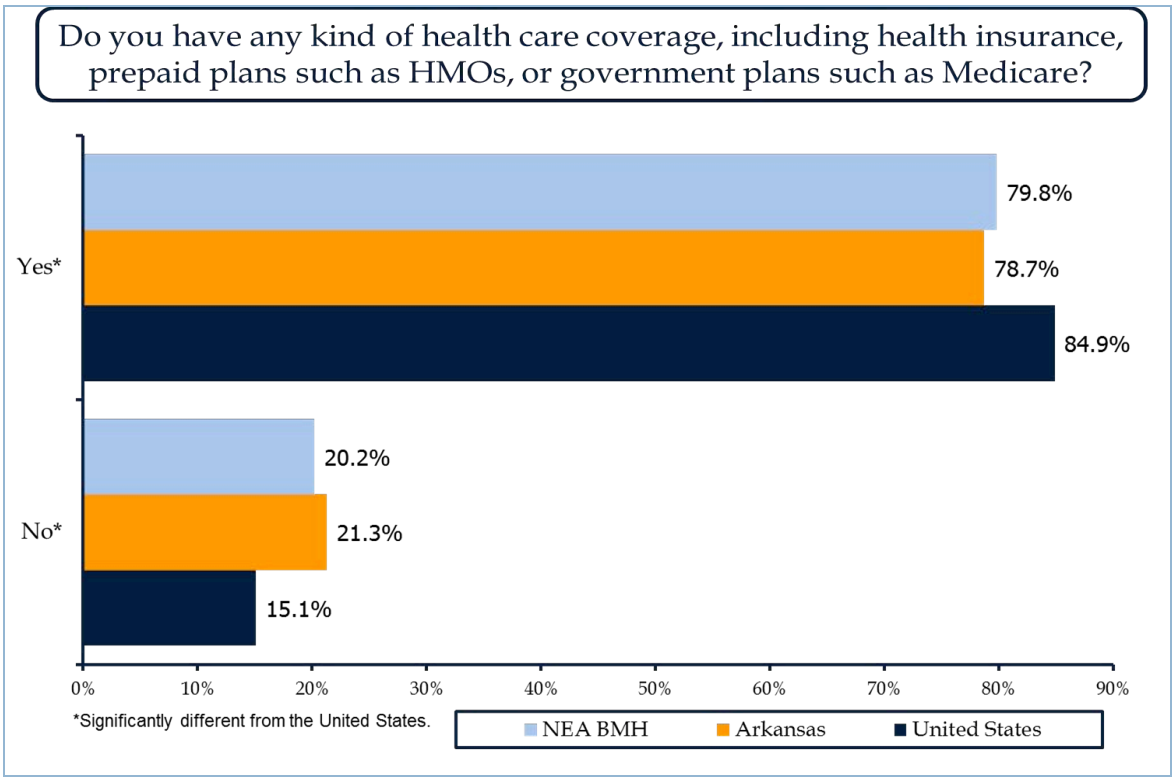
A report of the CHNA was made public on the hospital's website in September 2013. The Final Report serves as a compilation of the overall key findings of the CHNA. Detailed reports for each individual component were provided separately. An Implementation Strategy of how the hospital will address the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

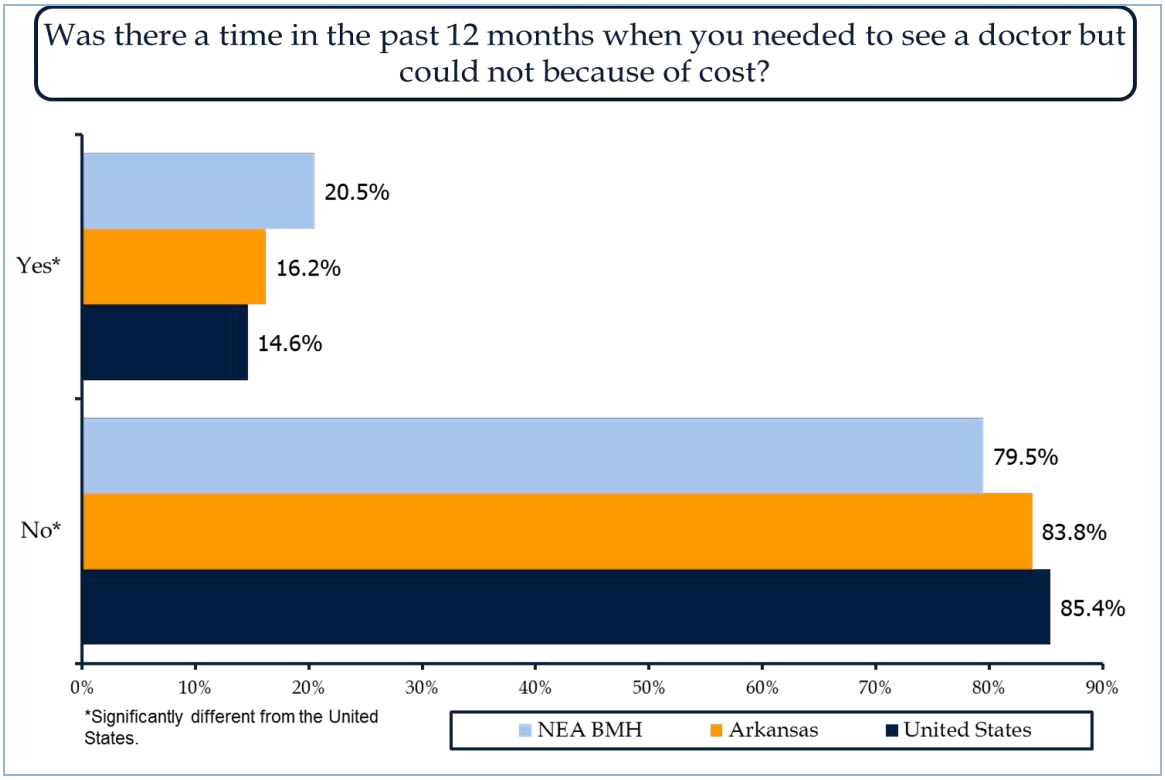
KEY ASSESSMENT FINDINGS

Household Survey Key Findings

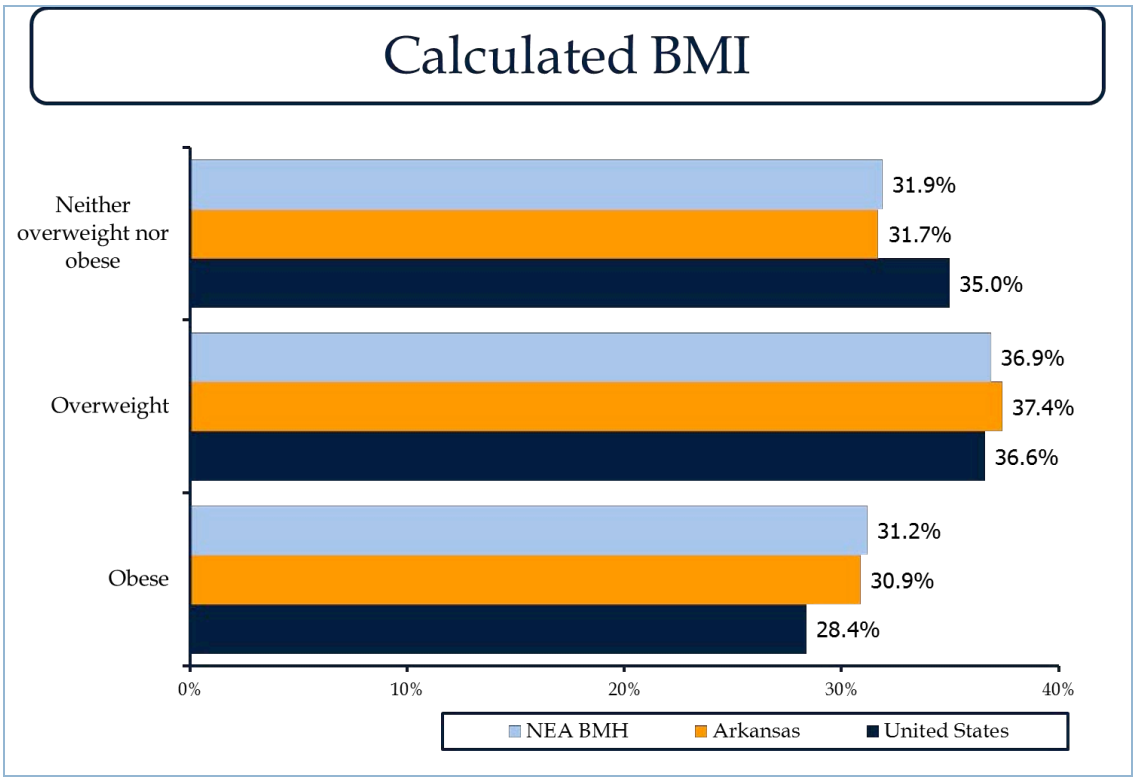
A household survey of the NEA Baptist Memorial Hospital service area included 548 randomly selected adults. The respondents were asked to rate their own health status, to provide information on behaviors and prevention activities, and to report the incidence of a variety of chronic illnesses such as diabetes and cardiovascular disease. When asked to rate their **general health**, 68.9% responded "good," "very good" or "excellent." Despite this strong majority, this is below the Arkansas (80.8%) and U.S. (83.6%) percentages. Adults locally were more likely to rate their health as "poor" or "fair" compared to these benchmarks. In addition to lower ratings for general health, the adults that were surveyed also reported more days of poor physical or mental health and days where their health interfered with daily functioning. With regard to days of poor mental health, area females were more likely than area males to report at least one poor mental health day in the previous month (55.6% vs. 29.4%).

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 80% of those surveyed reported that they have some form of health insurance. This is similar to Arkansas (78.7%), but is lower than the U.S. percentage (84.9%). When asked if they have one person they think of as their personal doctor or health care provider, 21.3% responded "no." This is a higher percentage when compared to Arkansas (16.3%). A similar percentage, 20.5%, reported that they have had a time in the past year when they could not see a doctor because of cost. This compares to 16.2% throughout Arkansas and 14.6% throughout the U.S. On a positive note, 75.1% of area adults have had a regular checkup in the past year, which is better than the 59.4% statewide and 68.1% nationally. Males and females in the hospital's service area did not differ in their likelihood of having a checkup in the past year.

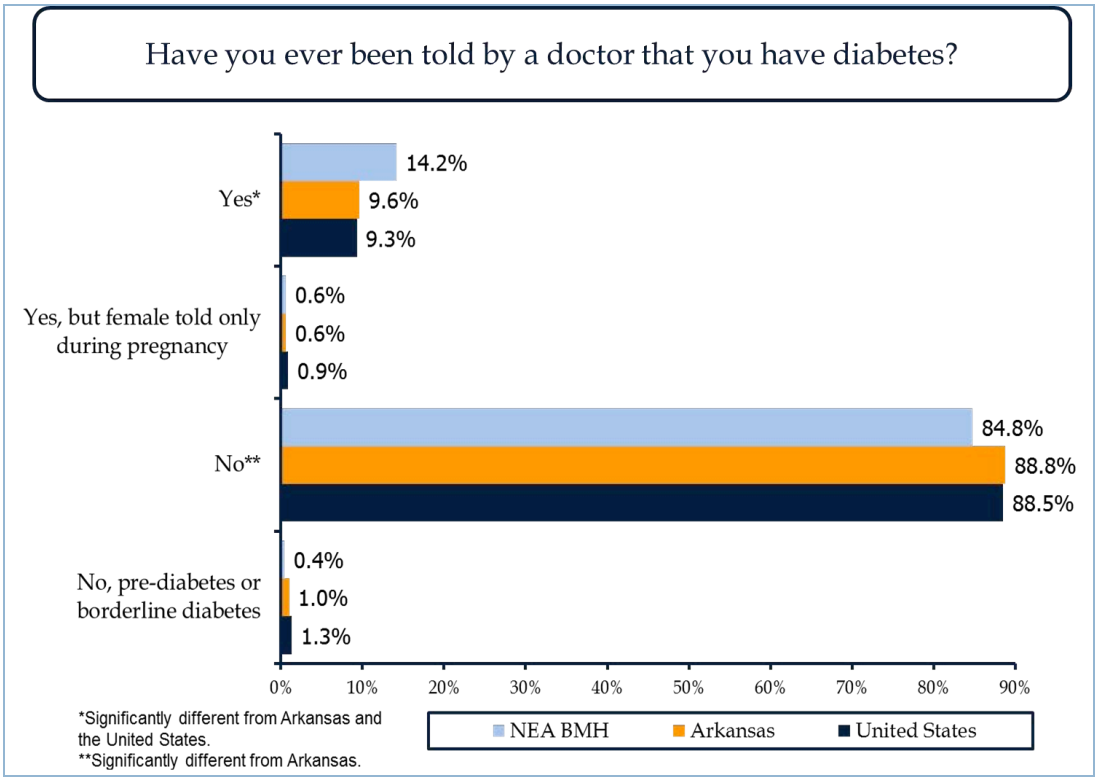




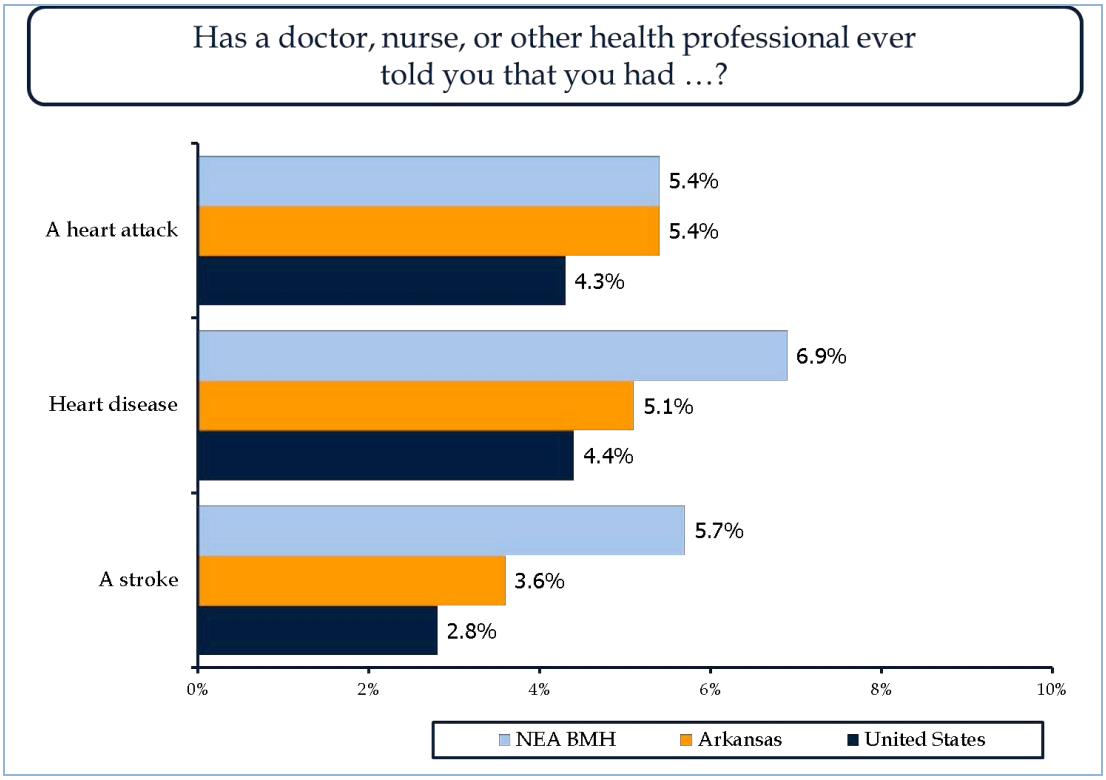
Weight and nutrition was assessed as well. **Body Mass Index (BMI)** was calculated for each survey respondent based on their reported height and weight. As shown in the graph below, approximately 31% of area adults are obese and another 36.9% are overweight. This looks similar to BMI statistics for the state of Arkansas, but compares less favorably to U.S. statistics. Additionally, 71.2% of those surveyed exercise in a typical month. This is similar to the 70.2% statewide, but slightly below the 75.6% nationally. Interestingly, while the BMI statistics show that 68.1% of area adults are overweight or obese, only 18.7% stated that they had been told by a health professional in the past two years that they were overweight or obese. Nearly 66% of those surveyed reported that they eat the recommended amount of fruits and vegetables on most days of the week. Sixty-eight percent (68%) of males locally report they eat the recommended number of servings compared to 63.9% of females.


Calculated BMI
Neither overweight nor obese
31.9%
31.7%
35.0%
Overweight
36.9%
37.4%
36.6%
Obese
31.2%
30.9%
28.4%
0%
10%
20%
30%
40%
NEA BMH
Arkansas
United States

Closely linked to being overweight or obese is the incidence of **diabetes**. Roughly 14% of survey respondents reported being told by a doctor that they have diabetes. This is greater than both the rate for Arkansas (9.6%) and the U.S. (9.3%). Roughly 45% also reported a family history of diabetes. The age of onset for their diabetes is similar to what is seen nationally. Approximately 36% of respondents with diabetes report taking insulin, 74.4% check their blood glucose levels, and 78.9% examine their feet daily for sores or irritations. Roughly three out of 10 of those with diabetes indicated that the disease has affected their eyes, which is above the 19.3% seen nationally. Slightly less than half of area individuals with diabetes (45%) have taken a course or class in how to manage their diabetes, compared to 54.8% throughout the country. There was not a significant difference between males and females with regard to having a diabetes diagnosis, but more males than females reported that they had taken a course or class on how to manage their diabetes (51.2% vs. 39.2%). Across all survey respondents, both those with and without diabetes, 55.4% have had a test for high blood sugar at some point in the previous three years. This is similar to what is seen nationwide. Locally, males were more likely to have had their blood sugar tested than females (63.3% vs. 47.8%).



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 Arkansas and the U.S. When asked if they have ever had a heart attack or myocardial infarction, 5.4% responded "yes." Slightly more (6.9%) stated that they have had a diagnosis of heart disease compared to 5.1% for Arkansas and 4.4% for the U.S. The incidence of stroke is similar to Arkansas, but statistically above the U.S. percentage. Nearly 6% have had a stroke compared to 3.6% statewide and 2.8% nationally. When asked about family history, 52% of those surveyed indicated that there is a family history of heart disease. No statistically significant differences were noted between males and females for any of the cardiovascular disease items.



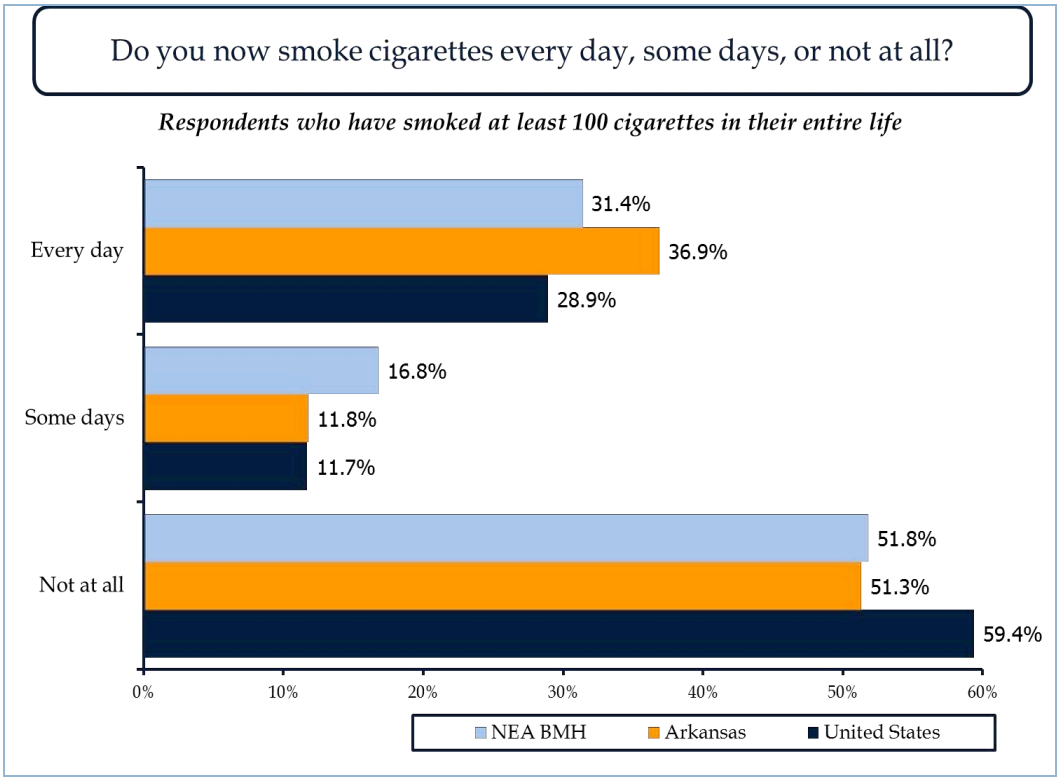
Those surveyed were asked a number of questions regarding **asthma**. Approximately 12% of area adults reported that they have had asthma at some point in their lifetime and within that group, 82.6% still have asthma. This rate is higher than the state (60.2%) and the U.S. (65.5%) benchmarks. Area asthma sufferers were also more likely to report diagnosis at a younger age and having had an asthma attack in the past year compared to national statistics.

Roughly 33% of the survey respondents reported being limited in some way because of physical, mental, or emotional problems. Additionally, 13.8% 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.

The status of the residents' **oral health** was assessed by asking a question regarding tooth decay and gum disease. Around 46% of those surveyed indicated that they have had at least one tooth removed because of gum disease or tooth decay. This is better than the percentage throughout Arkansas (54.1%), and similar to what is seen throughout the U.S. (45.5%). Among those who have had their teeth removed, more

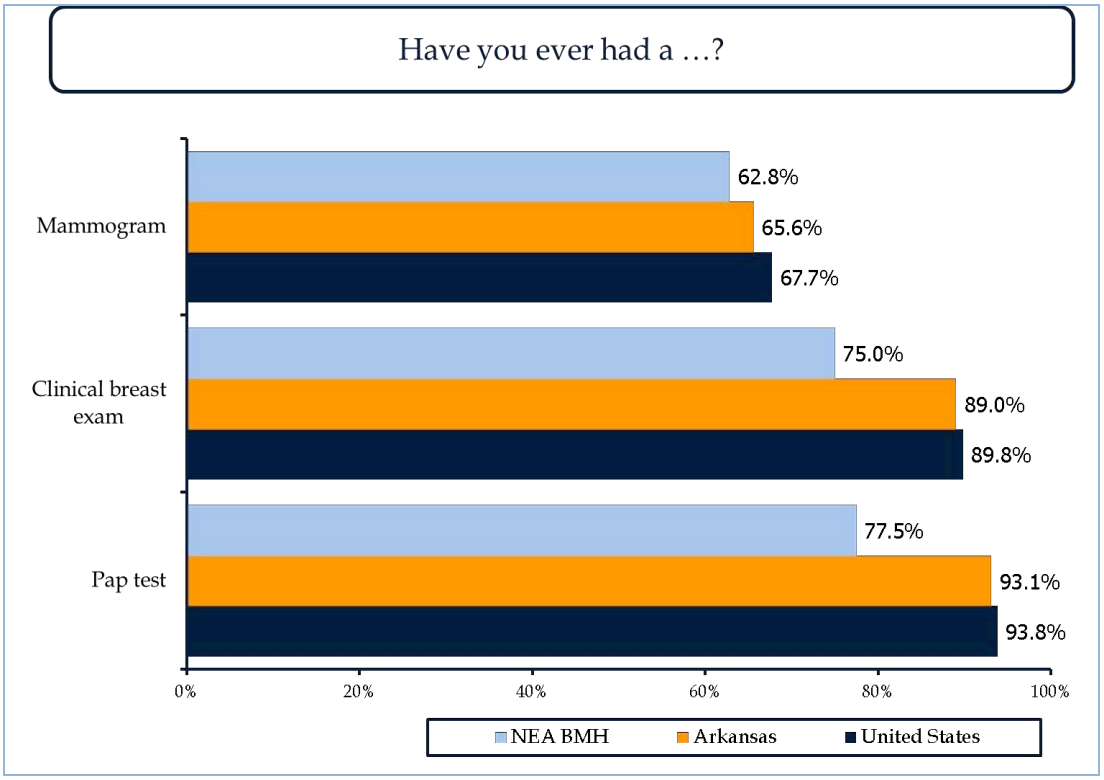
have had all of their teeth removed because of decay or gum disease. About 11% reported having all of their teeth removed, compared to 7.8% for Arkansas and 4.9% for the U.S.

Tobacco use was assessed through questions regarding cigarette smoking and chewing tobacco. Nearly 42% of those surveyed stated that they have smoked at least 100 cigarettes in their lifetime. This is slightly below Arkansas (47%), but equal to the U.S. (42%). As depicted in the following graph, 31.4% of these adults now smoke "every day" and another 16.8% smoke on "some days." These rates are similar to Arkansas, but higher than what is seen nationally. On a positive note, among those who smoke regularly, 72.1% reported that they had quit smoking for at least one day or longer in the past year. This is above the 55.8% for Arkansas and 59% nationally. Locally, males were more likely to have smoked at least 100 cigarettes in their lifetime compared to females (51.6% vs. 32.1%). Adults locally are also more likely than their peers nationally to use chewing tobacco or snuff. Roughly 8% reported that they use chewing tobacco every day or some days compared to 3.2% nationally. Males were more likely to report that they use chewing tobacco than females.

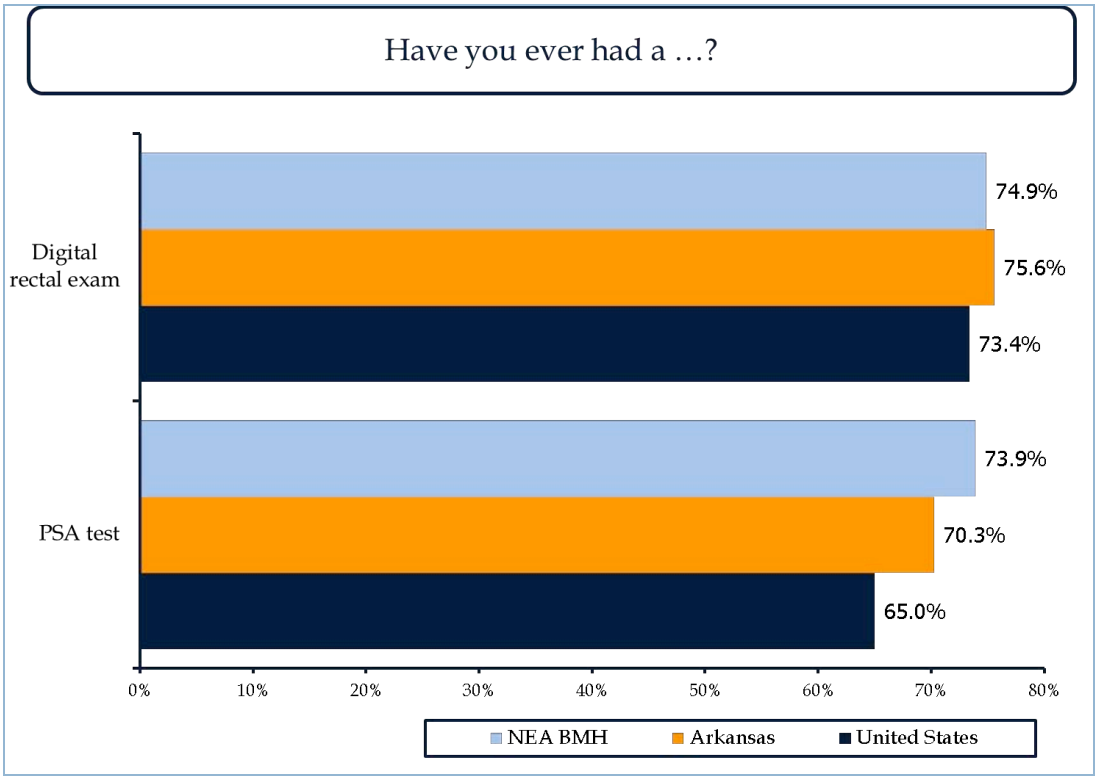


Seatbelt use stood out as an area of strength locally. The vast majority (84.4%) "always" wears seatbelts. This is similar to the U.S. (86.6%), but better than Arkansas (76.5%).

Female respondents were asked a variety of **women's health** questions. About 63% of area females have had a mammogram during their lifetime. This compares to 65.6% statewide and 67.7% nationally. While females locally are comparable to females statewide and nationally with regard to mammograms, the percentage who have had a clinical breast exam is significantly lower than what is seen throughout Arkansas and the U.S. Seventy-five percent (75%) of females locally have had a clinical breast exam. Statewide, the figure is 89% and nationally, the percentage is 89.8%. Pap tests compare unfavorably as well. Nearly 78% of area females have had a Pap test in their lifetime, which is well below the 93.1% throughout Arkansas and 93.8% throughout the country. Roughly one-third of area females have had a hysterectomy, similar to Arkansas, but slightly higher than the U.S.



Tests for **prostate cancer** include Prostate Specific Antigen (PSA) tests and digital rectal exams. These questions were asked of area males 40 years and older. Approximately 74% of the males in this age range have had a PSA test, which is above Arkansas (70.3%) and the U.S. (65%). A similar percentage of males have had a digital rectal exam, 74.9% locally compared to 75.6% statewide and 73.4% nationally. While the likelihood of ever having had a digital rectal exam compares favorably, the regularity of the test does not. Around 42% have had the test in the past year compared to 45.5% statewide and 51.9% nationally. When asked if they ever had a diagnosis of prostate cancer, 4.1% confirmed they had, similar to the state and national percentages.

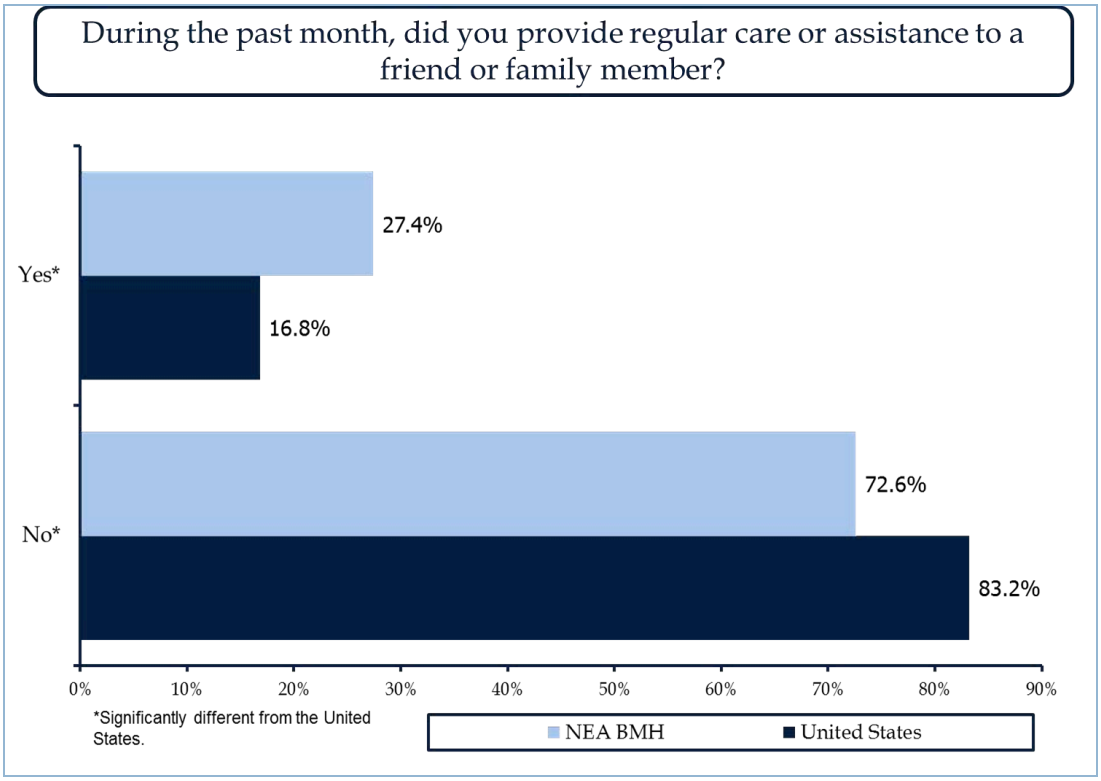


Colorectal cancer screening questions were included in the survey, as well. Around 38% of adults 50 years and older have had a blood stool test using a home kit, similar to statewide (40.3%), and nationally (38.6%). A higher percentage reported having had a colonoscopy or sigmoidoscopy. Around 63% of adults 50 and older have had a sigmoidoscopy or colonoscopy, similar to the 61% throughout Arkansas and 65.6% throughout the U.S.

About one out of 10 adults (9.7%) surveyed reported that they have had **cancer** at some point in their lifetime. This compares to 9.4% nationally. The most commonly reported cancers on the survey were breast cancer, non-melanoma skin cancer, and prostate cancer. One area of significant difference when compared to the national statistics is the percentage of individuals who reported thyroid cancer. Locally, 8.2% reported thyroid cancer compared to 2.5% nationally. Of those who have had cancer, 16.8% are currently receiving treatment for their cancer. On the survey, there were no statistically significant differences between males and females and their likelihood of having cancer.

Arthritis was reported by 35.2% of area adults. This is above what is seen nationally (30.3%). Locally, females were more likely to report being diagnosed with some form of arthritis, gout, lupus, or fibromyalgia compared to males (42.3% vs. 27.8%).

Caregiving is increasingly an issue throughout the country as the number of older adults continues to grow. Approximately 27% 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 (69.5%) take care of someone who is 65 years or older. Locally, males and females were just as likely to provide caregiving to a friend or family member.



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 also less healthy for obesity, diabetes, exercise, and stroke. Additional risky behaviors such as regular cigarette smoking and use of chewing tobacco put area adults at increased risk for poorer health outcomes. Women's health screenings for the area also reveal lower rates for mammograms, clinical breast exams, and Pap tests.

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 Craighead and Poinsett Counties, Arkansas. Craighead County is the home county for NEA Baptist Memorial, but Poinsett County also represents a large proportion of the hospital's service area. 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 less favorable to these comparisons.

The **demographics** of an area, as well as demographic shifts, can have a dramatic impact on the health care system. While Craighead County saw a 17.4% increase in population between 2000 and 2010, Poinsett County only saw a 4% decrease. When looking at the population by age, Craighead County has a younger population with more residents 0-14 years and fewer 65+ years compared to Poinsett County. The racial composition in Craighead County is more diverse than Poinsett County. Craighead County has a higher proportion of African American and Hispanic/Latino residents. For both counties, more than 95% of households are English-speaking only.

Population by Age (2010)

	U.S.		Arkansas		Craighead County		Poinsett County	
	n	%	n	%	n	%	n	%
0-14 years	61,227,213	19.8	592,125	20.4	20,334	21.1	4,941	20.1
15-19 years	22,040,343	7.1	203,805	7.0	7,570	7.8	1,708	6.9
20-24 years	21,585,999	7.0	199,650	6.8	8,758	9.1	1,414	5.8
25-34 years	41,063,948	13.3	375,892	12.9	13,912	14.4	2,766	11.3
35-54 years	86,077,322	27.9	773,474	26.5	24,049	25.0	6,668	27.1
55-64 years	36,482,729	11.8	350,991	12.0	10,080	10.5	3,186	13.0
65 years and over	40,267,984	13.1	419,981	14.5	11,740	12.1	3,900	15.7

Source: U.S. Census Bureau, 2010

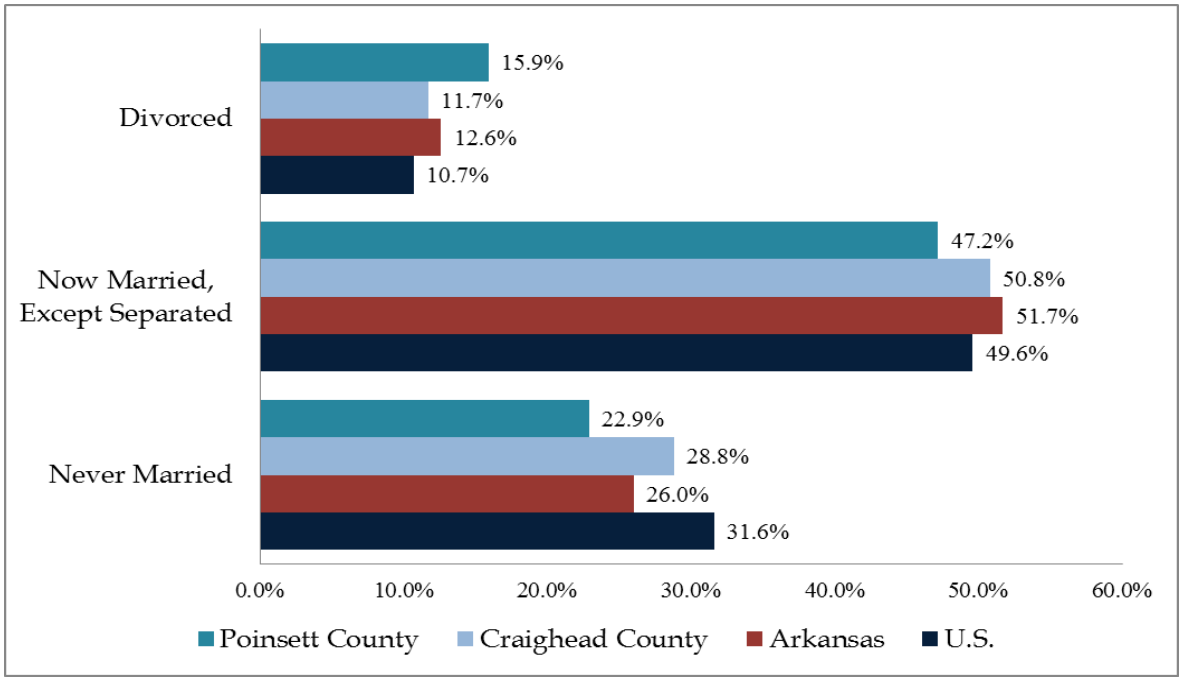
Household statistics for both counties show fewer vacant households than what is seen statewide and nationally. Average household sizes are similar to what is seen throughout Arkansas and the U.S. When looking at the percentage of single-parent households, Poinsett County has a higher proportion than Craighead County, Arkansas, and the nation. Nearly 14% of households in Craighead County are single-mother households, which is similar to Arkansas and the U.S. Poinsett County, on the other hand, has 15.1% of single-mother households. Likewise, the proportion of divorced adults in Poinsett County exceeds statewide and national figures. Divorces are not as common in Craighead County.

Households by Occupancy, Type, and Value (2010)

	U.S.		Arkansas		Poinsett County	
Female householder, no husband present	15,250,349	13.1	153,323	13.4	1,477	15.1

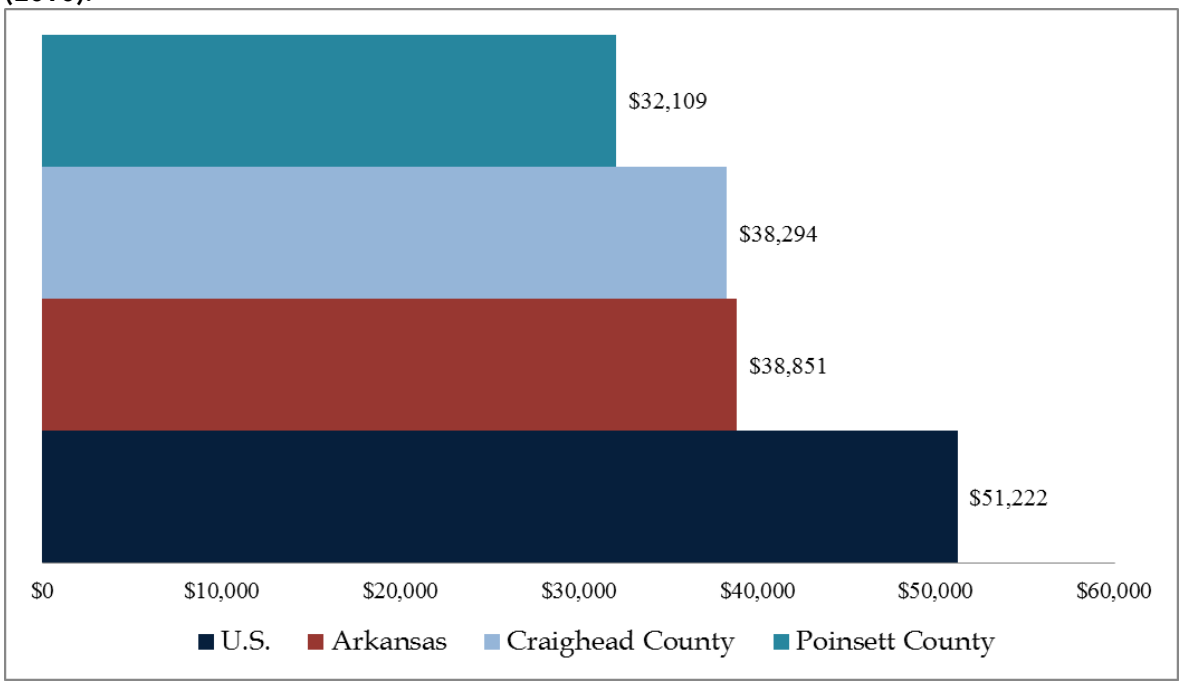
Sources: U.S. Census Bureau, 2010; U.S. Census Bureau, 2008-2010 ACS 3-year estimates

Marital status percentages, Poinsett County and Craighead County compared to Arkansas and U.S. (2010).



Income levels in the two counties differ. Craighead County income levels look very similar to Arkansas. Poinsett on the other hand, has a median household income about $6,000 less than Craighead. Both counties, however, are comprised of households whose median income levels are below what is seen nationwide. Arkansas as a whole is below the U.S. median income. Poverty rates for both counties exceed the U.S. figures and in many cases, the Arkansas figures as well. About 27% of all individuals in Poinsett County and nearly 21% in Craighead County live in poverty, compared to Arkansas, 18%, and the nation, 14%.

Median household income, Poinsett County and Craighead County compared to Arkansas and U.S. (2010).



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

	U.S.	Arkansas	Craighead County	Poinsett County
All families	10.5%	13.8%	16.4%	21.3%
With related children under 18 yrs	16.5%	22.5%	24.7%	33.1%
With related children under 5 yrs	17.9%	25.6%	33.6%	17.0%
Married couple families	5.1%	6.7%	7.1%	11.4%
With related children under 18 yrs	7.5%	10.4%	10.2%	18.3%
With related children under 5 yrs	6.8%	11.3%	18.5%	22.6%
Families w/ female householder, no husband	29.2%	38.1%	45.2%	42.9%
With related children under 18 yrs	38.1%	47.4%	54.6%	49.3%
With related children under 5 yrs	46.1%	53.8%	58.4%	10.6%
All people	14.4%	18.4%	20.7%	27.2%
Under 18 years	20.1%	26.8%	29.5%	41.7%
Related children under 18 years	19.7%	26.5%	28.9%	41.3%
18 years and over	12.5%	15.6%	17.7%	22.7%
65 years and over	9.4%	11.5%	11.3%	22.1%
Unrelated individuals 15 years & over	25.4%	31.3%	33.3%	37.2%

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

Individuals living and working in Craighead County are more likely than workers in Poinsett County to be employed closer to their homes. The average commute time for a Craighead County resident is 17.7 minutes while the commute time for Poinsett residents is 23.8 minutes, which is also closer to state and national averages.

The number of uninsured adults in Poinsett County is estimated to be nearly 20% compared to 17.5% in Craighead County. In Arkansas, 17.2% are estimated to be uninsured while 15% are uninsured nationally. As detailed in the table below, education levels for Craighead County are fairly similar to Arkansas and, in some instances, similar to the U.S. Poinsett County, however, falls below Arkansas averages regarding educational attainment. Both counties have fewer individuals with college degrees than what is seen nationally.

Educational Attainment, Population 25 Years and Over (2010)

	U.S.	Arkansas	Craighead County	Poinsett County
Less than 9th grade	6.2%	6.7%	6.3%	11.8%
Percent high school graduate or higher	85.3%	82.5%	82.7%	73.3%
Percent bachelor's degree or higher	28.0%	19.0%	22.4%	9.5%

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

The overall age-adjusted **mortality rates** for both counties exceed the mortality rate nationwide. The age-adjusted mortality rate for Craighead County is actually slightly lower than Arkansas as a whole. For Craighead County, stroke and accident death rates exceed state and national rates. Within Poinsett County, death rates for heart disease, malignant neoplasms (cancer), stroke, accidents, and chronic lower respiratory disease are all above state and national rates.

Mortality, All Ages by Race (2008)[a]

	U.S.	Arkansas	Craighead County	Poinsett County
Age-Adjusted Rate	7.6	9.1	8.9	11.1
White	7.5	8.9	8.8	11.3
African American	9.3	11.0	9.6	8.9

Sources: Arkansas Department of Health, 2008; Center for Disease Control and Prevention, 2008; [a] Rates per 1,000 population

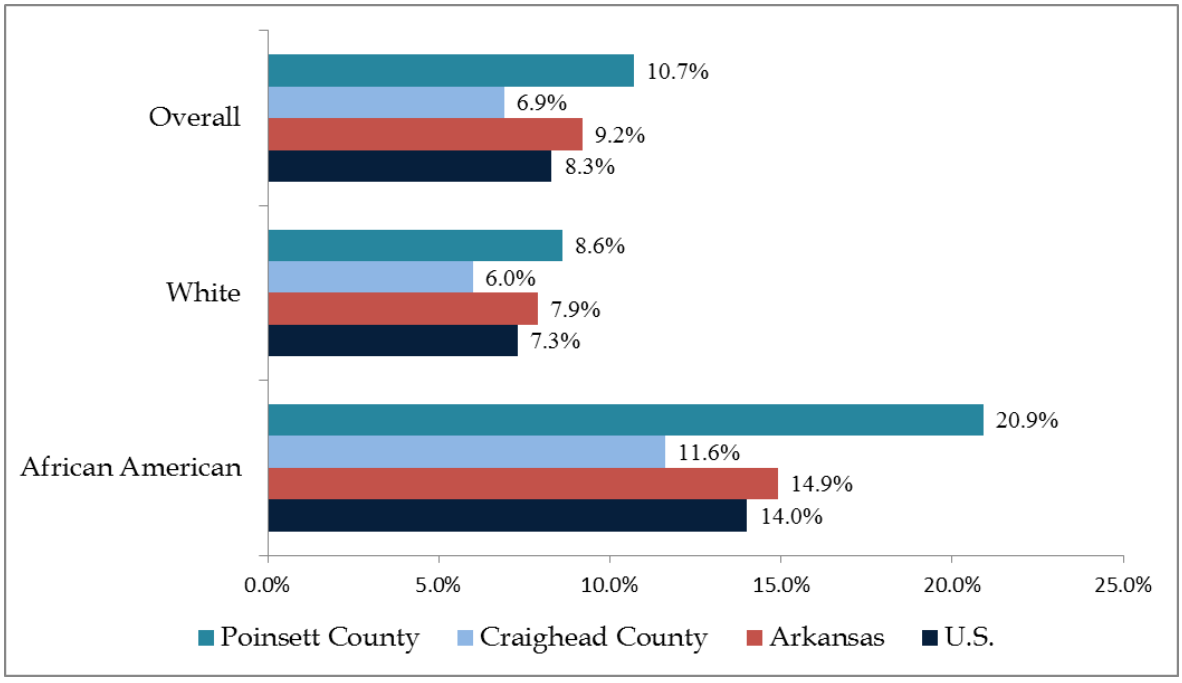
Infant mortality rates across both counties are alarming. The table below shows that African American infants are much more likely to die in both counties than White infants. Racial demographics aside, all infants born in Craighead County and Poinsett County have a higher likelihood of mortality than infants throughout Arkansas and the U.S. Birth rates in each county are fairly similar to state and national rates. The proportion of low birth rate babies in Craighead County compares similarly to state and national figures, but Poinsett County reveals higher rates of low-birth weight babies, especially among African American infants. The percentage of teen pregnancies is also greater in Poinsett County than Craighead County. The proportion of mothers who receive first-trimester prenatal care, while similar to Arkansas overall, is below the national percentage.

Infant Mortality Rates by Race (2002 – 2006, 5 – year averages)[a]

	U.S.	Arkansas	Craighead County	Poinsett County
Infant	6.8	8.4	9.9	12.5
White	5.7	7.0	8.6	12.3
African American	13.8	13.9	18.7	15.0

Sources: Arkansas Department of Health, 2002 – 2006; Center for Disease Control and Prevention, 2002 – 2006; [a] Rates per 1,000 live births

Percentage of low birth weight by race, Poinsett County and Craighead County compared to Arkansas and the U.S. (2006).



Overall **cancer** incidence rates within each county are vastly different. As shown in the table below, the overall cancer rate in Craighead County is below Arkansas and the U.S. Poinsett County has a higher rate of cancer than the comparisons. Poinsett County residents are more likely to have a diagnosis of breast, colorectal, lung, or prostate cancer than statewide and nationally. Lung cancer incidence rates for both Craighead and Poinsett Counties exceed the national rate. The cancer mortality rates reveal a similar pattern.

Cancer Incidence by Site and Gender (2004 – 2008)[a]

	U.S.	Arkansas	Craighead County	Poinsett County
Breast (Female only)	124.0	109.0	100.3	127.7
Colorectal	47.2	48.0	41.6	68.2
Male	55.0	56.2	50.1	83.2
Female	41.0	41.4	34.9	57.8
Lung and bronchus	62.0	81.8	82.6	125.5
Male	75.2	109.2	113.7	171.4
Female	52.3	61.0	58.8	92.0
Prostate (Male only)	156.0	156.4	140.6	151.3
All Sites	**464.4**	**452.5**	**442.6**	**539.5**
Male	**541.0**	**548.6**	**531.4**	**645.6**
Female	**411.6**	**381.2**	**380.5**	**468.8**

Source: National Cancer Institute, 2004 - 2008
[a] Age-adjusted incidence rates per 100,000 population

Cancer Mortality by Site and Gender (2004-2008)[a]

	U.S.	Arkansas	Craighead County	Poinsett County
Breast (Female only)	23.5	24.0	26.9	*
Colorectal	17.1	18.9	18.0	18.9
Male	20.7	23.2	23.1	*
Female	14.5	15.6	14.2	*
Lung and bronchus	51.6	67.0	45.8	99.8
Male	67.4	93.2	71.5	147.3
Female	40.1	47.4	26.9	66.7
Prostate (Male only)	24.4	26.2	18.9	39.6
All Sites	**181.3**	**201.7**	**194.2**	**257.9**
Male	**223.0**	**254.9**	**250.2**	**340.9**
Female	**153.2**	**164.1**	**156.1**	**205.1**

Source: National Cancer Institute, 2004 – 2008; [a] Age-adjusted rates per 100,000 population
* Years with 3 or fewer cases are not reported due to confidentiality requirements

Health risk factors such as smoking, excessive drinking, and an unhealthy weight are all related to poorer health outcomes. Obesity percentages for both counties are higher than what is seen nationally. These figures are in line with Arkansas statewide statistics. Access to healthy food is more limited in these two

counties as well as recreational opportunities. Excessive drinking is also higher than nationally and for Poinsett County. The incidence of smoking exceeds state and national averages. Poinsett County also has a smaller proportion of primary care providers than Craighead County.

Health Behaviors (2011)

	National Benchmark[c]	Arkansas	Craighead County	Poinsett County
Adult smoking	15%	23%	21%	31%
Adult obesity	25%	30%	32%	34%
Excessive drinking	8%	13%	9%	13%

Source: County Health Rankings, 2011

[c] National Benchmark represents the 90th percentile and is not an average

In closing, the secondary data points to varied populations and health issues between Craighead County and Poinsett County. Of the two, Poinsett County has poorer health outcomes and more risky behaviors such as smoking and excessive drinking, as well as higher rates of cancer. Issues that span both counties include obesity, access to healthy foods, and recreational opportunities. These issues are likely compounded by higher poverty rates throughout the area. On a positive note, homicides and suicides in both counties are below statewide and national rates. Cancer rates for Craighead County are much better than what is seen throughout Arkansas and the U.S.

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 health care 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 health care 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 health care 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 health care 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 do 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 Health Care

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.

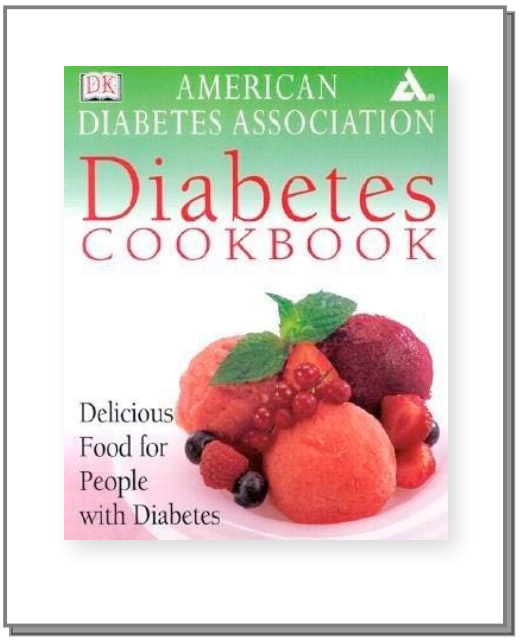
When asked where uninsured and underinsured individuals go for health care, participants indicated that uninsured residents often utilize the Emergency Department for primary health care because the Emergency Department will not turn them away if they do not have insurance. Others forgo care. Co-pays,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

- **Access to care:** All of the research components point to access to care as a key issue for residents. Key informants spoke of the ongoing need for care for the uninsured and underinsured. Focus group participants shared that their insurance, or lack thereof, can interfere with obtaining needed medications and supplies (e.g. testing strips, etc.). The household survey revealed that fewer adults in the area have health insurance coverage and are more likely to see cost as a barrier. Poverty rates and lower education levels in the area compound access to care issues. Specific to Poinsett County, the ratio of primary care providers to residents is much less favorable than Craighead County, Arkansas, and the nation.

- **Alcohol consumption:** Key informants pointed to concerns about substance abuse among residents. The secondary data profile revealed that significantly more adults across both counties engage in excessive drinking. The local figures exceed state and national percentages.

- **Cancer (lung):** Cancer incidence data varied dramatically between Craighead and Poinsett Counties. Poinsett County has a much higher rate of cancer incidence and mortality across all types of cancers. Lung cancer was an area of concern for both counties, with rates higher than what is seen in Arkansas and the U.S. Key professionals that were surveyed also identified cancer as one of the top health concerns. Smoking rates were also determined to be higher in the hospital's service area compared to other areas 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 Arkansas and 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 link 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.

- **General health:** Several measures from the assessment evaluated overall indicators of the community's health. Key findings from the household survey were that fewer adults reported "excellent" health and disability rates are higher among local adults. All of these factors are adjusted for age and therefore represented the overall adult population in the county.

- **Infant mortality rates:** The secondary data revealed that infants are dying at a faster rate in Craighead and Poinsett Counties than statewide and nationally. Related to this is the proportion of mothers who are receiving prenatal care in the first trimester. These percentages are lower in both counties when compared against U.S. percentages.

- **Obesity:** All four research components pointed to local issues with obesity. The household survey and the secondary data profile identified that the majority of local adults are overweight or obese. Access to healthy foods is limited in the area, as are recreational opportunities. 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.

- **Smoking:** Lung cancer incidence rates and mortality rates are much higher in the hospital's service area than statewide and nationally. The household survey also revealed that the percentage of "every day" smokers locally is above what is seen nationally and that chewing tobacco rates for the hospital's service area exceed state and national rates.

- **Social determinants of health:** Poverty levels are higher throughout the area than what is seen statewide and nationally. Education levels are lower of those who have earned a college degree or higher. Poinsett County residents show additional trends that are of concern, such as the decline in population and more aged population. These indicators are often referred to as social determinants of health as many studies have linked factors such as income and education to health status and outcomes.

- **Stroke:** The household survey respondents were more likely to report having had a stroke than respondents throughout Arkansas and the country. The mortality rate for strokes across both Craighead and Poinsett Counties also exceeds state and national rates.

- **Women's health:** Female survey respondents reported significantly lower rates of preventive screenings when compared against females throughout Arkansas and the U.S. Fewer local females have ever had a mammogram, have ever had a clinical breast exam and have ever had a pap test.

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 (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, NEA Baptist Memorial Hospital 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, NEA Baptist Memorial Hospital 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, NEA Baptist Memorial Hospital 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, NEA Baptist Memorial Hospital 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, NEA Baptist Memorial Hospital 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.