SOUTH MISSISSIPPI COUNTY REGIONAL MEDICAL CENTER
OSCEOLA, ARKANSAS

2013 COMMUNITY HEALTH NEEDS ASSESSMENT AND IMPLEMENTATION PLAN

ADOPTED BY BOARD RESOLUTION (DATE)[1]

QHR | Consulting Services

[1] Response to Schedule H (Form 990) Part V B 2

Mississippi County
Hospital System

Dear Community Resident:

South Mississippi County Regional Medical Center (SMCRMC), a division of Mississippi County Hospital System, welcomes you to review this document as we strive to meet the health and medical needs in our community. All not-for-profit hospitals are required to develop this report in compliance with the Patient Protection and Affordable Care Act.

The "2013 Community Health Needs Assessment" identifies local health and medical needs and provides a plan to indicate how SMCRMC will respond to such needs. This document suggests areas where other local organizations and agencies might work with us to achieve desired improvements and illustrates one way we, SMCRMC, are meeting our obligations to efficiently deliver medical services.

SMCRMC will conduct this effort at least once every three years. As you review this plan, please consider if, in your opinion, we have identified the primary needs and if our intended response should make appropriate needed improvements.

We do not have adequate resources to solve all the problems identified. Some issues are beyond the mission of the hospital and action is best suited for a response by others. Some improvements will require personal actions by individuals rather than the response of an organization. We view this as a plan for how we, with other organizations and agencies, can collaborate to bring the best each has to offer to address more pressing identified needs.

The report is a response to a federal requirement of not-for-profit hospital's to identify the community benefit it provides in responding to documented community need. Footnotes are provided to answer specific tax form questions; for most purposes, they may be ignored. Of greater importance is the potential for this report to guide our actions and the efforts of others to make needed health and medical improvements.

Please think about how to help us improve the health and medical services our area needs. I invite your response to this report. We all live and work in this community together and our collective efforts can make living here more enjoyable and healthier.

Thank you,
South Mississippi County Regional Medical Center

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EXECUTIVE SUMMARY

Executive Summary

South Mississippi County Regional Medical Center (SMCRMC) and Great River Medical Center (GRMC) function as two components of the Mississippi County Hospital System. The April 4, 2013 draft regulations state "…every hospital facility must document its CHNA in a separate CHNA report … if a hospital facility collaborates with other hospital facilities in conducting its CHNA, all of the collaborating hospital facilities may produce a joint CHNA report as long as all of the facilities define their community to be the same and conduct a joint CHNA process. In addition, the joint CHNA report must clearly identify each hospital facility to which it applies and an authorized body of each collaborating hospital facility must adopt the joint CHNA report as its own." This requirement guides the development of this report.

SMCRMC is organized as a not-for-profit hospital. A "Community Health Needs Assessment" (CHNA) is part of the necessary hospital documentation for "Community Benefit" under the Affordable Care Act (ACA), required of all not-for-profit hospitals as a condition of retaining tax-exempt status. A CHNA assures SMCRMC identifies and responds to the primary health needs of its residents.

This study is designed to comply with standards required of a not-for-profit hospital.[2] Tax reporting citations in this report are superseded by the most recent 990 H filings made by the hospital.

In addition to completing a CHNA and funding necessary improvements, a not-for-profit hospital must document the following:

- Financial assistance policy and policies relating to emergency medical care;
- Billing and collections; and
- Charges for medical care.

Further explanation and specific regulations are available from Health and Human Services (HHS), the Internal Revenue Service (IRS) and the U.S. Department of the Treasury.[3]

Project Objectives

SMCRMC partnered with Quorum Health Resources (QHR) for the following:[4]

- Complete a CHNA report, compliant with Treasury – IRS;
- Provide the Hospital with information required to complete the IRS – 990h schedule; and
- Produce information necessary for the hospital to issue an assessment of community health needs and document its intended response.

[2] Part 3 Treasury/IRS – 2011 – 52 Notice … Community Health Needs Assessment Requirements…
[3] As of the date of this report Notice of proposed rulemaking was published 6/26/2012 and available at http://federalregister.gov/a/2012-15537
[4] Part 3 Treasury/IRS – 2011 – 52 Section 3.03 (2) third party disclosure notice

Brief Overview of Community Health Needs Assessment

Typically, nonprofit hospitals qualify for tax-exempt status as a Charitable Organization, described in Section 501(c) 3 of the Internal Revenue Code; however, the term "Charitable Organization" is undefined. Prior to the passage of Medicare, charity was generally recognized as care provided to the less fortunate without means to pay. With the introduction of Medicare, the government met the burden of providing compensation for such care.

In response, IRS Revenue ruling 69-545 eliminated the Charitable Organization standard and established the Community Benefit Standard as the basis for tax-exemption. Community Benefit determines if hospitals promote the health of a broad class of individuals in the community, based on factors including:

- Emergency room open to all, regardless of ability to pay;
- Surplus funds used to improve patient care, expand facilities, train, etc.;
- Control by independent civic leaders; and
- All available and qualified physicians are privileged.

Specifically, the IRS requires:

- Effective on tax years beginning after March 23, 2012, each 501(c) (3) hospital facility is required to conduct a community health needs assessment at least once every three taxable years and adopt an implementation strategy to meet the community needs identified through such assessment;
- Assessment may be based on current information collected by a public health agency or nonprofit organization and may be conducted together with one or more other organizations, including related organizations;
- Assessment process must take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge or expertise of public health issues;
- The hospital must disclose in its annual information report to the IRS (Form 990 and related schedules) how it is addressing the needs identified in the assessment and, if all identified needs are not addressed, the reasons why (e.g., lack of financial or human resources);
- Each hospital facility is required to make the assessment widely available and ideally downloadable from the hospital web site;
- Failure to complete a community health needs assessment in any applicable three-year period results in a penalty to the organization of $50,000, e.g., if a facility does not complete a community health needs assessment in taxable years one, two, or three, it is subject to the penalty in year three. If it then fails to complete a community health needs assessment in

year four, it is subject to another penalty in year four (for failing to satisfy the requirement during the three-year period beginning with taxable year two and ending with taxable year four); and

- An organization that fails to disclose how it is meeting needs identified in the assessment is subject to existing incomplete return penalties.[5]

[5] Section 6652

APPROACH

Approach

To complete a CHNA, the hospital must:

- Describe processes and methods used to conduct the assessment:
  - Sources of data and dates retrieved;
  - Analytical methods applied;
  - Information gaps impacting ability to assess the needs;
  - Identify with whom the hospital collaborated;
  - Describe how the hospital gained input from community representatives:
  - When and how the organization consulted with these individuals;
  - Names, titles, and organizations of these individuals;
  - Any special knowledge or expertise in public health possessed by these individuals;
  - Describe the process and criteria used in prioritizing health needs;
  - Describe existing resources available to meet the community health needs; and
  - Identify programs and resources the hospital facility plans to commit to meeting each identified need and the anticipated impact of those programs and resources on the health need.

Quorum Health Resources, LLC (QHR) takes a comprehensive approach to assess community health needs. We perform several independent data analyses based on secondary source data, augment this with local survey data and resolve any data inconsistency or discrepancies from the combined opinions formed from local experts. We rely on secondary source data and most secondary sources use the county as the smallest unit of analysis. We asked our local experts, area residents, to note if they perceived the problems or needs, identified by secondary sources, to exist in their portion of the county.[6]

The data displays used in our analysis are presented in the Appendix. Data sources include:[7]

Web Site or Data Source	Data Element	Date Accessed	Data Date
www.countyhealthrankings.org	Assessment of health needs of Mississippi County compared to all AR counties	October 7, 2013	2002 to 2010

[6] Response to Schedule H (Form 990) Part V B 1 i
[7] Response to Schedule H (Form 990) Part V B 1 d

Web Site or Data Source	Data Element	Date Accessed	Data Date
www.communityhealth.hhs.gov	Assessment of health needs of Mississippi County compared to its national set of "peer counties"	October 7, 2013	1996 to 2009
Truven (formerly known as Thomson) Market Planner	Assess characteristics of the hospital's primary service area, at a zip code level, based on classifying the population into various socio-economic groups, determining the health and medical tendencies of each group and creating an aggregate composition of the service area according to the contribution each group makes to the entire area; and, to access population size, trends and socio-economic characteristics	October 7, 2013	2012
www.capc.org and www.getpalliativecare.org	To identify the availability of Palliative Care programs and services in the area	October 7, 2013	2012
www.caringinfo.org and iweb.nhpco.org	To identify the availability of hospice programs in the county	October 7, 2013	2012
www.healthmetricsandevaluation.org	To examine the prevalence of diabetic conditions and change in life expectancy	October 7, 2013	1989 through 2009
www.dataplace.org	To determine availability of specific health resources	October 7, 2013	2005
www.cdc.gov	To examine area trends for heart disease and stroke	October 7, 2013	2007 to 2009
www.CHNA.org	To identify potential needs among a variety of resource and health need metrics	October 7, 2013	2003 to 2010

Web Site or Data Source	Data Element	Date Accessed	Data Date
www.datawarehouse.hrsa.gov	To identify applicable manpower shortage designations	October 7, 2013	2013
www.worldlifeexpectancy.com/usa-health-rankings	To determine relative importance among 15 top causes of death	October 11, 2013	2010 published 11/29/12

Federal regulations surrounding CHNA have evolved to require local input from representatives of particular sectors. For this reason, Quorum has refined a process of gathering community input. In addition to gathering data from the above sources:

- We deployed a CHNA "Round 1" survey to our local expert advisors to gain local input on local health needs and the needs of priority populations. Local expert advisors were local individuals selected according to criteria required by the Federal guidelines and regulations[8] and the Hospital's desire to represent the regions geographically and ethnically diverse population;
- We received community input from 23 local expert advisors. Survey responses started Tuesday, September 24, 2013 at 10:43 a.m. and ending Monday, October 14, 2013 at 11:16 a.m.; and
- Information analysis augmented by local opinions showed how Mississippi County relates to its peers in terms of primary and chronic needs, as well as other issues of uninsured persons, low-income persons and minority groups; respondents commented on if they believe certain population groups (or people with certain situations) need help to improve their condition and if so, who needs to do what.[9]

When the analysis was complete, we put the information and summary conclusions before our local group of experts[10],[11] who were asked to agree or disagree with the summary conclusions. Experts were free to augment potential conclusions with additional statements of need; however, new needs did not emerge from this exchange.[12] Consultation with 14 local experts occurred via an internet based survey (explained below) during the period beginning Friday October 25, 2013 at 7:57 a.m. and ending Monday November 4, 2013 at 8:02 p.m.[13]

With the prior steps identifying potential community needs, the local experts participated in a structured communication technique called a Delphi method, originally developed as a systematic, interactive forecasting method which relies on a panel of experts who answer questionnaires in a

[8] Response to Schedule H (Form 990) Part V B 1 h; complies with 501(r)(3)(B)(i)
[9] Response to Schedule H (Form 990) Part V B 1 f
[10] Part response to Schedule H (Form 990) Part V B 3
[11] Response to Schedule H (Form 990) Part V B 1 f
[12] Response to Schedule H (Form 990) Part V B 1 e
[13] Response to Schedule H (Form 990) Part V B 1 h

series of rounds. We contemplated and implemented one round as referenced during the above dates. After each round, we provided an anonymous summary of the experts' forecasts from the previous round, as well as the reasons provided for their judgments. The process encourages experts to revise their earlier answers in light of the replies of other members of their panel. Typically, this process decreases the range of answers and moves the expert opinions toward a consensus "correct" answer. The process stops when we identify the most pressing, highest priority community needs.

In the SMCRMC process, each local expert allocated 100 points among all identified needs, having the opportunity to introduce needs previously unidentified and to challenge conclusions developed from the data analysis. A rank order of priorities emerged, with some needs receiving none or virtually no support and other needs receiving identical point allocations.

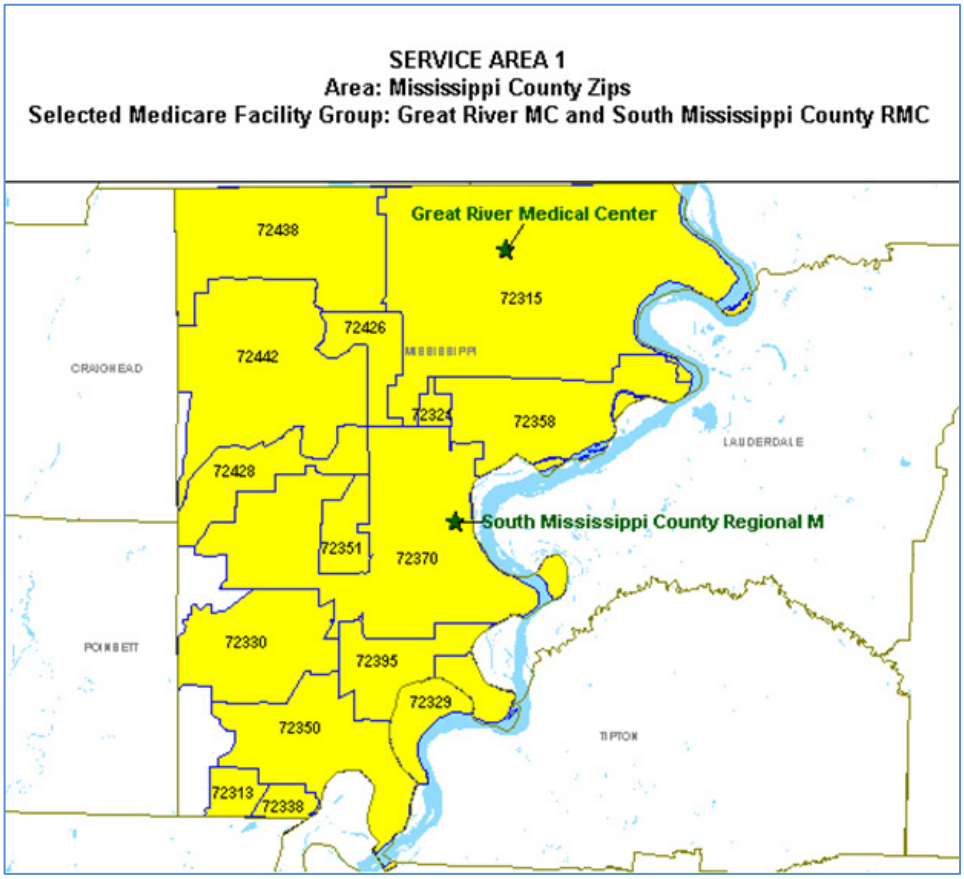
The proposed regulations clarify a CHNA need only identify significant health needs, and need only prioritize, and otherwise assess, those significant identified health needs. A hospital facility may determine whether a health need is significant based on all of the facts and circumstances present in the community it serves. The determination of the break point, Significant Need as opposed to Other Need, was a qualitative interpretation by QHR and the SMCRMC executive team where a reasonable break point in the descending rank order of votes occurred, indicated by the weight amount of points each potential need received and the number of local experts allocating any points to the need. Our criteria included the Significant Needs had to represent a majority of all cast votes. The Significant Needs also needed a plurality of local expert participation. When presented to the SMCRMC executive team, the dichotomized need rank order (Significant vs. Other) identified which needs the hospital needed to focus upon in determining where and how it was to develop an implementation response.[14]

[14] Response to Schedule H (Form 990) Part V Section B 6 g, h and Part V B 1 g

FINDINGS

Findings

Definition of Area Served by the Hospital Facility[15]



SMCRMC, in conjunction with QHR, defines its service area as Mississippi County in Arkansas which includes the following ZIP codes:

72313	Bassett	72338	Frenchmans Bayou	72395	Wilson
72315	Osceola	72350	Joiner	72426	Dell
72321	Burdette	72351	Keiser	72428	Etowah
72329	Driver	72358	Luxora	72438	Leachville
72330	Dyess	72370	Osceola	72442	Manila

In 2012, the hospital received 91.8% of its patients from this area.[16]

[15] Responds to IRS Form 990 (h) Part V B 1 a
[16] Truven MEDPAR patient origin data for the hospital; Responds to IRS Form 990 (h) Part V B 1 a

Demographic of the Community[17]

The 2013 population for Mississippi County is estimated to be 45,019,[18] and is expected to decline at a rate of -2.8% in contrast to the 3.3% national rate of growth and the Arkansas growth rate of 2.7%. Mississippi County in 2018 anticipates a population of 43,762.

According to population estimates utilized by Truven, provided by The Neilson Company, the 2013 median age for the county is 35.1 years, younger than the Arkansas median age (37.6 years) and the national median age (37.5 years). The 2013 Median Household Income for the area is $34,928, lower than the Arkansas median income of $38,286 and the national median income of $49,233. Median Household Wealth is $28,281, below the Arkansas value ($45,595) and the national value ($54,682). Median Home Value ($73,576) is below the Arkansas (104,545) and national (169,011) value. Mississippi County's unemployment rate as of July 2013 was 11.5%,[19] which is higher than the 7.6% statewide and the 7.7% national civilian unemployment rate.

The portion of the population in the county over 65 is 13.1%, below the Arkansas (15.3%) and the national average (13.9%). The portion of the population of women of childbearing age is 19.6%, above the Arkansas average of 19.3% and the national rate of 19.8%.

Demographics Expert 2.7
2013 Demographic Snapshot
Area: Missippi County, AR
Level of Geography: ZIP Code

DEMOGRAPHIC CHARACTERISTICS

	Selected Area	USA
2010 Total Population	46,160	308,745,538
2013 Total Population	45,019	314,861,807
2018 Total Population	43,762	325,322,277
% Change 2013 - 2018	-2.8%	3.3%
Average Household Income	$48,343	$69,637

	2013	2018	% Change
Total Male Population	21,832	21,284	-2.5%
Total Female Population	23,187	22,478	-3.1%
Females, Child Bearing Age (15-44)	8,839	8,510	-3.7%

POPULATION DISTRIBUTION

	Age Distribution				
Age Group	2013	% of Total	2018	% of Total	USA 2013 % of Total
0-14	10,415	23.1%	10,053	23.0%	19.6%
15-17	2,138	4.7%	2,022	4.6%	4.1%
18-24	4,306	9.6%	4,304	9.8%	10.0%
25-34	5,627	12.5%	5,493	12.6%	13.1%
35-54	11,246	25.0%	10,123	23.1%	26.9%
55-64	5,386	12.0%	5,354	12.2%	12.4%
65+	5,901	13.1%	6,413	14.7%	13.9%
Total	45,019	100.0%	43,762	100.0%	100.0%

HOUSEHOLD INCOME DISTRIBUTION

	Income Distribution		
2013 Household Inco	HH Count	% of Total	USA % of Total
<$15K	3,729	21.6%	13.8%
$15-25K	2,675	15.5%	11.6%
$25-50K	4,785	27.7%	25.3%
$50-75K	3,049	17.7%	18.1%
$75-100K	1,369	7.9%	11.7%
Over $100K	1,648	9.6%	19.5%
Total	17,255	100.0%	100.0%

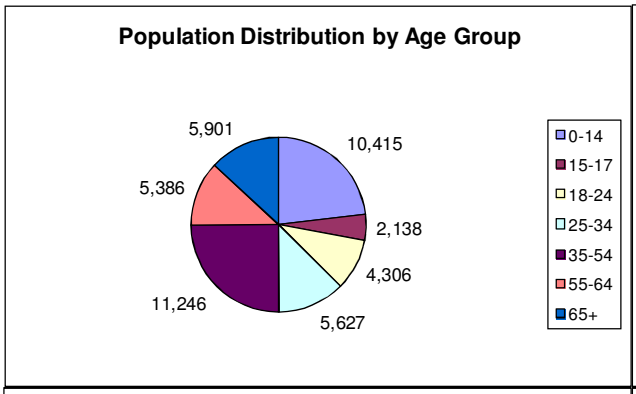
EDUCATION LEVEL

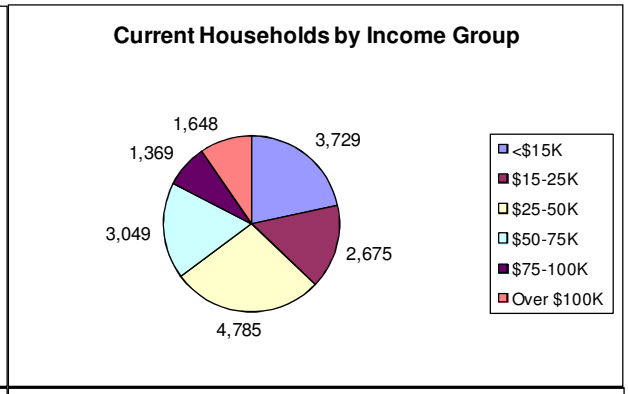
	Education Level Distribution		
2013 Adult Education Level	Pop Age 25+	% of Total	USA % of Total
Less than High School	2,805	10.0%	6.2%
Some High School	3,715	13.2%	8.4%
High School Degree	10,693	38.0%	28.4%
Some College/Assoc. Degree	7,709	27.4%	28.9%
Bachelor's Degree or Greater	3,238	11.5%	28.1%
Total	28,160	100.0%	100.0%

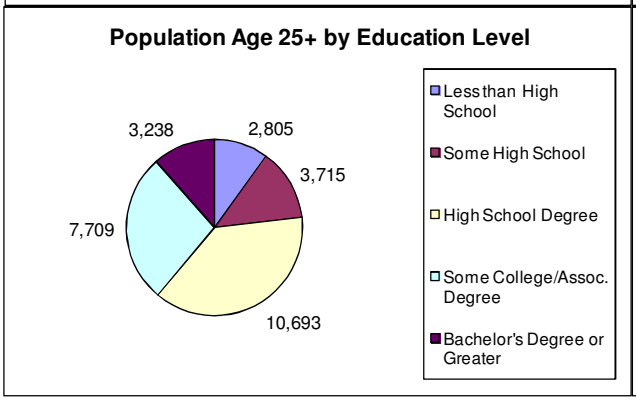
RACE/ETHNICITY

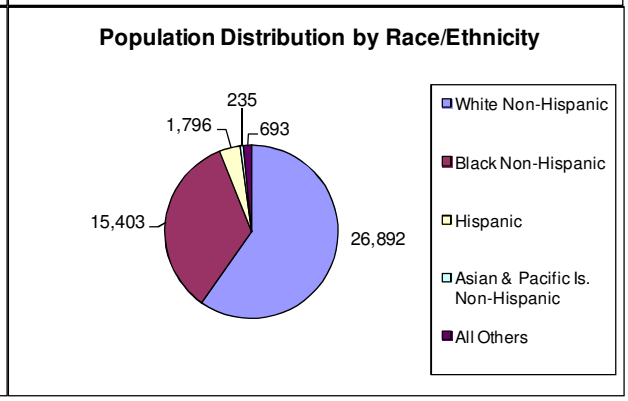
	Race/Ethnicity Distribution		
Race/Ethnicity	2013 Pop	% of Total	USA % of Total
White Non-Hispanic	26,892	59.7%	62.3%
Black Non-Hispanic	15,403	34.2%	12.3%
Hispanic	1,796	4.0%	17.3%
Asian & Pacific Is. Non-Hispanic	235	0.5%	5.1%
All Others	693	1.5%	2.9%
Total	45,019	100.0%	100.0%

[17] Responds to IRS Form 990 (h) Part V B 1 b
[18] All population information, unless otherwise cited, sourced from Truven (formally Thomson) Market Planner
[19] h http://research.stlouisfed.org/fred2/graph/?id=AR UR, http://research.stlouisfed.org/fred2/series/AR MSURN









2013 Benchmarks
Area: Missippi County, AR
Level of Geography: ZIP Code

Area	2013-2018 % Population Change	Median Age	Population 65+ % of Total Population	Population 65+ % Change 2013-2018	Females 15-44 % of Total Population	Females 15-44 % Change 2013-2018	Median Household Income	Median Household Wealth	Median Home Value
USA	3.3%	37.5	13.9%	16.3%	19.8%	-0.1%	$49,233	$54,682	$169,011
Arkansas	2.7%	37.6	15.3%	13.3%	19.3%	0.3%	$38,286	$45,595	$104,545
Selected Area	-2.8%	35.1	13.1%	8.7%	19.6%	-3.7%	$34,928	$28,281	$73,576

Demographics Expert 2.7
DEMO0003.SQP

The population was examined according to characteristics presented in the Claritas Prizm customer segmentation data. This system segments the population into 66 demographically and behaviorally distinct groups. Each group, based on annual survey data, is documented as exhibiting specific health behaviors. The makeup of the service area, according to the mix of Prizm segments and its characteristics, is contrasted to the national population averages to discern the following table of probable lifestyle and medical conditions present in the population. Items with red text are viewed as statistically important adverse potential findings. Items with blue text are viewed as statistically important potential beneficial findings. Items with black text are viewed as either not statistically different from the national normal situation or not being a favorable or unfavorable consideration in our use of the information.

Health Service Topic	Demand as % of National	% of Population Affected	Health Service Topic	Demand as % of National	% of Population Affected
Weight / Lifestyle			**Heart**		
BMI: Morbid/Obese	116.4%	29.7%	Routine Screen: Cardiac Stress 2yr	86.3%	13.5%
Vigorous Exercise	92.8%	47.2%	Chronic High Cholesterol	93.2%	20.8%
Chronic Diabetes	122.7%	12.8%	Routine Cholesterol Screening	84.8%	43.0%
Healthy Eating Habits	82.8%	24.5%	Chronic High Blood Pressure	109.3%	28.7%
Very Unhealthy Eating Habits	145.5%	4.0%	Chronic Heart Disease	121.4%	10.1%
Behavior			**Routine Services**		
I Will Travel to Obtain Medical Care	97.1%	31.2%	FP/GP: 1+ Visit	102.2%	90.3%
I Follow Treatment Recommendations	86.4%	34.9%	Used Midlevel in last 6 Months	99.6%	42.2%
I am Responsible for My Health	91.5%	51.3%	OB/Gyn 1+ Visit	87.9%	41.1%
Pulmonary			Ambulatory Surgery last 12 Months	100.6%	19.3%
Chronic COPD	114.3%	4.8%	**Internet Usage**		
Tobacco Use: Cigarettes	133.5%	34.6%	Use Internet to Talk to MD	81.5%	11.9%
Chronic Allergies	111.3%	25.6%	Facebook Opinions	84.5%	8.7%
Cancer			Looked for Provider Rating	89.3%	12.9%
Mammography in Past Yr	88.7%	40.2%	**Misc**		
Cancer Screen: Colorectal 2 yr	86.4%	21.8%	Charitable Contrib: Hosp/Hosp Sys	86.3%	20.6%
Cancer Screen: Pap/Cerv Test 2 yr	86.5%	52.2%	Charitable Contrib: Other Health Org	79.2%	30.9%
Routine Screen: Prostate 2 yr	92.1%	29.4%	HSA/FSA: Employer Offers	91.0%	46.7%
Orthopedic			**Emergency Service**		
Chronic Lower Back Pain	118.7%	26.7%	Emergency Room Use	112.5%	38.2%
Chronic Osteoporosis	114.1%	11.1%	Urgent Care Use	99.5%	23.5%

Leading Causes of Death

Cause of Death			Rank among all counties in AR	Rate of Death per 100,000 age adjusted		
AR Rank	Mississippi Co. Rank	Condition	(#1 rank = worst in state)	AR	Mississippi Co.	Observation
1	1	Heart Disease	1 of 75	218.8	386.2	Higher than expected
2,9,15,16,19,24, 28,30,31,32,33, 35,36,39	2	Cancer	21 of 75	197.3	217.5	Higher than expected
4	3	Stroke	29 of 75	50.8	66.9	Higher than expected
3	4	Lung	13 of 75	55.2	62.6	Higher than expected
12, 21, 25	5	Accidents	28 of 75	49.8	59.1	Higher than expected
7	6	Diabetes	23 of 75	27.1	32.8	Higher than expected
10	7	Flu - Pneumonia	26 of 75	21.1	29.4	Higher than expected
8	8	Kidney	11 of 75	20.4	26.0	Higher than expected
13	9	Blood Poisoning	9 of 75	15.9	23.8	Higher than expected
5	10	Alzheimer's	59 of 75	25.9	13.5	Lower than expected
14	11	Suicide	51 of 75	14.5	12.0	As expected
18	12	Liver	17 of 74	8.2	10.3	As expected
29	13	Homicide	25 of 75	7.8	7.9	Higher than expected
11	14	Hypertension	44 of 74	7.1	5.2	Lower than expected
27	15	Parkinson's	30 of 72	5.8	4.6	As expected

Primary and Chronic Disease Needs and Health Issues of Uninsured Persons, Low-Income Persons and Minority Groups

Some information is available to describe the size and composition of various uninsured persons, low income persons, minority groups and other vulnerable population segments. Studies identifying specific group needs, distinct from the general population at a county unit of analysis, are not readily available from secondary sources.

The National Healthcare Disparities Report results from a Congressional directive to the Agency for Healthcare Research and Quality (AHRQ). This production is an annual report to track disparities related to "racial factors and socioeconomic factors in priority populations." The emphasis is on disparities related to race, ethnicity and socioeconomic status and includes a charge to examine disparities in "priority populations," which are groups with unique health care needs or issues that require special attention.[20]

Nationally, this report observes the following trends:

- Measures for which Blacks were worse than Whites and are getting better:
    - Diabetes – Hospital admissions for short-term complications of diabetes per 100,000 population;
    - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over; and
    - Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement.
- Measures for which Blacks were worse than Whites and staying the same:
    - Cancer – Breast cancer diagnosed at advanced stage per 100,000 women age 40 and over ; breast cancer deaths per 100,000 female population per year; adults age 50 and over who ever received colorectal cancer screening; colorectal cancer diagnosed at advanced stage per 100,000 population age 50 and over; colorectal cancer deaths per 100,000 population per year;
    - Diabetes – Hospital admissions for lower extremity amputations per 1,000 population age 18 and over with diabetes;
    - Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year; Children ages 19-35 months who received all recommended vaccines;
    - Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months; people age 12 and over treated for substance abuse who completed treatment course;

[20] http://www.ahrq.gov/qual/nhdr10/Chap10.htm 2010

  - Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;
  - Supportive and Palliative Care – High-risk long-stay nursing home residents with pressure sores; short-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;
  - Timeliness – Adults who needed care right away for an illness, injury or condition in the last 12 months who got care as soon as wanted; emergency department visits where patients left without being seen; and
  - Access – People with a usual primary care provider; people with a specific source of ongoing care.
- Measures for which Asians were worse than Whites and getting better:
  - Cancer – Adults age 50 and over who ever received colorectal cancer screening; and
  - Patient Safety – Adult surgery patients who received appropriate timing of antibiotics.
- Measures for which Asians were worse than Whites and staying the same:
  - Respiratory Diseases – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care; and
  - Access – People with a usual primary care provider.
- Measures for which American Indians and Alaska Natives were worse than Whites for most recent year and staying the same:
  - Heart Disease – Hospital patients with heart failure who received recommended hospital care;
  - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
  - Respiratory Diseases – Hospital patients with pneumonia who received recommended hospital care;
  - Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement;
  - Supportive and Palliative Care – Hospice patients who received the right amount of medicine for pain; high-risk, long-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; and

  - Access – People under age 65 with health insurance.

- Measures for which American Indians and Alaska Natives were worse than Whites for most recent year and getting worse:
  - Cancer – Adults age 50 and over who ever received colorectal cancer screening; and
  - Patient safety – Adult surgery patients who received appropriate timing of antibiotics.
- Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and getting better:
  - Maternal and Child Health – Children ages 2-17 who had a dental visit in the calendar year;
  - Lifestyle Modification – Adult current smokers with a checkup in the last 12 months who received advice to quit smoking; adults with obesity who ever received advice from a health provider about healthy eating; and
  - Functional Status Preservation and Rehabilitation – Female Medicare beneficiaries age 65 and over who reported ever being screened for osteoporosis with a bone mass or bone density measurement.
- Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and staying the same:
  - Cancer – Women age 40 and over who received a mammogram in the last two years; adults age 50 and over who ever received colorectal cancer screening;
  - Diabetes – Adults age 40 and over with diagnosed diabetes who received all three recommended services for diabetes in the calendar year;
  - Heart Disease – Hospital patients with heart attack and left ventricular systolic dysfunction who were prescribed angiotensin-converting enzyme inhibitor or angiotensin receptor blocker at discharge; hospital patients with heart failure who received recommended hospital care;
  - HIV and AIDS – New AIDS cases per 100,000 population age 13 and over;
  - Mental Health and Substance Abuse – Adults with a major depressive episode in the last 12 months who received treatment for depression in the last 12 months;
  - Respiratory Disease – Adults age 65 and over who ever received pneumococcal vaccination; hospital patients with pneumonia who received recommended hospital care;
  - Lifestyle Modification – Adults with obesity who ever received advice from a health provider to exercise more;

  - Supportive and Palliative Care – Long-stay nursing home residents with physical restraints; high-risk, long-stay nursing home residents with pressure sores; short-stay nursing home residents with pressure sores; adult home health care patients who were admitted to the hospital; hospice patients who received the right amount of medicine for pain;
  - Patient Safety – Adult surgery patients who received appropriate timing of antibiotics;
  - Timeliness – Adults who needed care right away for an illness, injury or condition in the last 12 months who got care as soon as wanted;
  - Patient Centeredness – Adults with ambulatory visits who reported poor communication with health providers; children with ambulatory visits who reported poor communication with health providers; and
  - Access – People under age 65 with health insurance; people under age 65 who were uninsured all year; people with a specific source of ongoing care; people with a usual primary care provider; people unable to get or delayed in getting needed care due to financial or insurance reasons.

- Measures for which Hispanics were worse than non-Hispanic Whites for most recent year and getting worse:
  - Maternal and Child Health – Children ages 3-6 who ever had their vision checked by a health provider.

We asked a specific question to our local expert advisors about unique needs of priority populations. We reviewed their response to identify if any of the above trends were obvious in the service area. Accordingly, we place great reliance on the commentary received to identify unique population needs to which we should respond. Specific opinions from the local expert advisors are summarized as follows[21]:

- Needs of special population groups emphasize financial access hardships and note problems with the following;
- Basic access to medical and health care;
- Financial access to services by uninsured;
- Medical condition problems similar to what exists in the population at large, diabetes, hypertension, mental service access and dental care; and
- Three of the 20 responses indicated no unique concerns or there is a false proposition that access to healthcare, other than basic disease inoculation and life-threatening emergencies, is some sort of Constitutional "right" would be a good place to start.

[21] All comments and the analytical framework behind developing this summary appear in Appendix A.

Statistical information about special populations:

Access to Care: Mississippi County, AR

In addition to use of services, access to care may be characterized by medical care coverage and service availability

Uninsured individuals (age under 65)[1]	**5,476**
Medicare beneficiaries[2]	
Elderly (Age 65+)	**5,574**
Disabled	**2,360**
Medicaid beneficiaries[2]	**18,526**
Primary care physicians per 100,000 pop[2]	**53.4**
Dentists per 100,000 pop[2]	**25.6**
Community/Migrant Health Centers[3]	**Yes**
Health Professional Shortage Area[3]	**No**

nda No data available.

[1] The Census Bureau. Small Area Health Insurance Estimates Program, 2006.
[2] HRSA. Area Resource File, 2008.
[3] HRSA. Geospatial Data Warehouse, 2009.

Vulnerable Populations: Mississippi County, AR

Vulnerable populations may face unique health risks and barriers to care, requiring enhanced services and targeted strategies for outreach and case management.

Vulnerable Populations Include People Who[1]	
Have no high school diploma (among adults age 25 and older)	**10,463**
Are unemployed	**1,589**
Are severely work disabled	**1,808**
Have major depression	**2,988**
Are recent drug users (within past month)	**3,258**

nda No data available.

[1] The most current estimates of prevalence, obtained from various sources (see the Data Sources, Definitions, and Notes for details), were applied to 2008 mid-year county population figures.

Findings

Upon completion of the CHNA, QHR identified several issues within the SMCRMC community:

Conclusions from Public Input to Community Health Needs Assessment

Our group of 23 local expert advisors participated in an online survey to offer opinions about their perceptions of community health needs and potential needs of unique populations.

Responses were first obtained to the question: "What do you believe to be the most important health or medical issue confronting the residents of your County?" In summary, we receive the following commentary regarding the more important health or medical issues:

- Problem accessing quality primary care physicians;
- Obesity;
- Access and Availability of services; and
- A lower order of concerns about specific medical conditions including cancer, emergency service and clinic services and heart problems.

Responses were then obtained to the question: "Do you perceive there are any primary and/or chronic disease needs, as well as potential health issues, of uninsured persons, low income persons, minority groups and/or other population groups (i.e. people with certain situations) which need help or assistance in order to improve? If you believe any situation as described exists, please also indicate who you think needs to do what?" Generally it seemed people were thinking about low income residents when responding to this question. In summary, we received the following commentary regarding the more important health or medical issues confronting such individuals:

- Basic access to medical and health care;
- Financial access to services by uninsured;
- Medical condition problems similar to what exists in the population at large, diabetes, hypertension, mental service access and dental care;
- Three experts did not identify any unique needs;
- Two additional responses indicated no unique concerns; and
- One response believed there was an unnecessary entitlement attitude "a false proposition that access to healthcare, other than basic disease inoculation and life threatening emergencies, is some sort of Constitutional "right" ...."

Summary of Observations from Mississippi County Compared to All Other Arkansas Counties, in Terms of Community Health Needs

- In general, Mississippi County residents are considerably worse than average compared to the healthiest in Arkansas and the US;
- In a health status classification termed "Health Outcomes", Mississippi ranks number 73 among the 75 Arkansas ranked counties (best being #1) for 2012. Typifying the problem, Premature Death in Mississippi County is 13,682 years of potential life lost before age 75, per 100,000 population (age adjusted). This significantly exceeds the Arkansas rate of 9,250, and is more than double the national benchmark of 5,317. Perhaps a worse finding is this rate shows a three year increasing trend while the Arkansas and US rates have declined. Low Birth Weight Births, at 11.6%, exceed the Arkansas rate of 9.0%, and are nearly double the national rate of 6.0%. Poor or Fair Health, Poor Physical Health Days, and Poor Mental Health Days also show Mississippi County residents presenting with higher values (adverse indicators) than the Arkansas averages and significantly higher than US goals;
- In another health status classification "Health Factors", Mississippi County again ranks poorly compared to Arkansas and US averages, ranking as the second worst AR county. Health Behaviors and Social & Economic Factors are the two groups where Mississippi County ranks the lowest. Adult Smoking, Physical Inactivity, Motor Vehicle Crash Deaths and Sexually transmitted disease all significantly exceed the Arkansas rates and are more than double the national averages (Sexually transmitted disease is more than 10 times the US rate). Adult Obesity statistically exceeds the Arkansas value and the US value. Teen Birth Rate exceeds the Arkansas rate and is about 400% in excess of the national rate. Excessive Drinking is the only indicator having a beneficial finding in the Health Behaviors group as it is below the Arkansas rate and is at the national rate. Education Metrics (school years completed) are considerably lower than the AR and US rates (an adverse finding). Unemployment, Children in Poverty, Violent Crime, Inadequate Social Support and Children in Single Parent Households values exceed both the Arkansas and US values (adverse finding). Violent crime is about 12 times the US rate where as the other Mississippi County rates only exceed US rates by a factor of 2 rather than 12; and
- Mississippi County in terms of Physical Environmental also is among the worst counties in Arkansas. Air pollution is statistically excessive of the Arkansas and US averages. Access to recreational facilities is at half the Arkansas Rate and ¼ of the US rate. Drinking Water Safety is at the AR average but greatly inferior to the US rate. Fast Food Restaurants exist at a rate above the state average. All of the considerations are adverse to healthy findings. Mississippi County in terms of Clinical Care performs better but still remains lower than average for Arkansas. Uninsured rate (18%) is significantly better than the Arkansas rate but exceeds national rate (11%). Preventable Hospital Stays (106) per 1,000 is an indication of

physician shortage. It significantly exceeds the Arkansas average (79/1,000) and is more than double US average (49/1,000). This excessive rate (indicating not enough physicians) has not changed meaningfully since 2003 (the earliest date analyzed). The ratio of Population to Primary Care Physicians (2,574:1) also indicates a physician shortage as it exceeds the Arkansas average (1,613:1) and US (1,067:1). Diabetic Screenings and Mammography Screenings are below the Arkansas the national rates (adverse finding).

Summary of Observations from Mississippi County Peer Comparisons

The federal government administers a process to allocate all counties into "Peer" groups. County "Peer" groups have similar social, economic and demographic characteristics. Health and wellness observations when Mississippi County is compared to its national set of Peer Counties and compared to national rates include:

UNFAVORABLE observations occurring at rates worse than national AND worse than among Peers (Note the following list is more extensive in listing adverse findings than typically observed for other studies of other counties):

- LOW BIRTH WEIGHT (<2500 g);
- VERY LOW BIRTH WEIGHT (<1500 g);
- PREMATURE BIRTHS (<37 weeks);
- BIRTHS TO WOMEN UNDER 18;
- BIRTHS TO UNMARRIED WOMEN;
- NO CARE IN FIRST TRIMESTER;
- INFANT MORTALITY;
- WHITE NONHISPANIC;
- INFANT MORTALITY;
- NEONATAL INFANT MORTALITY;
- BREAST CANCER (Female);
- COLON CANCER;
- CORONARY HEART DISEASE;
- HOMICIDE;
- LUNG CANCER; and
- SUICIDE.

SOMEWHAT A CONCERN observations because occurrence is worse than national average BUT better than the Peer group average (Note the following list is shorter in listing potential adverse findings than typically observed for other studies of other counties):

- BLACK NONHISPANIC INFANT MORTALITY;
- POSTNEONATAL INFANT MORTALITY;
- MOTOR VEHICLE INJURIES; and
- STROKE.

BETTER performance than Peer and National occurrence rates: (Note the following list is the shortest listing of beneficial findings than observed for any other study conducted)

- BIRTHS TO WOMEN AGE 40-54; and
- UNINTENTIONAL INJURY.

Conclusions from the Demographic Analysis Comparing Mississippi County to National Averages

Mississippi County in 2013 comprises 45,019 residents. Since 2010 it has experienced a small population decrease and anticipates continued population decline through the next five years to result in 43,762 residents in 2018. The population is 59.7% nonHispanic White. Asian & Pacific Island nonHispanic constitute 0.5% of the population. Hispanics comprise 4.0% of the population. Black nonHispanic comprise the largest minority of the population at 34.2%. 13.1% of the population is age 65 or older. This is a smaller population segment than the elderly comprise elsewhere in Arkansas on average or in comparison to the national average. 19.6% of the women are in the childbirth population segment. This segment is slightly larger than as elsewhere on average in Arkansas but is lower than the national average. The median income, median household wealth and median home values all are below their respective Arkansas and national averages.

The following areas were identified from a comparison of the county to national averages:

Metrics impacting more than 25% of the population and statistically significantly different from the national average include the following. All are considered adverse findings unless otherwise noted:

- Obtained a Pap/Cervix test in last 2 years 13% below average impacting 52% of the population;
- I am Responsible for my Health 9% below average impacting 51% of the population;
- Engage in Vigorous Exercise is 7% below average impacting 47% of the population;
- Obtain routine cholesterol screening is 15% below average impacting 43% of the population;
- Had OB/GYN visit in last year is 12% below average impacting 41% of the population;

- Obtained Mammography Screening in last Year 11% below average impacting 40% of the population;
- Emergency Room Use 13% above average impacting 38% of the population;
- I Follow Treatment Recommendations 14% below average impacting 35% of the population;
- Use tobacco products / smoke 34% above average impacting 35% of the population;
- Morbid Obese 16% above average impacting 30% of the population;
- Obtained Routine Prostate Screen in last 2 Years 8% below average impacting 29% of the population;
- Chronic High Blood Pressure 9% above average impacting 29% of the population;
- Chronic Lower Back Pain 19% above average impacting 27% of the population; and
- Chronic Allergies 11% above average impacting 26% of the population.

Situations and Conditions statistically significantly different from the national average but impacting less than 25% of the population include the following. All are considered adverse findings unless otherwise noted:

- Healthy Eating Habits 17% below average impacting 24.5% of population;
- Obtained a Colorectal Screen in Last 2 Years 14% below average impacting 22% of the population;
- Obtained Cardiac Stress Test in Last 2 Years 14% below average impacting 13% of population;
- Chronic Diabetes 23% above average impacting 13% of the population;
- Chronic Osteoporosis 14% above average impacting 11% of the population;
- Chronic Heart Disease 21% above average impacting 10% of the population;
- Chronic COPD 14% above average impacting 5% of the population; and
- Very Unhealthy Eating Habits 46% above average impacting 4% of the population.

The sole beneficial finding in the analysis was:

- Chronic High Cholesterol 7% below average impacting 21% of the population.

Key Conclusions from Consideration of Other Statistical Data Examinations

Additional observations of Mississippi County found:

- Palliative Care (programs to relieve symptoms pain and stress) do not exist in the County. Hospice Care (programs to provide comfort care during terminal disease) do exist in the County;

- Mississippi County has a significantly lower death rate in 2 of the 15 leading causes of death and a significantly higher death rate in 10 of the 15 leading causes of death. Ranking Mississippi CO cause of death (in decreasing order of death rate)finds:
    1. Heart Disease The death rate (386.2 per 100,000) is a rate higher than expected, Mississippi County ranks #1 of the 75 AR ranked Counties (#1 rank = worse in state), this disease death rate is well above AR avg.;
    2. Cancer (217.5/100,000) higher than expected, rank #21, above AR avg.;
    3. Stroke (66.9/100,000) higher than expected, rank #29, above AR avg.;
    4. Lung (62.6/100,000) higher than expected, rank #13, above AR avg.;
    5. Accidents (59.1/100,000) higher than expected, rank #28, above AR avg.;
    6. Diabetes (32.8/100,000) higher than expected, rank #23, above AR avg.;
    7. Flu/Pneumonia (29.4/100,000) higher, rank #26, above AR avg.;
    8. Kidney (26.0/100,000) higher, rank #11, above AR avg.;
    9. Blood Poisoning (23.8/100,000) higher, rank #9, above AR avg.; and
    10. Alzheimer's (13.5/100,000) lower than expected, rank #59, below AR avg.
- Heart Disease Mortality during 2008 through 2010 (564.9) is much higher than the national average (358.6) and in comparison to the AR rate. The Mississippi County rate exceeds US and AR rates for the Black NonHispanic population segment, for the White NonHispanic population and for Asian/Pacific Islanders. There is insufficient data for the American Indian and Alaskan Native segment;
- The incident of Stroke deaths (113.4) is higher than the national rate (78.2) For the Black NonHispanic segment it was 157.3 and for the White NonHispanic segment it was 95.3. Data is insufficient for the Hispanic, American Indian and Alaskan Native, and Asian and Pacific Islander segments;
- Life expectancy for Men has increased; however, a highly unusual finding is life expectancy for Women has declined. Male life expectancy in 2009 was 68.6 years, 13.0 years behind the top US rates. Life expectancy for Women in 2009 was 75.7 years, 10.1 years behind the top US rates;
- Mississippi County is designated as a Health Professional Shortage Area (HPSA) for Mental Health but it is has no federal designation for primary care or for dental care. It does quality as a Medically Underserved Area (MUA). Primary care physicians per capita is below the AR average (41.3 physicians per 100,000 vs. AR average of 73.04), which is undesirable, but a smaller portion than average (15.1% vs. AR avg. 17.2%) lack consistent access to primary care, which is a desirable finding; and

- Over 41% of Children live in Poverty compared to only 26.7% in AR on average and only 19.9% in the US. In total, 26.09% of Mississippi County residents live in poverty (which exceeds AR avg. of 18.3% and US 14.3%). 48.7% of residents do not have recent dental exams and have poor dental health, which exceeds the AR and US avg. 29.4% of resident smoke a rate above AR and US avg. Accident Mortality, Asthma, Cancer, Chlamydia, Colon Cancer, Diabetes, Gonorrhea, Homicide, Lung Disease, Motor Vehicle Deaths, Obesity and Population with disability also have excessive incident rates.

EXISTING HEALTH CARE FACILITIES, RESOURCES AND SMCRMC IMPLEMENTATION PLAN

Existing Health Care Facilities and Resources Available to Respond to the Community Health Needs

We used the priority ranking of area health needs to organize the search for locally available resources.[22] The following list includes:

- Identifies the rank order of each identified Significant Need;
- Presents the factors considered in developing the ranking;
- Establishes a Problem Statement to specify the problem indicated by use of the Significant Need term;
- Identifies SMCRMC current efforts responding to the need;
- Establishes the Implementation Plan programs and resources SMCRMC will devote to attempt to achieve improvements;
- Documents the Leading Indicators SMCRMC will use to measure progress;
- Presents the Lagging Indicators SMCRMC believes the Leading Indicators will influence in a positive fashion; and
- Presents the locally available resources noted during the development of this report as believed to be currently available to respond to this need.

In general, SMCRMC is a 25 bed critical access hospital located in Osceola, AR. South Mississippi County Regional Medical Center is a 168 bed acute care medical facility located in Blytheville, AR. South Mississippi County Regional Medical Center and SMCRMC are the major hospitals in the service area. The next closest facilities are outside the service area and include:

- Crittenden Regional Hospital – a 143 bed acute care hospital located in West Memphis, AR (48 miles from Osceola; 50 minutes);
- Arkansas Methodist Medical Center – a 129 bed acute care hospital located in Paragould, AR (53.2 miles from Osceola; 1 hour and 14 minutes);
- NEA Baptist Memorial Hospital – a 100 bed acute care hospital located in Jonesboro, AR (70.74 miles from Osceola; 1 hour 12 minutes);
- St. Bernard's Medical Center – a 337 bed acute care hospital located in Jonesboro, AR (74.5 miles from Osceola; 1 hour 19 minutes);
- Pemiscot Memorial Health System – a 237 bed acute care hospital located in Hayti, MO (45.1 miles from Osceola; 46 minutes); and
- Hospitals in Memphis, TN: the closest of which is Regional Medical Center at Memphis – a 306 bed acute care facility located in Memphis, TN (56.7 miles from Osceola; 58 minutes).

[22] Response to IRS Form 990 h Part V B 1 c

Definitions of Significant Needs Listed in Highest to Lowest Rank Order of Need

1. PHYSICIANS – Top most of three local expert identified problems was accessing quality primary care physicians; Had OB/GYN visit below average impacts 41% of population; Preventable Hospital Stays admissions per 1,000, an indication of physician shortage, significantly exceeds AR average and more than double US average. This excessive rate has been relatively consistently in excess since 2003. The ratio of Population to Primary Care Physicians also indicates physician shortage as it exceeds AR and US average; No federal designation of primary care professional shortage area (HPSA) but area is qualified under federal designation as medically underserved (MUA); Primary care physicians per capita below AR average, undesirable finding; But smaller than average percent of population "lack consistent access to primary care", a desirable finding.

Issue to be addressed: Maintain the physician to population ratio

SMCRMC CURRENT SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- SMCRMC physician and midlevel recruitment.

SMCRMC IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:23

- SMCRMC will review the success of its physician recruitment process and enter discussions with the medical staff about how to construct the most desirable practice environment.

SMCRMC ANTICIPATES THE RESULTS FROM THE IMPLEMENTATION OF THIS PLAN WILL:

- Increase the utilization of the primary care resources in Mississippi County.

LEADING INDICATORS SMCRMC WILL USE TO IDENTIFY IMPROVEMENT:

- Total claims by hospital owned practices.
  - 2012 = 1401

LAGGING INDICATOR SMCRMC WILL USE TO IDENTIFY IMPROVEMENT:

- Primary care physicians per 100,000.
  - 2011 (most recent value) = 41.33 http://assessment.communitycommons.org/CHNA/Report.aspx?page=4

Other Local Resources:		
www.mchsys.org/staff/	Physician Tab on hospital home page 1520 North Division Street, Blytheville, AR 72315	870-838-7300
James Russell	1521 North 10th Street, Suite C Blytheville, AR 72315	870-762-5360

[23] This section in each need for which the hospital plans an implementation strategy responds to Schedule H (form 990) Part V Section B 6. a. and 6. b.

Tommy Wagner	434 Arkansas 18, Manila AR 72442	870-561-3300
Healthy Partners, Clinic www.eafhc.org	4102 Memorial Drive, Blytheville AR 72315	870-532-6001
Great River Charitable Clinic	33 Arkansas Street, Blytheville AR 72315	870-762-5459
E.A. Shaneyfelt	105 Baltimore, Manila AR 72442	870-561-4421
NEA Baptist Clinic, Osceola	616 West Keiser Street, Osceola AR 72370	8870-563-6070
Mississippi County Health Department Mcagov.com	1299 North 10th Street, Blytheville, AR 72315 720 West Lee Avenue, Osceola, AR 72370	870-763-7064 870-563-2521

2. CANCER – 2nd cause of death, higher than expected, Mississippi County rank #21 (#1 = worst of 75 AR CO), above AR average, A noted local expert lower order concern (after top 3 issues) included cancer; obtain Pap/Cervix test below average. impacts 52% of population; obtain Mammography Screening below average impacts 40% of population; obtain Routine Prostate Screen below average impacts 29% of population; Colorectal Screening below average impacts 22% of population; UNFAVORABLE (worse than US and Peers) death rates from Lung Cancer, Colon Cancer and Female Breast Cancer; Mammography Screenings below AR and US rates (adverse); Cancer and Colon Cancer excessive incident rates.

Issue to be addressed: Cancer detection and screening services need greater participation

SMCRMC SERVICES CURRENTLY AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

SMCRMC ANTICIPATES THE RESULTS FROM THE IMPLEMENTATION OF THIS PLAN WILL:

- Increased identification of disease at an early stage of its development.

SMCRMC WILL NOT RESPOND TO THIS NEED WITH AN IMPLEMENTATION PLAN

- Lack of resources and services.

Other local resources identified during the CHNA process, which are believed available to respond to this need, include the following:		
Boston Baskin Cancer Center	1522 North Division Street, Blytheville, AR 72315	870-762-1660
Cancer Centers of American	www.cancercenter.com	1-855-640-0013
Mississippi County Coalition for a Tobacco-Free Arkansas	www.misrgo.org	870-575-8257

St. Bernards Cancer Services	225 East Jackson, Jonesboro AR 72401 www.sbrmc.com/centeres-of-excellence/cancer-treatment-center/	870-207-4100
NEA Baptist	www.neabaptistclinic.com/aboutus/cancercenter 4808 East Johnson Avenue, Jonesboro AR 72401	870-935-4150
St. Jude Childrens Research Hospital www.stjude.org	262 Danny Thomas Pl, Memphis TN 38105	901-495-3300
West Clinic	TV Advertising	
American Cancer Society Look Good Feel Good Program	www.cancer.org	1-800-4-CANCER
Mississippi County Health Department Mcagov.com	1299 North 10th Street, Blytheville, AR 72315 720 West Lee Avenue, Osceola, AR 72370	870-763-7064 870-563-2521
Mayo Clinic	www.mayoclinic.com	480-301-8000
National Cancer Institute	www.cancer.gov	1-800-4-CANCER
Arkansas Prostate Cancer Foundation	www.arprostatecancer.org	1-800-338-1383

3. DIABETES – 6th cause of death, higher than expected, rank #23 (#1 = worst of 75 AR CO), above AR average; Third of three specific local expert concerns of the disadvantaged population groups was a set of medical condition problems similar to what exists in the population at large, diabetes, hypertension, mental service access and dental care; Chronic Diabetes above average impacts 13% of population; Diabetic Screenings below AR and US rate (adverse); Diabetes excessive incident rate.

Problem Statement: Increase diabetic awareness

SMCRMC SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- SMCRMC Diabetes management services; and
- Great River Charitable Clinic.

SMCRMC IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Coordinating efforts with the organizations listed below which offer resources responding to this need by identifying how SMCRMC services can benefit their initiatives. SMCRMC will initiate efforts by contacting each organization to establish a forum for effort collaboration;
- SMCRMC will establish an integrated approach to Diabetes by coordinating its efforts with obesity reduction efforts formulating a multi-component obesity prevention intervention initiative;[24]
- Increased public education regarding diabetes;
- Increase in compliance with disease management initiatives; and
- Establish data collection process for new diabetic patients.

LEADING INDICATOR SMCRMC WILL USE TO MEASURE PROGRESS:

- Volume of new diabetic patients at hospital owned physician practices.
    - 2012 participants = future values determined by data collection efforts

LAGGING INDICATOR SMCRMC WILL USE TO IDENTIFY IMPROVEMENT

- Percent Medicare Enrollees with Diabetes with annual exam (2010 value) = 71.66%

http://assessment.communitycommons.org/CHNA/Report.aspx?page=4&id=509.

Other local resources identified during the CHNA process, which are believed available to respond to this need, include the following:		
Great River Charitable Clinic	33 Arkansas Street, Blytheville AR 72315	870-762-5459
East Arkansas Area Agency on Aging www.e4aonline.com	120 West Highland Drive, Jonesboro AR 72401	870-236-3903
Mississippi County Health Department Mcagov.com	1299 North 10th Street, Blytheville, AR 72315 720 West Lee Avenue, Osceola, AR 72370	870-763-7064 870-563-2521
Mississippi County Hospital System www.mchsys.org	1520 North Division Street, Blytheville AR 72315	870-838-7300

[24] http://www.countyhealthrankings.org/policies/multi-component-obesity-prevention-interventions

North East Arkansas Center on Aging www.centeronagingne.com	Blytheville: 1101 David Lane, Blytheville AR 72315 Joiner: South Hwy 61, Joiner AR 72350 Leachville: 46 Cashion Route 2, Box c-9, Leachville AR 72438 Osceola: 701 North Walnut, Osceola AR 72370	Mississippi County Senior Citizens Center: 870-762-1222 Joiner Senior Citizens Center: no listed phone number Leachville Senior Citizens Center: 870-539-2331 Osceola Senior Citizens Center: 870-563-1314

4. DENTAL – Third of three specific local expert concerns of the disadvantaged population groups was a set of medical condition problems similar to what exists in the population at large, diabetes, hypertension, mental service access and dental care; No federal designation of professional shortage area for dental care.; 48.7% of residents DO NOT have recent dental exams and "poor dental health" rate exceeds AR and US average.

Problem Statement: Increase the Dentist to population ratio

SMCRMC SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- SMCRMC is able to stabilize patients presenting with dental emergencies and refer the patient for further treatment.

SMCRMC WILL NOT HAVE AN IMPLEMENTATION PLAN FOR THIS NEED

Other local resources identified during the CHNA process, which are believed available to respond to this need, include the following:		
Thomas E. Westbrook	507 Hutson Street, Blytheville AR 72315	870-762-5274
Higginbotham Family Dental	3710 East Main Street, Blytheville AR 72315	870-762-1331
Joshua Toney	519 West Main Street, Blytheville AR 72315	870-763-1000
Van O. Parker	501 North 6th Street, Blytheville AR 72315	870-763-2100
Family Dentistry	525 North 2nd Street, Blytheville AR 72315	870-763-8323
Mississippi County Health Dept Mcagov.com	1299 North 10th Street, Blytheville, AR 72315 720 West Lee Avenue, Osceola, AR 72370	870-763-7064 870-563-2521
Childrens Dental Group Pediatric Dental Specialists	646 B East Main Street, Blytheville AR 72315	870-824-6676

5. ACCESS/AFFORDABILITY – Third of three local expert identified problems Access and Availability of services; First of three specific local expert concerns of the disadvantaged

population groups was lack of basic access to medical and health care; Second of three specific local expert concerns of the disadvantaged population groups was financial access to services by uninsured; Uninsured rate is significantly better than AR rate but exceeds US rate.

Problem Statement: Local residents should not be denied access to care because of limited payment ability

SMCRMC SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- SMCRMC financial assistance policy and procedures.

SMCRMC IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Expand use of nurse practitioners; and
- Require provider training in cultural competency;
- Increase use of telemedicine as a way for patients to access qualified health and mental health professionals; and
- Encourage enrollment in existing programs such as Medicaid via outreach/education and expedited enrollment.

ANTICIPATED RESULTS FROM SMCRMC IMPLEMENTATION PLAN

- SMCRMC efforts can help address the symptoms of and results from problems of affordability and access but it can do little to impact the underlying causes of this problem which stem from unemployment, limited education, adverse lifestyle choices and other factors.

LEADING INDICATOR SMCRMC WILL USE TO MEASURE PROGRESS:

- Volume of patient financial assistance efforts should increase from 2012 volumes.
    - 2012 charity care value =$12,743

LAGGING INDICATOR SMCRMC WILL USE TO IDENTIFY IMPROVEMENT

- Percent adults without any regular doctor.
    - 2006 to 2010 (most recent data) = 15.08%

http://assessment.communitycommons.org/CHNA/Report.aspx?page=4&id=504

Other local resources identified during the CHNA process, which are believed available to respond to this need, include the following:		
Great River Charitable Clinic	33 Arkansas Street, Blytheville AR 72315	870-762-5459
Haven www.thehavenofneainc.org	P.O. Box 1062, Blytheville AR 72316	870-562-6669

Mississippi County Union Mission, Inc. www.mcunionmission.org	P.O. Box 501, 400 East Walnut Street Blytheville AR 72315	1-800-503-8380
Ministerial Alliance	Mike Welch	870-763-6041

6. COMPLIANCE BEHAVIOR/PREDISPOSING CONDITIONS – Number of residents responding I am Responsible for my Health as a belief is below average. impacts 51% of pop.; I Follow Treatment Recommendations below average impacts 35% of population; Education Metrics considerably lower than AR and ½ of US rates (an adverse finding), Unemployment exceeds AR and US average; Over 41% of "Children live in Poverty" only 26.7% in AR on average and only 19.9% in US are in poverty. This rate exceeds total of Mississippi County residents living in poverty and exceeds comparison rates to AR and US; Population with disability excessive incident rate.

Problem Statement: Increase the number of residents engaged in treatment and compliant with treatment efforts.

SMCRMC SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- SMCRMC Chronic Disease readmission prevention program
- SMCRMC Case Management Services
- SMCRMC Pharmaceutical Care program

SMCRMC IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- Continue above initiatives
- Implement diabetic education initiatives
- Collaborate with other resources

ANTICIPATED RESULTS FROM SMCRMC IMPLEMENTATION PLAN

- Increased treatment compliance

LEADING INDICATOR SMCRMC WILL USE TO MEASURE PROGRESS:

- HCAHPS percent of patients who reported that YES, they were given information about what to do during their recovery at home.
    - 10/1/2011 to 9/30/2012 results = 74%

LAGGING INDICATOR SMCRMC WILL USE TO IDENTIFY IMPROVEMENT

- The percentage of adults aged 65 and older who self-report that they have ever received a pneumonia vaccine.
    - 2005 to 2011 = 60.1% http://assessment.communitycommons.org/CHNA/Report.aspx?page=4&id=507

Other local resources identified during the CHNA process, which are believed available to respond to this need, include the following:		
Great River Charitable Clinic	33 Arkansas Street, Blytheville AR 72315	870-762-5459
East Arkansas Area Agency on Aging www.e4aonline.com	120 West Highland Drive, Jonesboro AR 72401	870-236-3903
Mississippi County Health Department Mcagov.com	1299 North 10th Street, Blytheville, AR 72315 720 West Lee Avenue, Osceola, AR 72370	870-763-7064 870-563-2521
Mississippi County Hospital System www.mchsys.org/wellness	1520 North Division Street, Blytheville AR 72315	870-838-7300
North East Arkansas Center on Aging www.centeronagingne.com	Blytheville: 1101 David Lane, Blytheville AR 72315 Joiner: South Hwy 61, Joiner AR 72350 Leachville: 46 Cashion Route 2, Box c-9, Leachville AR 72438 Osceola: 701 North Walnut, Osceola AR 72370	Mississippi County Senior Citizens Center: 870-762-1222 Joiner Senior Citizens Center: no listed phone number Leachville Senior Citizens Center: 870-539-2331 Osceola Senior Citizens Center: 870-563-1314

7. HOMICIDE – UNFAVORABLE (worse than US and Peers) death rate from Homicide; Violent Crime values exceed both the AR and about 12 times US avg. value (adverse finding); Homicide excessive incident rate.

Problem Statement: The incident of violent crime needs to decrease

SMCRMC SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- SMCRMC emergency service.

SMCRMC DOES NOT INTEND TO DEVELOP AN IMPLEMENTATION PLAN FOR THIS NEED BECAUSE:

- Resource constraints (i.e. hospital has history of low to no profitability and focus need to be on improving operations);
- Lack of expertise of competency responding to the underlying causes seem to relate to social services and law enforcement rather than to health care professionals;

- A lack of identified effective interventions to address the need; and
- Need is addressed by other facility or organization including local law enforcement and economic development.

Other local resources identified during the CHNA process, which are believed available to respond to this need, include the following:		
Blytheville Police Department www.blythevillepd.org	201 West Walnut Street, Blytheville AR 72315	870-762-0405
Mississippi County Sheriff Department www.usacops.com/ar/s72358	685 North County Road 599, Luxora AR 72358	870-762-2243
Arkansas State Police www.asp.state.ar.us	One State Police Plaza Drive, Little Rock, AR 72209	501-618-8000
Haven www.thehavenofneainc.org	P.O. Box 1062, Blytheville AR 72316	870-562-6669
Osceola Police Department	401 West Keiser Avenue, Osceola AR 72370	870-563-5213
Gosnell Policy Department www.cityofgosnell.us/gosnellpolicedepartment.html	307 South Airbase Highway, Gosnell AR 72315	870-532-8545

8. Lung – 4th cause of death, higher than expected, rank #13 (#1 = worst of 75 AR CO), above AR average; Lung Disease excessive incident rate.

Problem Statement: The number of Lung Disease related deaths needs to decrease.

SMCRMC SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- SMCRMC Physicians and medical practices as listed on hospital website;
- SMCRMC Stop smoking program; and
- SMCRMC smoke free campus and facilities.

SMCRMC IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- SMCRMC will initiate efforts by contacting each organization to establish a forum for effort collaboration; and
- Continue with current tobacco use prevention efforts.

ANTICIPATED RESULTS FROM SMCRMC IMPLEMENTATION PLAN

- Enhanced awareness will result in patients presenting earlier in the disease process.

LEADING INDICATOR SMCRMC WILL USE TO MEASURE PROGRESS:

- Percent of tobacco use of Medicaid patient who receive tobacco counseling and medication at discharge.
    - 2013 to abstract going forward

LAGGING INDICATOR SMCRMC WILL USE TO IDENTIFY IMPROVEMENT

- The percentage of adults aged 65 and older who self-report that they have ever received a pneumonia vaccine.
    - 2005 to 2011 = 60.1% http://assessment.communitycommons.org/CHNA/Report.aspx?page=4&id=507

Other local resources identified during the CHNA process, which are believed available to respond to this need, include the following:		
March of Dimes www.archofdimes.com	272 Southwest Drive, Jonesboro AR 72401	870-932-0300
Boston Baskin Cancer Center	1522 North Division Street, Blytheville, AR 72315	870-762-1660
Cancer Centers of American	www.cancercenter.com	1-855-640-0013
Mississippi County Coalition for a Tobacco-Free Arkansas	www.misrgo.org	870-575-8257
St. Bernards Cancer Services	225 East Jackson, Jonesboro AR 72401 www.sbrmc.com/centeres-of-excellence/cancer-treatment-center/	870-207-4100
NEA Baptist	www.neabaptistclinic.com/aboutus/cancercenter 4808 East Johnson Avenue, Jonesboro AR 72401	870-935-4150
West Clinic	TV Advertising	
American Cancer Society Look Good Feel Good Program	www.cancer.org	1-800-4-CANCER

Mississippi County Health Department Mcagov.com	1299 North 10th Street, Blytheville, AR 72315 720 West Lee Avenue, Osceola, AR 72370	870-763-7064 870-563-2521
Mayo Clinic	www.mayoclinic.com	480-301-8000
National Cancer Institute	www.cancer.gov	1-800-4-CANCER

9. Stroke – 3rd cause of death, higher than expected, rank #29 (#1 = worst of 75 AR CO), above AR average; SOME CONCERN as rate exceeds Peers or US avg. for Stroke; Stroke deaths higher than US rate; excessive stroke deaths for Black Non-Hispanic and White Non-Hispanic. Data insufficient for other population segment comparisons

Problem Statement: The incident of death from Strokes needs to decline

SMCRMC SERVICES AVAILABLE TO RESPOND TO THIS NEED INCLUDE:

- SMCRMC Swing Bed Services;
- SMCRMC Emergency service;
- SMCRMC Physical and Speech Therapy program for neurological impairments;
- STROKE Telemedicine program with UAMS;
- Stroke registry;
- Community health outreach (twice monthly); stroke program at high school; and
- Monthly stroke drills.

SMCRMC IMPLEMENTATION PLAN PROGRAMMATIC INITIATIVES:

- SMCRMC will enhance efforts to make residents aware of stroke symptoms and benefits from rehabilitation.

ANTICIPATED RESULTS FROM SMCRMC IMPLEMENTATION PLAN:

- Patients having stroke related degenerative conditions would have enhanced restorative and coping skills; and
- Increased public awareness of stroke indications resulting in increased presentation of patients earlier in the condition onset where intervention is most effective.

LEADING INDICATOR SMCRMC WILL USE TO MEASURE PROGRESS:

- Portion of patients presenting with stroke indications in the emergency service receiving beneficial therapeutic intervention.
    - 2012 stroke victims receiving telemedicine services for stroke = program began November of 2012 with 0 victims in November/December.

LAGGING INDICATOR SMCRMC WILL USE TO IDENTIFY IMPROVEMENT:

- Age-Adjusted Death Rate, Stroke Mortality (Per 100,000 Pop.).
  - 2006-2010 (most recent) = 69.51 http://assessment.communitycommons.org/CHNA/Report.aspx?page=6&id=625

Other local resources identified during the CHNA process, which are believed available to respond to this need, include the following:		
Mississippi County Hospital System www.mchsys.org/services	www.mchsys.org	870-838-7300
University of Arkansas for Medical Services (UAMS) www.uams.edu/angels/clinical_telemidicine/	University of Arkansas for Medical Sciences Office of Institutional Advancement 4301 West Markham # 716 Little Rock, AR 72205-7199	501-526-7425
Arkansas Department of Health www.healthy.arkansas.gov/	4815 West Markham Street Little Rock, AR 72205	501-661-2000
University of Arkansas for Medical Sciences (AR SAVES) http://arsaves.uams.edu/	University of Arkansas for Medical Sciences Office of Institutional Advancement 4301 West Markham # 716 Little Rock, AR 72205-7199	501-526-7425
St. Bernards Medical Center www.sbrmc.com	225 East Jackson, Jonesboro, AR 72401	870-207-4100
Health South Rehabilitation Hospital of Jonesboro www.healthsouthjonesboro.com	1201 Fleming Avenue, Jonesboro, AR 72401	870-932-0440
Elmcroft of Blytheville www.elmcroft.com/senior-living	1401 East Moultrie Drive, Blytheville, AR 72315	870-838-0033
Methodist of Memphis www.methodisthealth.org	1265 Union Avenue, Memphis TN 38104	901-516-7000
American Heart Association www.heart.org	909 West 2nd Street Little Rock, AR 72203	501-707-6600

Definitions of Other Identified Needs Listed in Rank Order of Need

10. PRIORITY POPULATION – Generally local experts considered low-income residents as disadvantaged. Three local experts did not identify any unique needs and three of 20 responses indicated no unique concerns or there was "a false proposition that access to

healthcare, other than basic disease inoculation and life-threatening emergencies, is some sort of Constitutional "right" would be a good place to start."; Children in Poverty and Children in Single-Parent Households values both exceed AR and about double US average (adverse finding); Inadequate Social Support values exceed both the AR and about double US values (adverse finding).

11. CORONARY HEART DISEASE – Leading cause of death, death rate higher than expected, Mississippi County ranks #1 (#1 = worse of 75 AR CO), death rate well above AR average, A noted local expert lower order concern (after top 3 issues) included heart problems; Obtain Cardiac Stress Test 14% below average impacts 13% of population; Chronic Heart Disease above average impacts 10% of population; UNFAVORABLE (worse than US and Peers) death rate for Coronary Heart Disease; Heart Disease Mortality during 2008 to 2010 much higher than US and AR average rate; Black Non-Hispanic population, White Non-Hispanic and Asian/Pacific Islanders the heart death rate exceed US and AR rates. Data insufficient for other population segment comparisons.
12. MENTAL HEALTH/SUICIDE – Third of three specific local expert concerns of the disadvantaged population groups was a set of medical condition problems similar to what exists in the population at large, diabetes, hypertension, mental service access and dental care; UNFAVORABLE (worse than US and Peers) death rate for Suicide; MS CO federal designated Mental Health Professional Shortage Area (HPSA).
13. OBESITY/OVERWEIGHT – Second of three local expert identified problems; Engage in Vigorous Exercise below average impacts 47% of population; Morbid Obese above average impacts 30% of population; Healthy Eating Habits below average impacts 24% of population; Very Unhealthy Eating Habits above average impacts 4% of population; Physical Inactivity significantly exceed AR average rate more than double US rate; Adult Obesity statistically exceeds AR and US average.; Obesity excessive incident rate; fast food restaurants exist at rate above AR average
14. CHRONIC COPD/PULMONARY – Chronic Allergies above avg. impacts 26% of pop.; Chronic COPD above avg. impacts 5% of pop.; Asthma excessive incident rates.
15. LIFE EXPECTANCY/PREMATURE DEATH – Premature Death (potential life lost before age 75) significantly exceeds AR rate, more than double US rate and shows a three year increasing trend while AR and US rates declined; Male Life expectancy increased, however, a highly unusual finding is life expectancy for Women declined.

16. PREVENTION – Poor or Fair Health, Poor Physical Health Days and Poor Mental Health Days are higher values (adverse indicators) than AR average and significantly higher than US goals.
17. SMOKING/TOBACCO USE – Use tobacco products/smoke above average impacts 35% of population; Adult Smoking significantly exceed AR average rate more than double US rate; 29.4% of resident smoke a rate above AR and US average.
18. EMERGENCY SERVICES – A noted local expert lower order concern (after top 3 issues) included emergency service; Emergency Room Use above avg. impacts 38% of population.
19. MATERNAL AND INFANT MEASURES – BETTER performance than Peers and US rates for Births to Women Age 40-54; SOME CONCERN as rate exceeds Peers or US average for Black Non-Hispanic Infant Mortality and Post-Neonatal Infant Mortality; UNFAVORABLE (worse than US and Peers death rates) for Low Birth Weight, Very Low Birth Weight, Premature Births, Births to Women Under 18, Births to Unmarried Women, No Care in First Trimester, Infant Mortality, White Non-Hispanic Infant Mortality and Neonatal Infant Mortality; Low Birth Weight Births exceed the AR rate and nearly double US rate; Teen Birth Rate exceeds AR average. and about 400% in excess of US rate.
20. ALZHEIMER'S – 10th cause of death but occurs at rate lower than expected, rank #59 (#1 = worst of 75 AR CO), below AR average.
21. SEXUALLY TRANSMITTED DISEASE – Sexually transmitted disease significantly exceed AR rate more than 10 times US rate; Chlamydia and Gonorrhea excessive incident rates.
22. ACCIDENTS – 5th cause of death, higher than expected, rank #28 (#1 = worst of 75 AR CO), above AR average.; BETTER performance than Peers and US rates for Unintentional Injury; SOME CONCERN as rate exceeds Peers or US average for Motor Vehicle Injuries; Motor Vehicle Crash Deaths significantly exceed AR average rate more than double US rate; Accident Mortality excessive incident rates; Motor Vehicle Deaths excessive incident rate.
23. BLOOD PRESSURE (High) – Third of three specific local expert concerns of the disadvantaged population groups was a set of medical condition problems similar to what exists in the population at large, diabetes, hypertension, mental service access and dental care; Chronic High Blood Pressure above average impacts 29% of population.

24. FLU/PNEUMONIA – 7th cause of death, higher than expected, rank #26 (#1 = worst of 75 AR CO), above AR average.
25. ALCOHOL ABUSE – Excessive Drinking below AR average and equals US rate.
26. CHOLESTEROL (HIGH) – The sole beneficial finding in population characteristic analysis was the incident of Chronic High Cholesterol 7% below average impacts 21% of population; Obtain routine cholesterol screening below average impacts 43% of population.
27. KIDNEY – 8th cause of death, higher than expected, rank #11 (#1 = worst of 75 AR CO), above AR average.
28. BLOOD POISONING – 9th cause of death, death rate as expected, rank #9 (#1 = worst of 75 AR CO), above AR average.
29. CHRONIC OSTEOPOROSIS (bone disease)/CHRONIC LOWER BACK – Chronic Lower Back Pain above average impacts 27% of population; Chronic Osteoporosis above average impacts 11% of population.
30. PALLIATIVE CARE & HOSPICE – Palliative care programs do not exist in CO, Hospice programs do exist.
31. PHYSICAL ENVIRONMENT – Air pollution statistically excessive of AR and US average Access to recreational facilities is at half the AR Rate and ¼ of US rate. Drinking Water Safety at AR average but vastly inferior to US rate.

Overall Community Need Statement and Priority Ranking Score:

Significant Needs Where Hospital Developed Implementation Plan

1. PHYSICIANS;
3. DIABETES;
5. ACCESS/AFFORDABILITY;
6. COMPLIANCE BEHAVIOR/PREDISPOSING CONDITIONS;
8. LUNG; and
9. STROKE.

Significant Needs Where Hospital Did Not Develop Implementation Plan[25]

2. CANCER;

[25] Reference Schedule H (Form 990) Part V Section B 7

4. DENTAL; and

7. HOMICIDE.

Other Needs Where Hospital Developed Implementation Plan

(None)

Other Needs Where Hospital Did Not Develop Implementation Plan

10. PRIORITY POPULATION;

11. CORONARY HEART DISEASE;

12. MENTAL HEALTH/SUICIDE;

13. OBESITY/OVERWEIGHT;

14. CHRONIC COPD/(LUNG DISEASE)/PULMONARY;

15. LIFE EXPECTANCY/PREMATURE DEATH;

16. PREVENTION inc. Education and Motivation to make responsible health decisions;

17. SMOKING/TOBACCO USE;

18. EMERGENCY SERVICES;

19. MATERNAL AND INFANT MEASURES;

20. ALZHEIMER'S;

21. SEXUALLY TRANSMITTED DISEASE;

22. ACCIDENTS;

23. BLOOD PRESSURE (High);

24. FLU/PNEUMONIA;

25. ALCOHOL ABUSE;

26. CHOLESTEROL (HIGH);

27. KIDNEY;

28. BLOOD POISONING;

29. CHRONIC OSTEOPOROSIS/CHRONIC LOWER BACK;

30. PALLIATIVE CARE & HOSPICE; and

31. PHYSICAL ENVIRONMENT.

APPENDIX

Appendix A – Area Resident Survey Response[26]

A total of 23 residents participated in an on-line survey to offer opinions regarding their perceptions of community health needs.

The first question was open-ended: "In your own words ...What do you believe to be the most important health or medical issue confronting the residents of your County?"Answers were placed in a "Word Cloud" format for analysis and generated the following image:

Word Clouds are analytical tools which give greater visual prominence to words appearing more frequently in the source text. This information visualization establishes a portrait of the aggregate responses, presenting the more frequently used terms with greater text size and distinction in the visual depiction. Common article words (i.e., "a," "the," etc.), non-contextual verbs (i.e., "is," "are," etc.) and similar words used when writing sentences are suppressed by this application.

The specific comments we received were as follows:

- Access to primary care and additional care without leaving the county.
- Lack of available qualified medical professionals, especially primary care physicians and a modern hospital with specialists within the county. Access to primary doctors is extremely limited since many won't take new patients. People will use the emergency rooms as their first medical contact instead of obtaining acute and/or preventive care at their doctor's

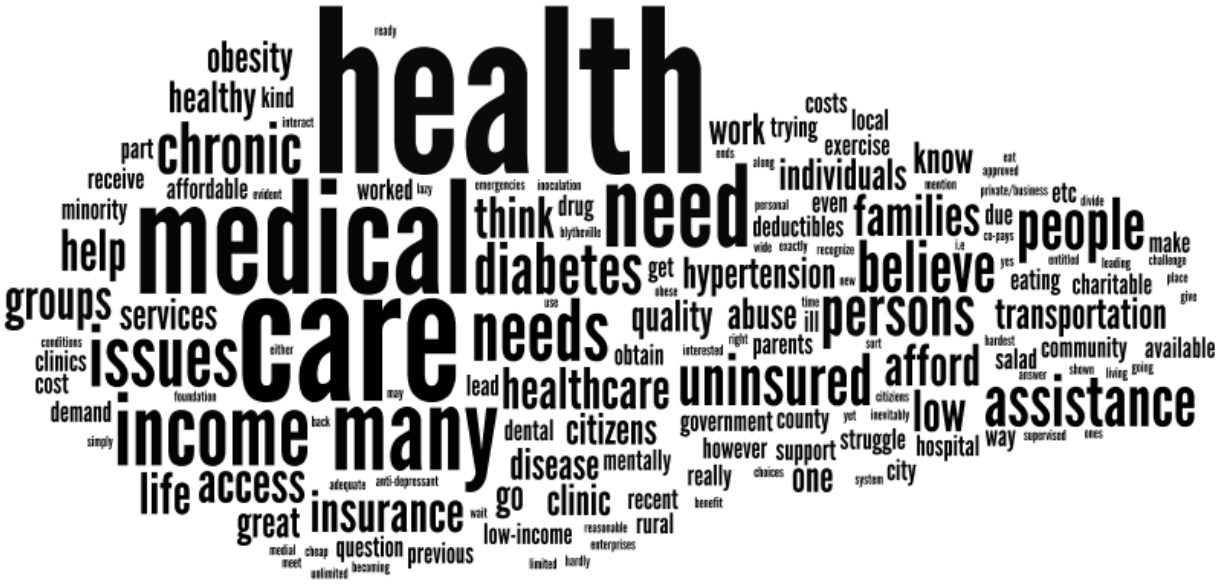
[26] Responds to IRS Schedule H (Form 990) Part V B 1 h

office. People have to travel 50-60 miles to get diagnostic and specialized care. Confidence in the hospitals within the county is extremely low.

- High cancer rates
- Inadequate number and quality of primary care physicians.
- Continued access to quality healthcare which would include a county hospital, a variety of physicians representing all areas of healthcare, physicians working in cooperation with the hospital, an urgent care center opened at nights and on weekends.
- the lack of local physicians who admits & follows patient in local hospital
- The long term sustainability of our hospital system.
- Obesity. Teen births.
- I believe the most important health or medical issue confronting the residents of Mississippi County is obesity.
- Access to specialized medical services.
- Emergency medical care
- Availability of health care and UHC partnership by health care providers is essential to our plant population
- The most pressing need is more quality primary care providers. Much more mental health care is needed, including clinical diseases and life experiences situations (ex. grief and loss management). Better collaboration with medical specialist and institutions is improving but needs to improve. An effort to build trust within the community for the quality of health care available locally.
- I believe that obesity, and all the related problems that arise from obesity, as well as mental health issues, such as depression, afflict many of our residents.
- "Cancer
- Obesity
- Back issues"
- getting people covered (getting people off of the emergency room program)
- Cancer
- Long-term availability of/access to general practitioners
- Expanding the services that are offered here in Mississippi County with equipment and more doctors, so that people here won't have to go to other areas (Memphis and Jonesboro) for treatment.

- I would have to say heart disease is the most important health issues. As a daughter of parents that both have heart problems, it is a very big part of our lives. Obesity contributes to the problems. It seems like more and more people are being diagnosed with HTN, CAD, and other heart problems. My father had a massive MI last year, and almost did not survive.
- I think easy access to well-qualified medical personnel is a major issue. I use physicians in another county where I can make an appointment, see the doctor at the appointed time, and receive quality care. The physician shortage in Mississippi County results in long waits with a sense of being "rushed" when one finally gets to see the doctor.
- There is an issue with professionalism in staff of the offices around here, I feel as though if I go somewhere for treatment of a migraine the doctor should know to turn his music either down or off. Overall hospitality of staff is something that is easily trainable and should be emphasized more within the hiring process, more than likely if someone is walking into a doctor's office or the hospital it is not for a good or happy reason therefore, the staff that is there should be as happy as possible to counteract the very nature of their business.

We then asked the participants to respond to the question" Do you perceive there are any primary and/or chronic disease needs, as well as potential health issues, of uninsured persons, low-income persons, minority groups and/or other population groups (i.e. people with certain situations) which need help or assistance in order to improve? If you believe any situation as described exists, please also indicate who you think needs to do what."



Specific comments were as follows:

The hospital needs to function like a network of urgent care facilities.

- Single parents with low income and an inability to afford medical care even if they have a medical plan available. Co-pays and deductibles are costs they cannot afford when trying to pay rent, utilities, transportation, childcare, food, etc. Most wait to obtain medical care for themselves and their families when a medical condition becomes acute and may have already become a chronic issue (i.e., hypertension, diabetes, etc.). If local officials could use part of the county tax receipts to help qualifying families who have medical insurance but can't afford deductibles and copays then the potential to help individuals/families prevent medical issues from becoming chronic/severe. If a foundation could be established through a partnership of local government and private/business donations then the health of the county's residents could be positively impacted.
- Rural Health Clinics are ready available to the uninsured at a reasonable rate. Travel to the doctor's office or Rural Health clinics is an obstacle for many. City Bus transportation would help with transportation
- Drug abuse, hypertension, diabetes. Need a community wide approach to educate citizens on lifestyle choices that impair health. Any effort to improve quality of life would be beneficial.
- There is a large group of citizens with low income and chronic health issues. Many individuals do not qualify for Medicaid, Medicare or other health related services and are unable to obtain medical care. There are also a great many citizens that are uninsured due to the cost of health insurance even though they are employed.
- Obesity and the chronic health conditions which lead to and grow out of it. This needs much more involvement from our hospital, supported by our health department, schools, libraries and other interested and involved parties.
- Create a more exercise and fitness activities
- As stated in the previous question I believe obesity, due to unhealthy diets and lack of exercise, is one of the major health issues facing our citizens. The hardest part for many population groups is eating healthy at low cost. You can eat healthy without eating a salad however many do not know how to and many cannot afford to.
- I am not really in a position to recognize specific health issues that might need attention. However, in reading the results of the recent medical clinic done by the military, there was a very high demand for dental work.
- No
- "Obesity, diabetes, hypertension are persistent, chronic medical needs.
- The mentally ill have very limited resources, few practitioners, few services, no supervised living. The families with mentally ill members have no support.
- I expect care of aging parents is going to be an increasingly larger challenge.

- People with new access to health care via Affordable Care Act will need to learn how to effectively access health care and appropriately interact with the system.
- There is a social/class/racial divide in the community about quality of medicine locally. I know many upper income folks who go out of town for routine medical services."
- I believe that there are many people in our city who are either under insured or simply do not have insurance. This is evident by the turnout shown at the recent Operation Healthy Delta. From my observation the need for dental work as well as optometry was great. I believe that the Mississippi County Charitable Clinic, in Blytheville, serves a great need. In my opinion, expanding the Charitable Clinic and ensuring they have what they need will help bridge the gap for those in need.
- I believe the primary/and or chronic disease needs of uninsured, low-income persons, minority groups involves alcoholism and drug abuse and the health issues that go along with those diseases.
- uninsured, and pain and anti-depressant abuse
- Yes there are needs and I believe that everyone should be entitled to affordable health care. I think health care should be based on a persons income, but not as a crutch to lazy people.
- Unlimited access to healthcare by uninsured and/or low-income persons is leading/will lead to 1) skyrocketing costs for people with insurance and self-pays, not to mention the healthcare enterprises themselves, 2) demand for healthcare outstripping supply, leading inevitably to rationing of care, and 3) deterioration of the quality of care as a result of the first two factors. In terms of solutions, pushing back against the false proposition that access to healthcare, other than basic disease inoculation and life-threatening emergencies, is some sort of Constitutional "right" would be a good place to start.
- I am sure there are, but I don't really know exactly what they would be, so I don't think that could give a very educated answer on that one.
- I do think the lower income families need assistance with their medical needs. For instance, my father, as discussed in previous question has yet to receive government assistance. He worked his entire life from the time he was 14 years old. He is now 60. He cannot get approved for assistance of any kind. My mother is working trying to support the household but from personal experience, one income does not go very far. I feel that this day and age, individuals that have hardly worked can work get more assistance than the ones that struggle to make some kind of life for themselves. Low income persons, minority groups, and other persons struggle with heart disease and diabetes. Most are obese. It is cheaper to buy $1 hamburger than to fix a salad. Most people choose the cheap way out to make ends meet. Diet and way of life contributes to some of the medial problems.

- I have concerns for individuals who fail to receive adequate pre-natal care, those who have diabetes, and children in school with attention-deficit disorders. I think those are groups who have health issues that could benefit from additional assistance.

Appendix B – Process to Identify and Prioritize Community Need[27]

Priority Ranked Community Health Need	Local Expert Advisor		% of Total Response	Cummulative Response	Point Break from Preceding Need	Need Determination
	Total Votes	Number of Advisors voting				
1. PHYSICIANS	133	11	12.09%	12.09%		Significant Need
2. CANCER	103	8	9.36%	21.45%	30	
3. DIABETES	79	9	7.18%	28.64%	24	
4. DENTAL	71	9	6.45%	35.09%	8	
5. ACCESS / AFFORDABILITY	64	7	5.82%	40.91%	7	
6. COMPLIANCE BEHAVIOR / PREDISPOSING CONDITIONS	63	6	5.73%	46.64%	1	
7. HOMICIDE - UNFAVORABLE	58	7	5.27%	51.91%	5	
8. LUNG	40	8	3.64%	55.55%	18	
9. STROKE	38	8	3.45%	59.00%	2	
10. PRIORITY POPULATION	36	5	3.27%	62.27%	2	Other Identified Needs
11. CORONARY HEART DISEASE	33	6	3.00%	65.27%	3	
12. MENTAL HEALTH / SUICIDE	32	7	2.91%	68.18%	1	
13. OBESITY/OVERWEIGHT	30	6	2.73%	70.91%	2	
14. CHRONIC COPD / PULMONARY	29	6	2.64%	73.55%	1	
15. LIFE EXPECTANCY / PREMATURE DEATH	28	7	2.55%	76.09%	1	
16. PREVENTION inc Education and Motivation to make responsible health decisions	28	7	2.55%	78.64%	0	
17. SMOKING / TOBACCO USE	24	7	2.18%	80.82%	4	
18. EMERGENCY SERVICES	23	6	2.09%	82.91%	1	
19. MATERNAL AND INFANT MEASURES	23	5	2.09%	85.00%	0	
20. ALZHEIMER'S	22	6	2.00%	87.00%	1	
21. SEXUALLY TRANSMITTED DISEASE	21	8	1.91%	88.91%	1	
22. ACCIDENTS	21	5	1.91%	90.82%	0	
23. BLOOD PRESSURE (High)	16	5	1.45%	92.27%	5	
24. FLU / PNEUMONIA	16	5	1.45%	93.73%	0	
25. ALCOHOL ABUSE	12	5	1.09%	94.82%	4	
26. CHOLESTEROL (HIGH)	12	5	1.09%	95.91%	0	
27. KIDNEY	12	4	1.09%	97.00%	0	
28. BLOOD POISONING	11	5	1.00%	98.00%	1	
29. CHRONIC OSTEOPOROSIS / CHRONIC LOWER BACK	8	5	0.73%	98.73%	3	
30. PALLIATIVE CARE & HOSPICE	8	4	0.73%	99.45%	0	
31. PHYSICAL ENVIRONMENT	6	4	0.55%	100.00%	2	
Total	1,100	11	100.00%			

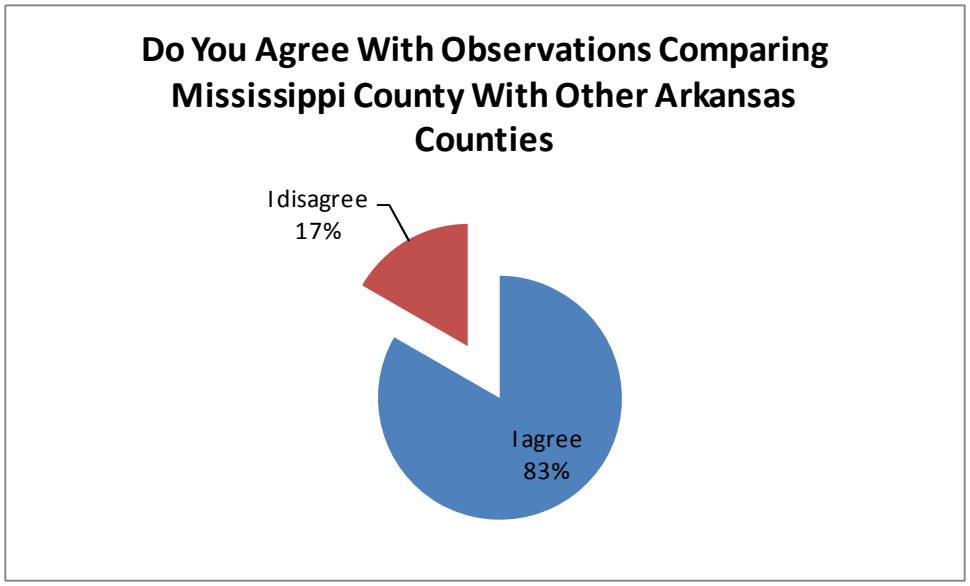
[27] Responds to IRS Schedule H (990) Part V B 1. g. and V B 1. h. NOTE In the ranking process, one Local Expert allocated 3 points to a reserve to be used for identifying an additional need, different from the prior 27 identified issues. The new issue was not identified by the Local Expert. Accordingly, a 28th need was not identified.

Individuals Participating as Local Expert Advisors in Either/Both Rounds of Survey Input

Organization	Position	Area of Expertise
SourceGas	Division Manager	Business
Health Department	Local Health Nurse	public health
Folkner	RN Safety and Health	long time nurse in community
Gibson Oil Co Inc	President	long term resident
Town of Etowah	Mayor	Management
Great River Medical Center	Physician	Physician and long time resident
American Greetings	Plant Manager	.
Holmes Financial Services, Inc.	Owner	resident, 40 years
Harshman Rentals	Owner	business owner long ter resident
First National Bank of Eastern Arkansas	Sr. Vice President	Banking
City of Blytheville	Mayor	Long term area resident, Mayor
Arkansas Northeastern College	President	education, long-term resident
Denso Manufacturing Arkansas, Inc.	Administration Manager	Human Resource responsibility for 500 associates in addition to family members
BancorpSouth Bank/City Council of Wilson	Loan Officer / Alderman Ward 1 Position 1	Long term area resident
Nucor-Yamato Steel Co.	Controller	Industry
Mississippi County Library System	Assistant Director	Public health outreach
Westminster Village	Executive Director	Non profit retirement community
That Bookstore in Blkytheville	retired	long term resident and business owner
Main Street Blytheville	Executive Director	Tourism, Economic Development
NIBCO Inc	HR Manager	representative of benefits
gunn's supermarket	owner	retail, long term resident, people
County Goverment	County Judge	CEO of County Govt
Blytheville Schools	Superintendent	Educational expert
Armorel School District	Superintendent	education
ANC	instructor	engineer
Healing in the Hood, Inc	Director	Mentor
ADH- Miss. Co. Health Dept.	LPN	Public Health
Arkansas Department Of Health	R.N.	Public Health
The Episcopal Church	Vicar	faith, and faith based community action
Tenaris	Community Relations Specialist	Long Term Resident/Community Concerns

Advice Received from Local Experts

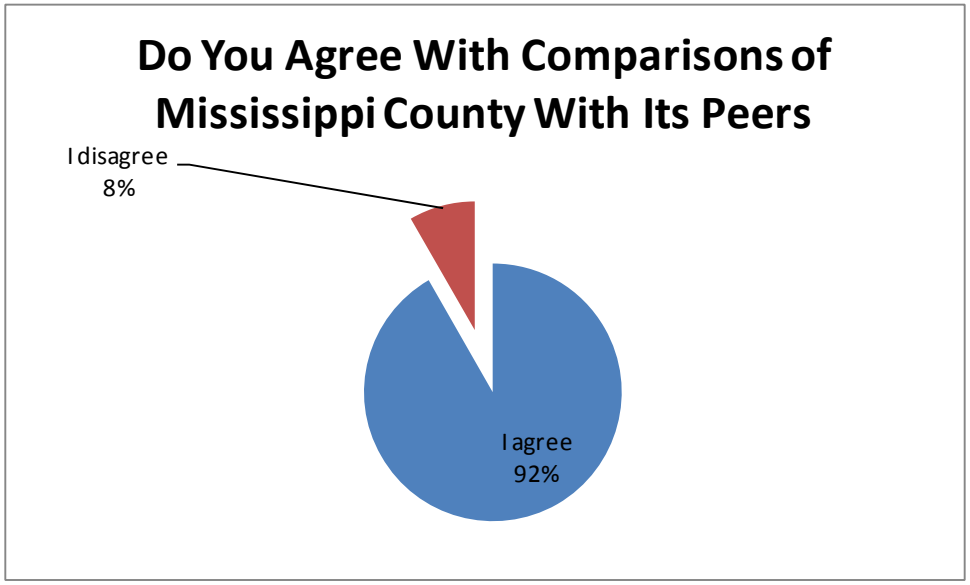
Q. Do you agree with observations formed about the comparison of Mississippi County to all other Arkansas counties?



Clarifying Comments:

- The information presented above may at one time be close to accurate, I feel Health Care in Mississippi County has improved in the last 3 years,
- I believe there are more uninsured and there aren't enough services for people
- In general, these facts are consistent with other facts I have seen. I am surprised at the Air pollution comment.

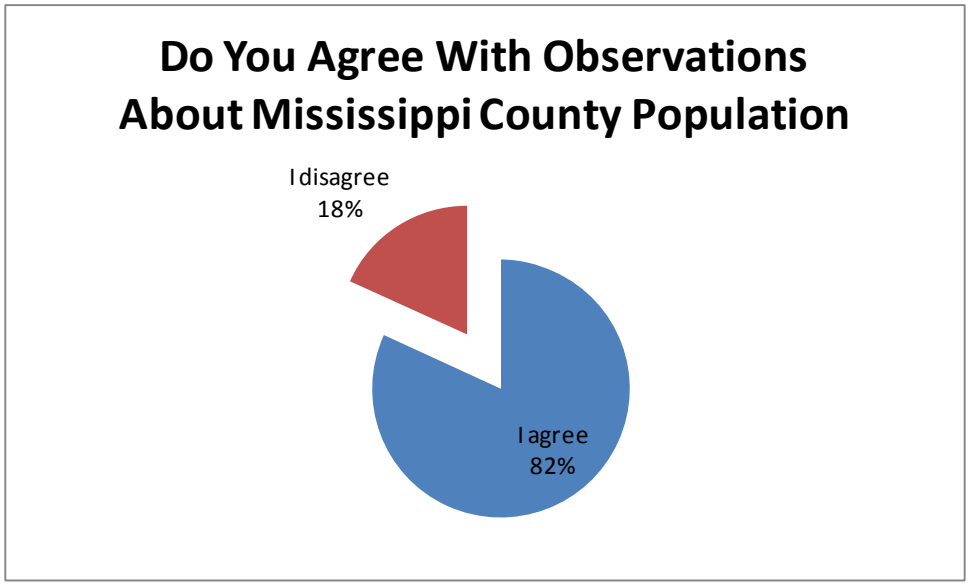
Q. Do you agree with observations formed about the comparison of Mississippi County to its Peer counties?



Clarifying Comments:

- (none)

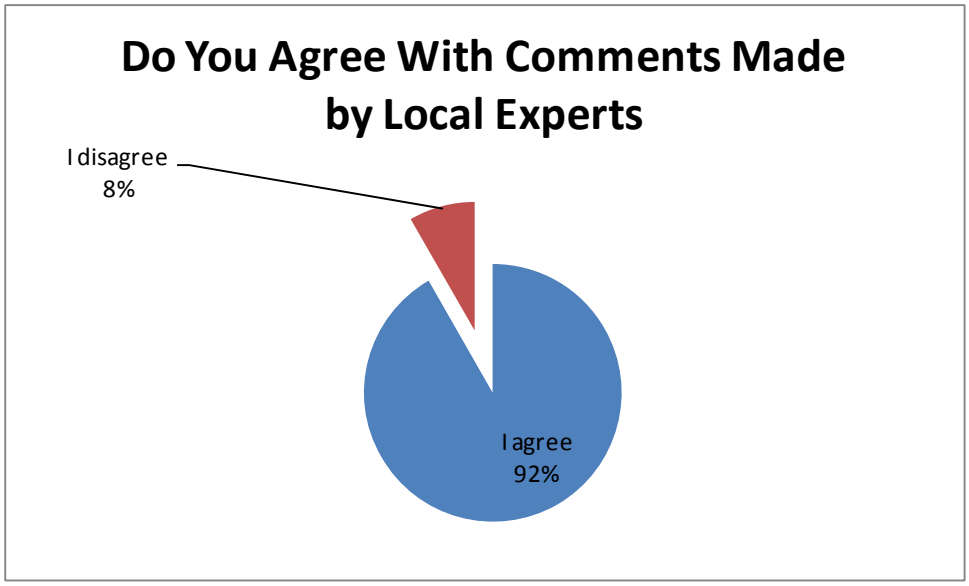
Q. Do you agree with observations formed about population characteristics of Mississippi County?



Clarifying Comments:

- I believe those numbers are incorrect
- Interesting to note that Chronic High Cholesterol is better than averages, but eating habits are worse.

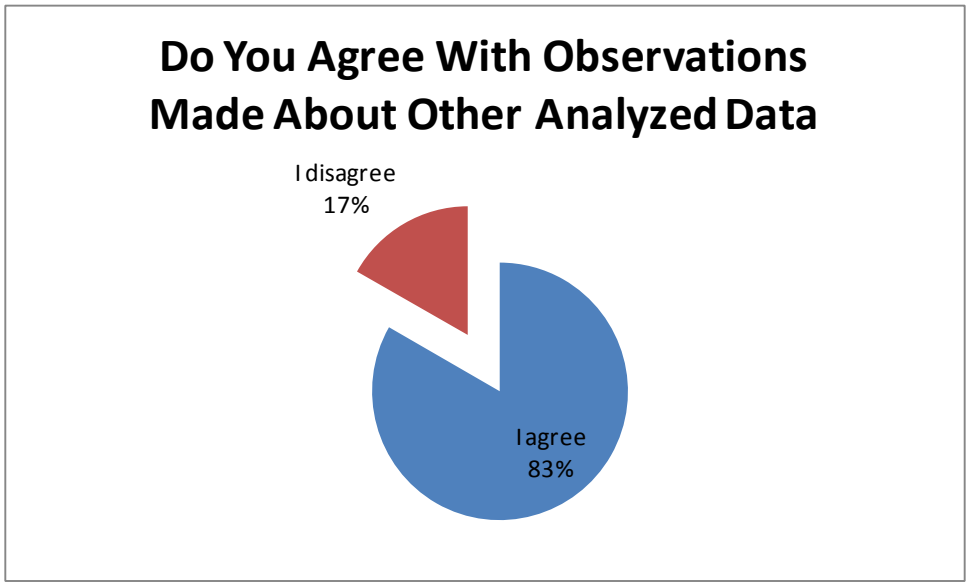
Q. Do you agree with observations formed about the opinions from local residents?



Clarifying Comments:

- we do have problems reaching doctors here, also there is no clear cut price for tests or procedures for non insured persons
- Not enough specialists in the county. Mississippi County residents must travel to other counties or other states for many services. Not all Primary Care physicians refer enough patients on to specialists when they do not know what is wrong with a patient, therefore the patient does not get help until too late.
- Specifically, I do not agree with the final response above regarding the entitlement attitude.

Q. Do you agree with observations formed about additional data analyzed about Mississippi County?



Clarifying Comments:

- Hospice care exists.

Appendix C – Illustrative Schedule H (Form 990) Part V B Potential Response[28]

Community Health Need Assessment Answers

1. ***During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)? If "No," skip to line 9***

   Illustrative Answer – Yes

   If "Yes," indicate what the Needs Assessment describes (check all that apply):

   a. ***A definition of the community served by the hospital facility;***
   b. ***Demographics of the community;***
   c. ***Existing health care facilities and resources within the community that are available to respond to the health needs of the community;***
   d. ***How the data was obtained;***
   e. ***The health needs of the community;***
   f. ***Primary and chronic disease needs and health issues of uninsured persons, low-income persons and minority groups;***
   g. ***The process for identifying and prioritizing community health needs and services to meet the community health needs;***
   h. ***The process for consulting with persons representing the community's interests;***
   i. ***Information gaps that limit the hospital facility's ability to assess all of the community's health needs; and***
   j. ***Other (describe in Part VI)***

   Illustrative Answer – check a. through i. Answers available in this report are found as follows:

   1. a. – See Footnotes #15 (page 11) and #16 (page 11);

   1. b. – See Footnotes #17 (page 12);

   1. c. – See Footnote #22 (page 28);

   1. d. – See Footnotes #7 (page 6);

   1. e. – See Footnotes #12 (page 8);

   1. f. – See Footnotes #9 (page 8); and #11 (page 8);

[28] Questions are drawn from 2012 Schedule H Forms (as of January 16, 2013) and may have changed at the time when the hospital is to make its 990 h filing

1. g. – See Footnote #27 (page 54);

1. h. – See Footnote #8 (page 8), #13 (page 8), #26 (page 48) and #27 (page 54;

1. i. – See Footnote #6 (page 6); and

1. j. – No response needed.

2. ***Indicate the tax year the hospital facility last conducted a Needs Assessment: 20 _ _***

Illustrative Answer – 2013

See Footnote #1 (Title page)

3. ***In conducting its most recent CHNA, did the hospital facility take into account input from representatives of the community served by the hospital facility, including those with special knowledge of or expertise in public health? If "Yes," describe in Part VI how the hospital facility took into account input from persons who represent the community, and identify the persons the hospital facility consulted.***

Illustrative Answer – Yes

See Footnotes #10 (page 8)

4. ***Was the hospital facility's CHNA conducted with one or more other hospital facilities? If "Yes," list the other hospital facilities in Part VI.***

Illustrative Answer – Yes (Great River Medical Center)

5. ***Did the hospital facility make its CHNA report widely available to the public? If "Yes," indicate how the Needs Assessment was made widely available (check all that apply)***

    a. ***Hospital facility's website;***
    b. ***Available upon request from the hospital facility; and***
    c. ***Other (describe in Part VI).***

Illustrative Answer – check a. and b.

The hospital will need to obtain Board approval of this report, document the date of approval and take action to make the report available as a download from its web site. It also may be prudent to place a notice in a paper of general circulation within the service area noting the report is available free upon request.

6. ***If the hospital facility addressed needs identified in its most recently conducted Needs Assessment, indicate how (check all that apply):***

    a. ***Adoption of an implementation strategy that addresses each of the community health needs identified through the CHNA;***
    b. ***Execution of an implementation strategy;***

c. Participation in the development of a community-wide community plan;
d. Participation in the execution of a community-wide plan;
e. Inclusion of a community benefit section in operational plans;
f. Adoption of a budget for provision of services that address the needs identified in the CHNA;
g. Prioritization of health needs in its community;
h. Prioritization of services that the hospital facility will undertake to meet the needs in its community; and
i. Other (describe in Part VI).

Illustrative Answer – check a, b, g, and h.

6. a. – See footnote #23 (page 29);

6. b. – See footnote #23 (page 29);

6. g. – See footnote #14 (page 9); and

6. h. – See footnote #14 (page 9).

7. Did the hospital facility address all of the needs identified in its most recently conducted CHNA? If "No," explain in Part VI which needs it has not addressed and the reasons why it has not addressed such needs?

Illustrative Answer – No

Part VI suggested documentation – See Footnote #25 (page 45)

8. a. Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?
b. If "Yes" to line 8a, did the organization file Form 4720 to report the section 4959 excise tax?
c. If "Yes" to line 8b, what is the total amount of section 4959 excise tax the organization reported on Form4720 for all of its hospital facilities?

Illustrative Answer – No